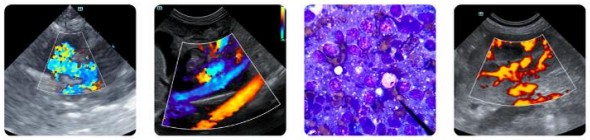


PATIENT

Buddy Ropars

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

18 years

WEIGHT

9.3lbs

INTERPRETED BY

Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Jennifer Todd, DVM

HOSPITAL NAME

Lambs Gap Animal Hospital

REFERRING VET

Dr. Kinney

INVOICE

46704

DATE

2/5/26

PRESENTING CLINICAL SIGNS

History: Grade II/VI systolic heart murmur. Being treated chronically for hyperthyroidism and feline asthma. On Methimazole 2.5mg BID and Fluticasone inhaler BID. Pre-anesthetic labs show elevated renal enzymes (Creat=2.1, BUN=39, SDMA=15, Phos WNL), mild anemia (HCT=28%), T4=1.8 and cardiac BNP=794. Assess prior to dental. BP: 176, 177, 184mmHg.

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, 10mm/mV. The average heart rate is 210bpm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. The P morphology is positive. The QRS is inverted. No ectopic beats, pauses or other dysrhythmias observed.
ECG diagnosis: Normal sinus tachycardia.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is mild to moderately hypertrophied. There is a mildly hyperechoic endocardium consistent with fibrosis and ventricular remodeling. Mild papillary muscle remodeling. The right ventricle is subjectively normal in size and morphology. There no left atrial enlargement present. No right atrial enlargement present. Normal RVOT velocity. Systolic anterior motion (SAM) of the mitral valve is present. The LVOT velocity is normal; however, an intermittent obstruction is suspected. There is mild eccentric mitral regurgitation present secondary to SAM. No other significant valvular regurgitation is present. There is no pericardial effusion noted. No pleural effusion appreciated. No obvious cardiac tumors.

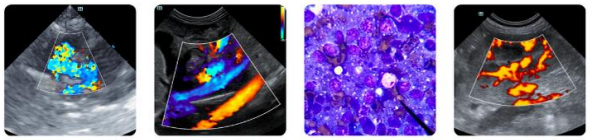
CARDIAC CHART

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	0.35-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	4.2	NM	0.73	1.3	0.69	58	90
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	1.0	1.2	1.1		1.5	1.2	NM

***Note: All measurements based upon multi-modal images and methods. An average value is reported.*
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

The diagnosis is hypertrophic obstructive cardiomyopathy (HOCM). This indicates LV thickening (mild to moderate in this case) with a dynamic LVOT obstruction (SAM) and secondary mitral



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regurgitation as the cause of the heart murmur. The hypertrophy and obstruction are both mild. There is no left atrial enlargement present, indicating the risk of spontaneous CHF and/or a thrombotic event is currently low. No additional issues are identified. The ECG is unremarkable with a normal sinus tachycardia.

While no medications have been shown to definitively alter long term outcome at this stage of disease, atenolol is often initiated to decrease the outflow obstruction. Given the age of the patient, mild obstruction and concurrent asthma, this is not recommended in this case. No additional medications are indicated prior to significant atrial dilation. *Regarding the newly available drug Felycin:* This medication has not been tested in cats with a significant obstruction (i.e. HOCM) and is not recommended in this case.

Long term prognosis is guarded for subclinical HOCM, with a great deal of variability in rate of progression. The REVEAL study showed that approximately 7% of asymptomatic cats with HOCM will develop CHF or a cardiogenic thrombus within 1 year, 20% within 5 years, and ~30% within 10 years. Close monitoring for progressive LA dilation going forward will help better predict long term outcome.

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

The reported blood pressure is elevated, which may be relevant in light of LV hypertrophy. If thought to be accurate, vasodilator therapy is likely warranted, in addition to full systemic screening.

Anesthetic risk is considered mild; however, judicious fluid administration is advised if needed with careful monitoring to screen for fluid overload. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, isoflurane maintenance. Avoid ketamine, telazol, acepromazine and Dexdomitor. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine).

Risk for complication with steroid or fluid use typically follows LA dilation, which in this case is low. That said, any cat can experience acute intolerance and monitoring for this phenomenon is always advised (a change in RR/RE, particularly during the initiation phase).

PLAN

Treat systemic hypertension if indicated.

Screening blood pressure and T4 are recommended every 6 months.

Recommend recheck echocardiogram in 6-12 months to assess for progression, sooner if clinical issues arise.

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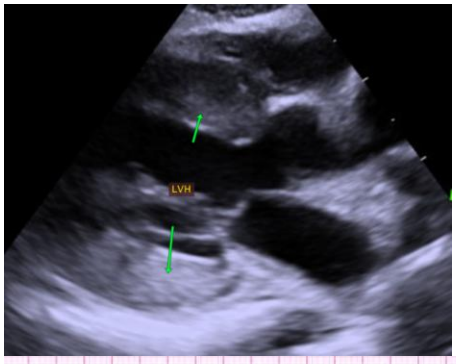
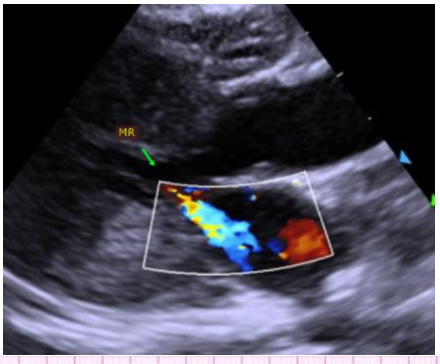
IMAGES





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.

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