



PATIENT

Lil Willie Vogler

SPECIES

Feline

BREED

DLH

SEX

Male Neutered

AGE

10 years

WEIGHT

11.75 lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

HOSPITAL NAME

Mass Veterinary Services

REFERRING VET

Dr. Masloski

INVOICE

27607

DATE

11/22/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. Since previous study; January 2022: Large intestinal mass GI bx --> granular small cell lymphoma; reactive lymph nodes. started prednisolone, Had intestinal resection and anastomosis. Currently, Lil Willie is doing well. Eating and drinking normally with some sneezing noted the past few weeks. Activity level remains the same. On exam: tachycardia, arrhythmia with pauses noted, grade III/VI murmur noted best on sternum, PSS, lung fields clear, compressible thorax, mm pink, moist. Current medications: 1) Prednisolone 2) Leukoran/chlorambucil 3) Metamucil 1/4 tsp daily *Sedated with propofol for study -Pertinent previous echo findings (3/3/21 MML): LA 1.3 cm; LA:Ao 1.2; IVS 0.49 cm; PW 0.53 cm; normal LA size; largely normal LV wall thicknesses; normal MV structure and motion; LVOT Vmax 0.73 m/s

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.

Left ventricle: The LV diameter is normal with adequate myocardial function. The LV wall thicknesses are largely normal. There is a diffusely hyperechoic endocardium consistent with mild fibrosis. The endocardium appears mildly remodeled. The papillary muscles are mildly remodeled and hyperechoic.

Left atrium: The left atrium is normal in dimension. No obvious spontaneous contrast or thrombi seen.

Mitral valve: The mitral valve is normal in structure. Systolic anterior motion is seen on multi-modal imaging. Mild MR secondary to SAM.

Aortic valve/aorta: The aortic valve is normal in morphology and mobility. Elevated aortic outflow velocity with a dynamic profile. No aortic insufficiency.

Right ventricle: Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.

Right atrium: The right atrium is normal in dimension.

Tricuspid valve: The tricuspid valve appears normal with trivial tricuspid regurgitation.

Pulmonic valve/pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Elevated RVOT velocity with a dynamic profile.

Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.

Heart rhythm: ECG reveals a sinus rhythm with an average HR of 188bpm.

2-Dimensional Measurements

Ao diam (cm)	1.2
LA diam (cm)	1.6
LA:Ao (Swe)	1.3
IVS thickness (cm)	0.52y
LVID diastole (cm)	1.6
PW thickness (cm)	0.50
LVID systole (cm)	0.8
FS (%)	50y

Doppler Measurements

PV Vmax (m/s)	2.9
AoV Vmax (m/s)	4.3
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Interesting case. While the LA and LV remain normal, dynamic obstructions are now seen in both the RVOT and LVOT. While a dynamic RVOTO is benign, development of SAM causing and LVOTO is considered pathologic. Volume depletion can contribute to both of these findings, and lab work should be assessed. Regardless of murmur origin, no LVH has



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developed which likely suggests this is a purely stress-related development. No additional issues are identified.

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Even with an LVOTO identified, no obvious indication for atenolol therapy prior to LV hypertrophy and/or LA dilation. Follow up is certainly advised. Prognosis is guarded prior to assessing for progression.

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RECOMMENDATIONS

- Given these findings, no medications are indicated.

SEX
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- Anesthetic risk is considered mild, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Avoid vasodilators as this may worsen the obstruction. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, isoflurane maintenance.

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- Risk for complication with steroid use typically follows LA dilation, which in this case is mildly elevated. Monitoring of RR/RE is advised particularly in the initiation phase.
- Monitor at home for any respiratory signs or blood clot events (neurologic change, paralysis, etc.) in the future.

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PLAN

- Recommend recheck echocardiogram in 6-12 months to screen for progression.

IMAGES

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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.

REFERRING VET

Dr. Masloski

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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Echocardiogram performed by: Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)

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