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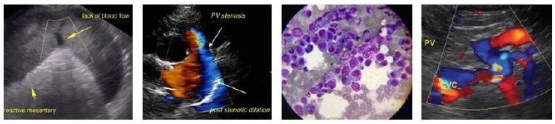

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT
Daisy Petroczy

SPECIES
Feline

BREED
DSH

SEX
Female Spayed

AGE
5 years

WEIGHT
7.5lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Kelly Reschny, RVT

HOSPITAL NAME
Snelgrove Veterinary Services

REFERRING VET
Dr. Gunsinger

INVOICE
23239

DATE
3/23/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. Previous diagnosis of severe hypertrophic cardiomyopathy with secondary tachycardia and LVOT obstruction (reports not included). Arrhythmia on examination. Grade V/VI murmur.
-Current medications: Clopidogrel 18.75mg q24h, Atenolol 6.25mg q12h.

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; 50mm/s, 20mm/mV. The average heart rate is 175bpm (range 156-200bpm). The rhythm is suspected to be sinus in origin, although P waves are difficult to identify throughout; atrial fibrillation is not ruled out. Occasional premature beats identified, suspected APCs.
ECG diagnosis: Suspect underlying sinus rhythm with isolated APCs; AF is not ruled out.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is moderate to severely hypertrophied with regions of asymmetry. There is a diffusely hyperechoic endocardium consistent with fibrosis and ventricular remodeling. Papillary muscle remodeling and irregularity. A perimembranous VSD is seen just below the aortic valve. The flow appears highly velocity and left to right, although not measured. The right ventricle appears normal. There is marked left atrial enlargement present with a horizontal component. Subtle smoke. No obvious thrombi. No right atrial enlargement present. There is systolic anterior motion (SAM) of the mitral valve present creating a mild LVOTO (not captured on doppler). There is mild mitral regurgitation. No AI and trace PI. Scant pericardial effusion. No pleural effusion noted. 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	3.42	160	0.74	1.55	0.80	41	77
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	>3.0	>3.0	2.6		0.8	1.8	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.

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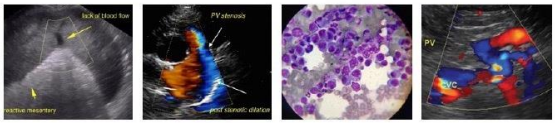

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Hypertrophic obstructive cardiomyopathy persists with evidence of congestive heart failure. The LV is thickened with a dynamic LVOT obstruction (SAM). The obstruction appears minimal which may suggest primary hypertrophic or end-stage disease. Most importantly there is marked left atrial dilation with subtle smoke, indicating the risk for spontaneous CHF and/or a thrombotic event is and will be elevated lifelong. Finally, a VSD is noted with left to right flow, which is likely insignificant compared to severe HOCM. No additional issues are identified.

A small amount of pericardial effusion is noted, which given the severity of disease is certainly suspicious for early congestive heart failure. Full life-long cardiac support is recommended as below, even prior to clinical signs. If able to be stabilized and medicated, the prognosis is poor for cats with CHF long term, however most are able to be managed for an average of 6-12 months on medications if tolerated.

The ECG is most consistent with a sinus rhythm and frequent APCs. Atrial fibrillation is also possible and is not ruled out on this insensitive single lead tracing. Regardless, the average heart rate is reasonable, without significant tachycardia. That being said, patients in active CHF can experience bradycardia and if this is noted in the future, Atenolol should certainly be discontinued. For now, a slight dose decrease to q24h is recommended in the acute phase with monitoring of heart rate in 1-2 weeks.

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

Elective anesthesia, fluid therapy and/or steroids are not advised as all pose high risk for complication.

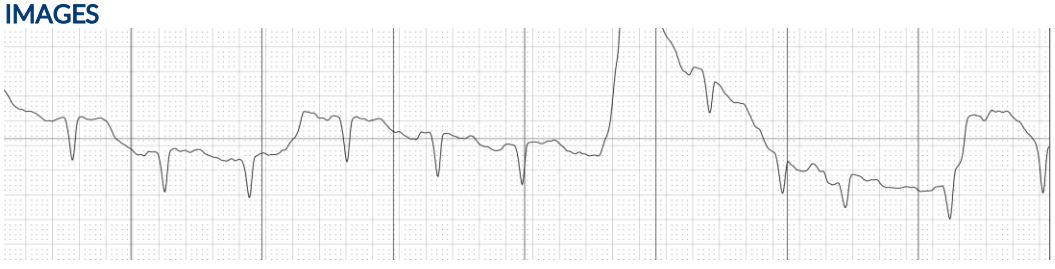
PLAN

Institute Lasix 1-2mg/kg PO q12h. Institute low-dose Pimobendan 0.625mg PO q12h. Continue Plavix as prescribed. Decrease Atenolol to 6.25mg q24h. If patient is or becomes unstable, immediate hospitalization is recommended.

Monitor BP, heart rate and renal panel in 10-14 days, then every 3-4 months lifelong. If doing well, eating and BP >130mmHg, institute Benazepril 0.5mg/kg PO q12h at that time. If BP <130mmHg, do not institute ACEI. If average heart rate is >200bpm on this exam, increase Atenolol back to q12h dosing; otherwise maintain q24h dosing.

Recommend recheck echocardiogram in 6 months to assess for progression and need for Atenolol, sooner if clinical issues arise.

IMAGES



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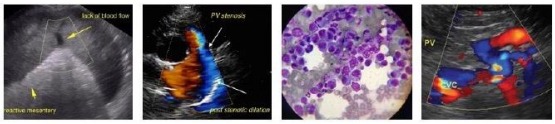

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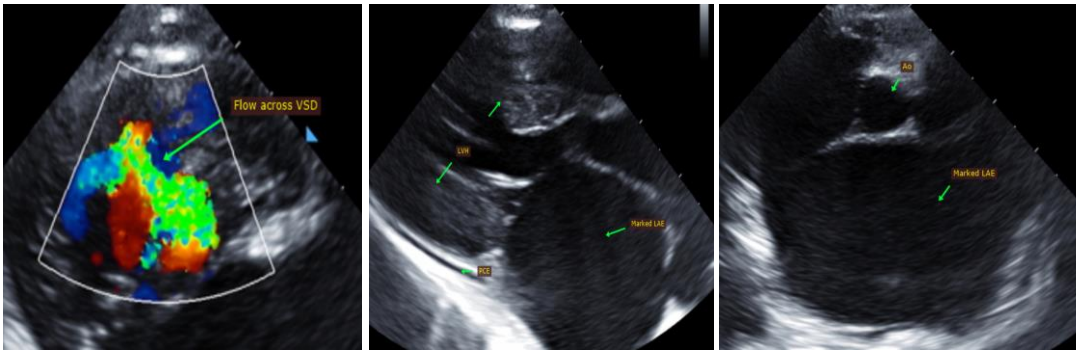

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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