SonoPath
Clinical Sonography & Telecytology
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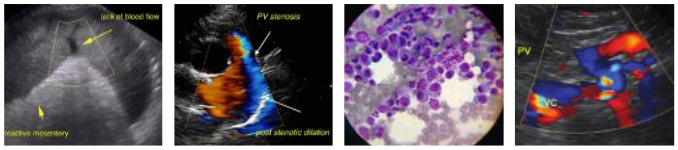

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Scar Martino

SPECIES
Feline

BREED
DSH

SEX
Male Neutered

AGE
10 years

WEIGHT
8.8lbs

INTERPRETED BY
Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY
A. Nicastro, DVM

HOSPITAL NAME
Sun Dog Cat Moon

REFERRING VET
Dr. Clayton

INVOICE
30163

DATE
4/11/23

PRESENTING CLINICAL SIGNS

History: Recheck echo. Presented on 3/31 with ataxia, lethargy, anorexia, mild anemia (HCT 30.12), hypoalbuminemia (1.9), treated with Cerenia, SQF, VitB12. SQF, VitB12. Represented on 4/4 with little to no improvement -- AUS performed with Dr. Nicastro (bilateral renomegaly, R renal cortical infarct, R cranial retroperitonitis, chronic pancreatitis, urinary bladder debris). Started on mirtazapine and pradofloxacin -- P improved markedly, e/d normal, playing with housemate. Acutely in morning of 4/10 P became non weightbearing on L forelimb. On presentation, LF paw cool, no deep pain, absent withdrawal. Sensation from carpus proximal. Grade 1 murmur with S1 gallop. BNP SNAP abnormal. Rx clopidogrel 18.75mg PO q24h. Diagnosed with HCM in 2018 when presented for seizure-like episodes. BP: 160-170mmHg.
-Pertinent previous echo findings (2018): Mild HOCM without LAE.

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

A video of an anesthesia monitor is included. Sinus tachycardia with little HR variation; recorded HR 230-250bpm appears accurate. 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 thickness is moderately increased with regions of irregularity. There is a diffusely hyperechoic endocardium consistent with fibrosis and ventricular remodeling. 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. Mild RVOT obstruction. There is systolic anterior motion (SAM) of the mitral valve present, with a mildly elevated LVOT velocity (dynamic profile). There is mild eccentric mitral regurgitation present secondary to SAM. No other obvious valvular regurgitation is present. There is scant pericardial effusion noted. No pleural effusion appreciated. No tumors seen.

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	4.0.	NM	0.74	1.24	0.72	58	89
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	1.6	1.5		1.8	2.0	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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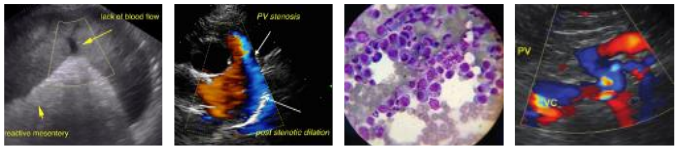

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The diagnosis is hypertrophic obstructive cardiomyopathy. This indicates LV hypertrophy (moderate in this case) with a mild dynamic LVOT obstruction (SAM) and secondary MR. There is mild left atrial dilation, indicating the risk of spontaneous CHF and/or a thrombotic event, while currently low, may be elevated in the future. A screening BP and T4 are recommended every 6 months, as both can exacerbate disease.

The finding of pericardial effusion and an acute four-limb paralysis is concerning for cardiogenic causes, although this is rare to see with only mild LA enlargement. If no systemic issues have been identified and the physical exam findings are suggestive of a thrombus, I would treat as such and utilize Lasix therapy. A neurology consultation may be beneficial from a paralysis standpoint. Additionally reassessing the amount of PCE in 5-7 days is recommended to assess response. This is a highly unusual presentation in the absence of steroid or fluid therapy; however, continuing treatment would be the safest option. If the effusion persists despite lasix, continued systemic evaluation is recommended (particularly in light of reported anemia) and Lasix can be discontinued in this instance. No obvious indication for Atenolol based upon the mild nature of the obstruction.

Anesthesia is not advised at this time.

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

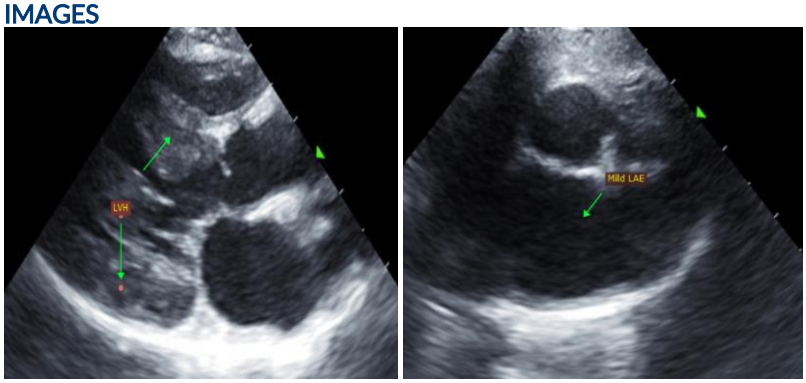
PLAN

Continue Plavix as prescribed. Consider a neuro/ortho evaluation. Institute Lasix 1-2mg/kg PO q12h. Reassess PCE in 5-7 days if possible. If persistent or progressive, discontinue Lasix and consider noncardiac causes. If resolved, continue Lasix is recommended lifelong with addition of an ACE-I if tolerated from a renal standpoint.

Monitor renal values and BP lifelong.

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

IMAGES



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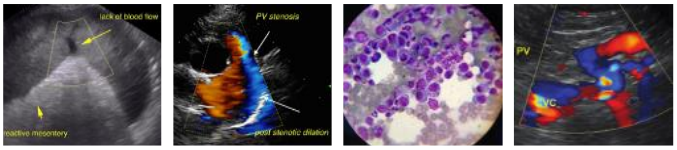

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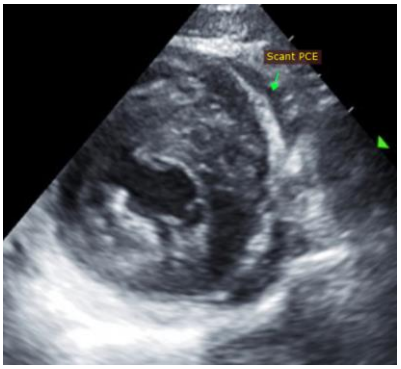

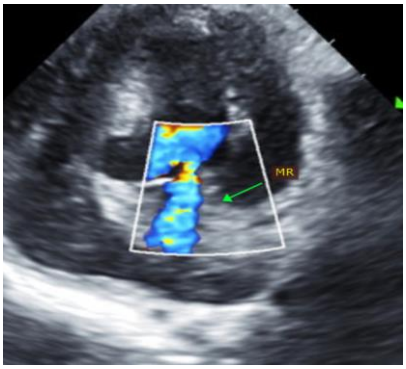

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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