



PATIENT

KitKat Fargo

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

5 years

PRESENTING CLINICAL SIGNS

History: Acute presentation: Apparently painful, vocalizing and unable to use his right hind.

-Abnormal PE/Chem/CBC/UA Results: BAR, vocalizing and painful, eyes normal, peripheral lymph nodes unremarkable, ears clear, hydration reasonable, oral examination NSF, increased respiratory rate and effort, extreme tachycardia, abdominal palpation NSF, bloody diarrhea fecal staining over the perianal region. Neutropenia and monocytopenia (significance not clear). Stress hyperglycemia.

-Current medications: We started furosemide at 2mg/kg Q8, pimobendan 1.25mg Q12, heparin and will institute clopidogrel Q24.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is moderate to severely hypertrophied. There is a diffusely hyperechoic endocardium consistent with fibrosis.

There is severe papillary muscle hypertrophy and remodeling. The left atrium is markedly enlarged. Significant intraatrial smoke without an obvious thrombus. The right atrium is normal in size. The right ventricle appears normal. The mitral valve is normal. No evidence of systolic anterior motion. There is mild central mitral regurgitation present, secondary to SAM. There is trace tricuspid regurgitation. Blood flow through both the LVOT and RVOT is decreased in velocity. Scant pericardial effusion, No obvious pleural effusion is visualized.

CARDIAC CHART

WEIGHT

9.7lbs

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

IMAGING PERFORMED BY

Alastair Westcott,
DVM

HOSPITAL NAME

Dr. Alastair Westcott,
DVM

REFERRING VET

Dr. Westcott

INVOICE

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FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm) <small>(Moise, Pipers)</small>	LVIDd (cm) <small>(Moise, Pipers)</small>	LVWd (cm) <small>(Moise, Pipers)</small>	FS (%)	EF (%)
NORMAL PARAMETER	-----	150-240	0.35-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	4.4	NM	0.81	1.2	0.82	63	93
FELINE CARDIAC PARAMETERS	LA/AO <small>(Boon)</small>	LA/AO HEART BASE <small>(Swe) (Abbott)</small>	LA 2D short axis Base view (cm) <small>(Abbott)</small>	LVOT VEL <small>(m/s)</small>	RVOT VEL <small>(m/s)</small>	E max <small>(m/s)</small>	
NORMAL	<1.5	<1.3	<1.2	<1.6	<1.3	<0.9	
PATIENT	NM	2.7	2.66	0.61	0.75	NM	
<p><i>*Note: All measurements based upon multi-modal images and methods. An average value is reported.</i> Adapted from June Boon, Veterinary Echocardiography, 1998 Abbott J & MacLean H JVIM 2006;20: 111-119, Moise et al. Am J Vet Res 47:1476, 1986. Pipers et al. Am J Vet Res 40:882, 1979.</p>							

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Hypertrophic cardiomyopathy (HCM) is typically a rule out diagnosis once systemic hypertension and hyperthyroidism are ruled out. In a cat this young however, severe congenital HCM is considered the likely diagnosis. The severity of disease is high, with marked LA dilation and wall thickening. The heart rate is markedly elevated with a somewhat irregular rhythm. The importance of a baseline ECG cannot be stressed enough as antiarrhythmic therapy may be warranted.

The PE/history is suggestive of a thrombus (saddle thrombus, ATE), and this exam all but confirms a cardiac origin as the cause. Cats of any age who develop an ATE unfortunately carry a **poor to grave prognosis**, with those who survive the initial clot event often succumbing within weeks to months to a recurrent thrombus or CHF. Should the pain be poorly controlled or



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significant azotemia occur, an ascending clot would be suspected, and **humane euthanasia is recommended.**

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Time and supportive care to ensure patient comfort is the best way to approach an ATE should the owners elect to go forward. Heparin can be utilized in hospital to help decrease the risk for clot ascension and further clot development; however, there is no safe or recommended therapy to disrupt the current thrombus. Other possible complications include reperfusion injury, limb necrosis, CHF/arrhythmias. Assuming the pain can be controlled, some cats are able to regain some or all function in the limbs over time while others may not. Lifelong cardiac support and anti-coagulation is recommended. Given concurrent respiratory signs and scant pericardial effusion, treatment for CHF is also recommended. Please see medication recommendations below.

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Referral to a multi-specialty center would certainly be the gold standard in a case like this should the owners elect to proceed. Discussion with the owner is advised.

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PLAN

Baseline BP and ECG are strongly recommended to determine if antiarrhythmic therapy is warranted; consider submission for evaluation. In hospital: Supportive care through limb manipulation/temperature support, monitoring electrolytes/renal values q6hours, monitoring BP in both fore and hindlimbs, heparin therapy if able/elected, pain control (methadone, buprenex, etc.). Consider 24-hour facility with specialty care if possible. Do not utilize an ACE-I in this case as hypotension is almost certainly present.

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Initiate Plavix 18.75mg PO SID (NOTE: this medication is very bitter and may causing foaming at the mouth- coat in entirety). If patient is breathing normally, institute Lasix 1-2mg/kg PO q12h. Continue Pimobendan as prescribed.

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DVM

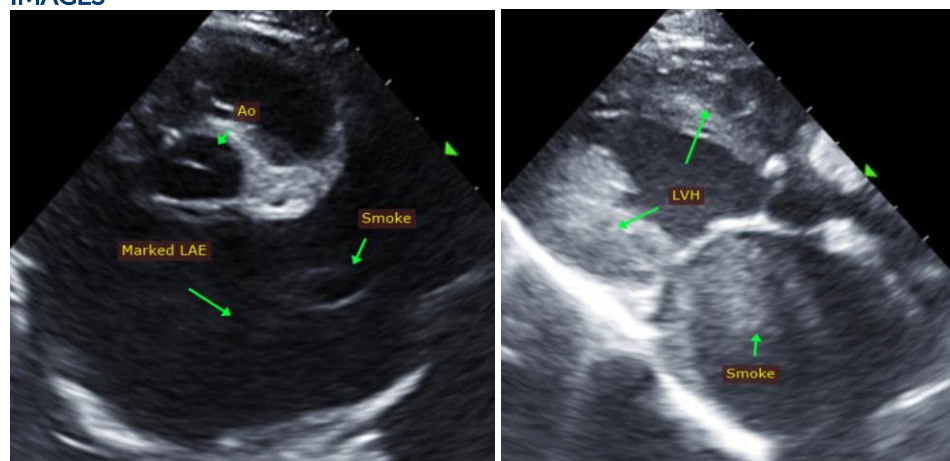
Recheck renal values in 10-14 days, then every 3-4 months lifelong. Close monitoring of respiratory rate and effort at home.

Recheck echocardiogram in 6 months once stable on oral medications to reassess for progression.

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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Thank you for this referral. This report was generated using transcription software, and minor dictation errors may be present. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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