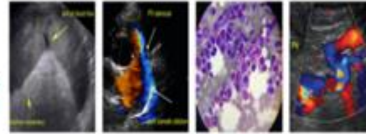
Mass Veterinary Services



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Jinx Connors

SPECIES
Feline

BREED
DLH

SEX
Female Spayed

AGE
4 years

WEIGHT
13.81lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
28687

DATE
2/123

PRESENTING CLINICAL SIGNS

History: Recheck echo. History mitral valve dysplasia, LVOTO, mild-moderate LAE on prior echo 7/26/22 (MML). Presently, no coughing, good appetite, normal energy level. Grade III/VI systolic murmur, normal lung sounds. On Atenolol 25mg 1/4 tab twice a day. *No sedation
-Pertinent previous echo measurements: LA 1.5 cm; LA:Ao 1.4; LV 2.0 cm; LVOT Vmax 2.7 m/s.

ELECTROCARDIOGRAPHIC FINDINGS *Note: Single lead ECGs are evaluated as a rhythm strip. Morphology/MEA cannot be definitively commented on.

A single lead ECG is available; 25mm/s, 20mm/mV. The average heart rate is 188bpm with a largely regular rhythm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. P and QRS morphologies are positive. Two isolated VPCs are identified; monomorphic. No supraventricular premature beats, pauses or other dysrhythmias observed.
ECG diagnosis: Normal sinus tachycardia with isolated VPCs.

ECHOCARDIOGRAM FINDINGS

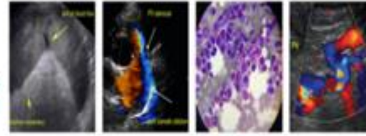
2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV diameter is mildly increased with adequate myocardial function. The LV wall thicknesses is largely normal with a focal septal hypertrophy. There is a mildly hyperechoic endocardium consistent with mild fibrosis. The papillary muscles are mildly hypertrophied. The endocardium appears mildly remodeled.
Left atrium: The left atrium and auricle are minimally dilated. No spontaneous contrast or thrombi seen.
Mitral valve: The anterior leaflet of the mitral valve is mildly elongated. Abnormal anterior motion is seen during systole. Mild eccentric mitral regurgitation.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Mildly elevated LVOT outflow velocities 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 no tricuspid regurgitation.
Pulmonary valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity; laminar flow.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.

2-Dimensional Measurements

Measurement	Value
Ao diam (cm)	1.1
LA diam (cm)	1.4
LA:Ao (Swe)	1.3
IVS thickness (cm)	0.66
LVID diastole (cm)	1.9
PW thickness (cm)	0.43
LVID systole (cm)	0.51
FS (%)	50

Doppler Measurements

Measurement	Value
PV Vmax (m/s)	0.97
AoV Vmax (m/s)	1.8
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA



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INTERPRETATION OF THE FINDINGS

Mitral valve dysplasia persists with overall stability. The focal septal thickening is unchanged without global LV hypertrophy. The LVOTO is mildly improved on Atenolol and the left atrial dimension unchanged. No additional issues are identified.

Long term prognosis remains guarded; however, stability is certainly a good sign. Close monitoring for progression of LA dilation in the future will help determine long term prognosis.

The ECG does show occasional VPCs. These are likely due to stress in this patient with structural disease. No treatment is warranted based upon what is seen here. Additionally, it is worth noting that the resting heart rate remains elevated despite Atenolol Therapy. Based upon this a slight dose change may be warranted if this is consistent finding. No additional medications are warranted at this time.

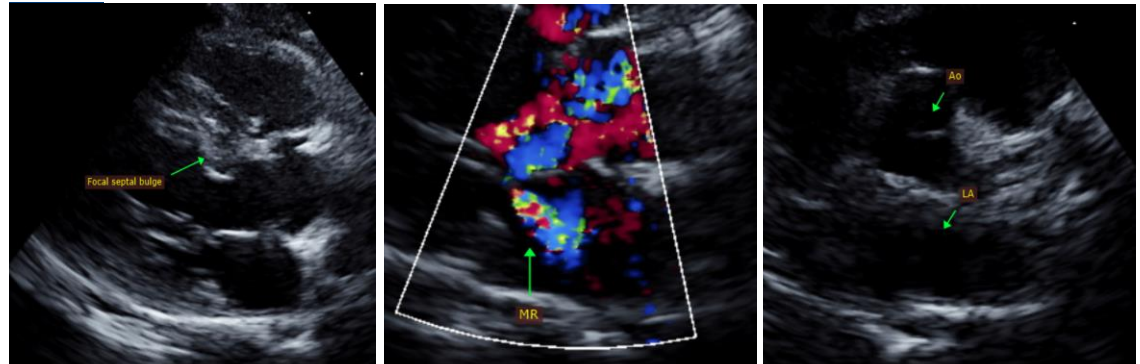
RECOMMENDATIONS

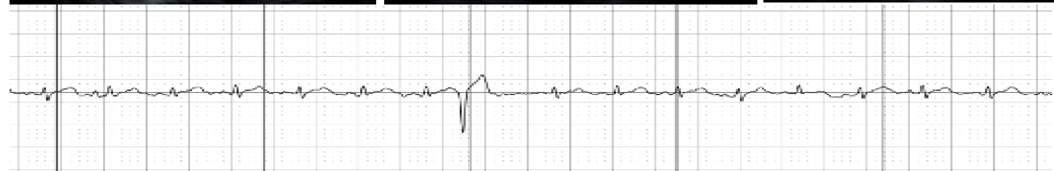
- Continue Atenolol as prescribed. If heart rate remains significant elevated in the future, an alternative dosing schedule may be indicated, such as ½ tab PO q24h.
- Anesthetic risk is considered mildly elevated, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs 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.
- Monitor for any clinical evidence of cardiac compromise, including respiratory changes and/or signs of a blood clot event (paralysis, neurologic changes, etc.).

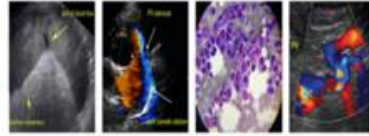
PLAN

- Recommend recheck echocardiogram in 6 months to assess for progression/regression, sooner if clinical signs arise in the interim.

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.

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.

Maggie Machen Lamy, DVM
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com

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