

PATIENT
Brooklyn 2nd Chance

SPECIES
Feline

BREED
DMH

SEX
FI

AGE
5mo

WEIGHT
6.94lbs

INTERPRETED BY
Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan,
RDCS

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
29606

DATE
3/15/23

PRESENTING CLINICAL SIGNS

History: Brooklyn is referred to evaluate a heart murmur noted in January. She needs to be spayed. She is eating well and remains active, but does get winded. Occasional cough noted. On exam: NSR, grade IV/VI parasternal murmur, PSS, lung fields clear, compressible thorax, mm pink, moist, CRT<2. BP: 140 mmHg x 5. *Sedated with propofol for study

ECHOCARDIOGRAM FINDINGS

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

Left ventricle: The LV is severely dilated with adequate myocardial function. Increased LV sphericity. LV wall thicknesses are decreased. A large (0.29cm) perimembranous ventricular septal defect (VSD) is visualized. The flow is left to right; max velocity 4.9m/s.

Left atrium: The left atrium is moderate to severely dilated. No obvious spontaneous contrast.

Mitral valve: The mitral valve is normal with no mitral regurgitation.

Aortic valve/aorta: The aortic valve is normal in morphology and mobility. Subaortic ridge seen causing a narrow LVOT. Mildly elevated aortic outflow velocity; fixed profile. No aortic insufficiency.

Right ventricle: The RV appears normal with no evidence of hypertrophy.

Right atrium: Normal RA dimension.

Tricuspid valve: The tricuspid valve appears normal with no tricuspid regurgitation.

Pulmonic valve/pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity; laminar flow. Significant MPA and branch dilation.

Pericardium/other: Small volume pericardial effusion. no pleural effusion noted. No obvious cardiac masses.

Heart rhythm: ECG reveals a sinus rhythm with an average HR of 180 bpm.

2-Dimensional Measurements

Ao diam (cm)	0.9
LA diam (cm)	1.6
LA:Ao (Swe)	1.7
IVS thickness (cm)	0.28
LVID diastole (cm)	1.96
PW thickness (cm)	0.41
LVID systole (cm)	1.2
FS (%)	40

Doppler Measurements

PV Vmax (m/s)	2.2
AoV Vmax (m/s)	2.4
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

The cause of the murmur is a perimembranous ventricular septal defect (VSD). The defect is large in dimension, with high velocity left to right flow. There is evidence of severe left heart volume overload, with both a dilated LA and LV. The MPA is dilated due to the extra volume, although the velocity through the region is normal. Additionally there is subaortic stenosis present, with a fixed outflow tract obstruction. This appears to be comparatively insignificant, without LV hypertrophy at this time. The velocity is suspected to be mildly under-estimated due to sedation. No additional congenital defects are visualized.

While VSDs in cats are often of minimal lifelong clinical significance, this particular case appears to have progressed to CHF at a young age with pericardial effusion seen. Despite no significant clinical signs, immediate lifelong cardiac support is recommended. Patient



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will always be at risk for recurrent left-sided CHF, development of PAH and shunt reversal, blood clot formation or acute sudden death in the future. The prognosis is poor long term, and our goal is to stabilize the patient for the short term. Euthanasia should be elected if QOL suffers.

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RECOMMENDATIONS

- If patient becomes unstable, overnight hospitalization is recommended.
- Institute Lasix 1-2mg/kg PO q12h.
- Institute Pimobendan 0.625mg PO q12h.
- Institute Plavix (1/4 of a 75mg tablet PO q24h – this medication is bitter along the cut edge).
- Monitor at home for any associated clinical signs, including respiratory changes or signs of a thrombus.
- **Elective anesthesia, steroid or fluid therapy is not advised.**

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- Recheck renal panel and BP in 1-2 weeks. If doing well, able to be medicated and BP >130mmHg, institute ACEI 0.5mg/kg PO q12h.
- Recheck echocardiogram in 6 months, sooner if any clinical signs arise in the interim.

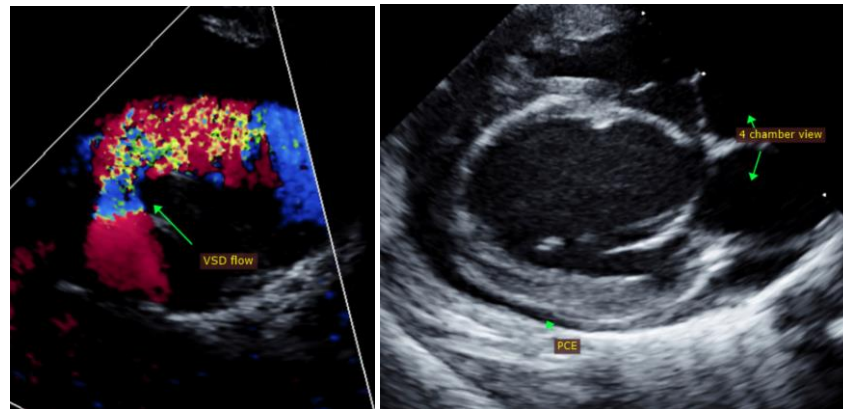
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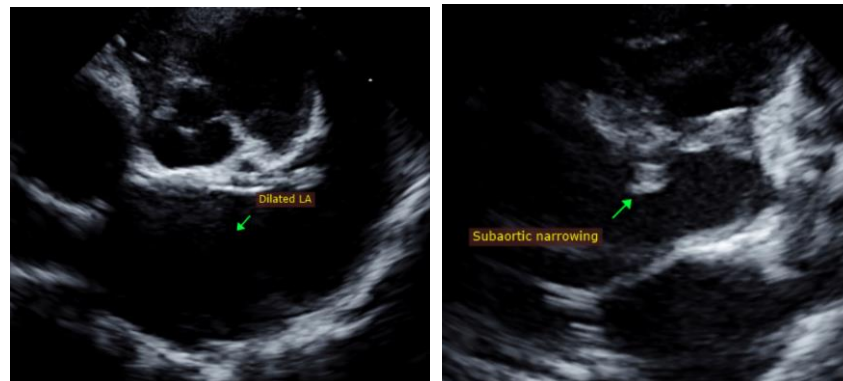
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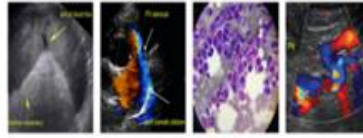
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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DMH

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

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

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