



**PATIENT**

Oliver Ginowiecki

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Male Neutered

**AGE**

7.22.09

**WEIGHT**

8.8lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
DVM, DACVIM  
(Cardiology)

**IMAGING PERFORMED BY**

Stephanie Pearce,  
RDCS, RVT

**HOSPITAL NAME**

Perry Hall Animal  
Hospital

**REFERRING VET**

Dr. Miller

**INVOICE**

22548

**DATE**

2.14.22

**PRESENTING CLINICAL SIGNS**

History: Recheck echo. Doing well clinically. Cardiac murmur grade 3/6.  
 -Pertinent abnormal PE/Chem/CBC/UA Results: Lab work overall unremarkable - slight increase in SDMA but excellent USG.  
 -Current medications: Atenolol 25mg - 1/2 tablet by mouth SID  
 -Blood pressure: BP: 140mmHG  
 -Sedation used: Not required to complete full diagnostic ultrasound.  
 -Pertinent previous ultrasound results (11/14/2017): HOCM, mild LAE. IVSd: 0.72, LVWd: 0.56, LA: 1.3, AV max: 3.5.  
 -STAT: Not requested

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is asymmetric with moderate septal hypertrophy. There is a diffusely hyperechoic endocardium consistent with fibrosis and ventricular remodeling. Asymmetric papillary muscle hypertrophy. The right ventricle is subjectively normal in size and morphology. There is mild left atrial enlargement present. No right atrial enlargement present. Normal RVOT velocity. There is minimal systolic anterior motion (SAM) of the mitral valve is seen, with a normal LVOT velocity. There is trace eccentric mitral regurgitation present secondary to SAM. No other obvious valvular regurgitation is present. There is no pericardial effusion noted. No pleural effusion appreciated.

**CARDIAC CHART**

FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm) (Moise, Pipers)	LVIDd (cm) (Moise, Pipers)	LVWd (cm) (Moise, Pipers)	FS (%)	EF (%)
NORMAL PARAMETER	-----	150-240	3.5-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	4.0	168	0.73	1.3	0.46	49	84
FELINE CARDIAC PARAMETERS	LA/AO (Boon)	LA/AO HEART BASE (Swe) (Abbott)	LA 2D short axis Base view (cm) (Abbott)		LVOT VEL (m/s)	RVOT VEL (m/s)	E max (m/s)
NORMAL	<1.5	<1.3	<1.2		<1.6	<1.3	<0.9
PATIENT	NM	1.44	1.3		1.4	1.3	NM

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.

### INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Remarkably stable disease is appreciated here. Asymmetric hypertrophy is unchanged with no progression in LA dimension. The systolic anterior motion appears well controlled with Atenolol and normal velocities are documented today. No additional issues are identified.

Given a lack of progression, continue Atenolol going forward with no indication for additional medications. Prognosis is guarded long-term due to the highly variable rates of progression with subclinical feline cardiomyopathy.

Monitor at home for any respiratory signs or blood clot events (neurologic change, paralysis, etc.) in the future.

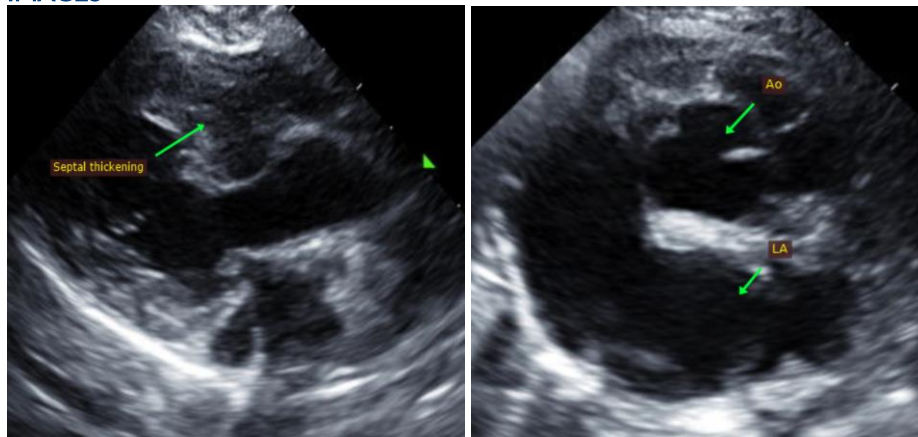
Anesthetic risk is considered mild, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Avoid vasodilators as this may worsen the obstruction. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, isoflurane maintenance. Additionally, steroids should be used with caution on older cats, as even a 'normal' geriatric heart can develop evidence of intolerance and fluid retention.

### PLAN

Continue Atenolol as prescribed.

Recommend recheck echocardiogram annually, sooner if clinical issues arise.

### IMAGES



**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.

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