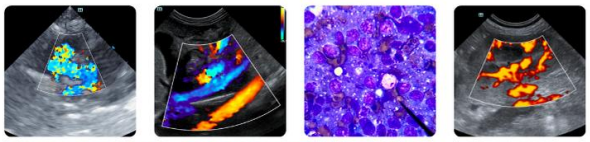


PATIENT

Sambo Taylor

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

12.10 years

WEIGHT

12lbs

INTERPRETED BY

Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Country Companion Animal Hospital

REFERRING VET

Dr. Wanner

INVOICE

47419

DATE

4/3/26

PRESENTING CLINICAL SIGNS

History: Presented for labored breathing and arrythmia; CXR consistent with pleural and pericardial effusion. Started on Lasix 10mg BID and decreased to 5mg BID if comfortable. Titrate to 10mg am and 5mg pm if needed. Renal function impaired with kidney stones present. On Clavamox for pyoderma, gabapentin for hyperesthesia. Sedated with Gabapentin.
-Abnormal PE/Chem/CBC/UA Results: BP: 96/72, 101/86 mmHg (calm) - Time of Echo: No HM appreciated, arrythmia noted that is irregularly irregular, PQ moderate with intermittently mismatching. Mild increased RE, short shallow. - CXR: Pleural effusion - CBC: HCT 27% L, Plt Est Adequate, Neut 10842 mild H, Lymph 973mildL, Eos 1807 mild H, WBC 13.9-n, Platelet Count 152K L, due to platelet clumping. RBC 8.2-n, MCV 33 L-microcytic, HGB 7.8 L, , MCHC 29 mild L-hypochromic - Chem: BUN 65 H, Creatinine 2.5 H

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, 20mm/mV. The average heart rate is 180bpm with an irregular rhythm. Some sinus node conduction is suspected although AF is possible. Rare isolated VPCs.
ECG diagnosis: Rule out atrial fibrillation v sinus rhythm with APCs. Isolated VPCs.

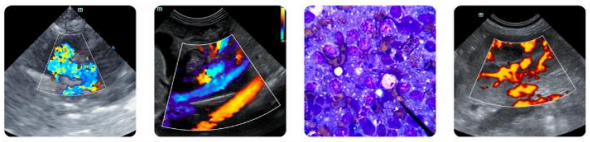
ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is mildly hypertrophied with mild remodeling of the endocardium. There is a diffusely hyperechoic endocardium consistent with fibrosis. There is mild papillary muscle hypertrophy and remodeling. Decreased systolic function. The left atrium is markedly enlarged with a horizontal component and auricular involvement. Significant smoke seen. The right atrium is mildly enlarged. The RV is affected as well. The mitral valve is normal, with normal mobility. No evidence of systolic anterior motion. Mild mitral regurgitation present. Mild tricuspid regurgitation. Blood flow through both the LVOT and RVOT are normal in velocity. Trace AI. Scant pericardial and pleural effusion seen. No obvious cardiac masses.

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	5.4	NM	0.64	1.2	0.65	32	60
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	2.8	2.5		0.7	0.8	NM

Note: All measurements based upon multi-modal images and methods. An average value is reported.
Adapted from June Boon, Veterinary Echocardiography,1998



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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

Hypertrophic cardiomyopathy (HCM) is a rule out diagnosis for LV hypertrophy once a patient is confirmed euthyroid and normotensive. Given the end-stage nature of the findings, primary disease is suspected. End-stage physiology implies systolic dysfunction has developed and LV hypertrophy is now less apparent. Regardless, what is seen here is marked, with development of pericardial and pleural effusion. This suggests the patient is unstable and immediate lifelong cardiac support is recommended as below. If the patient is significantly tachypneic in hospital, a dose of injectable Lasix may be helpful (2mg/kg) +/- recommend referral for overnight supportive care/oxygen therapy.

The ECG does show a likely tachyarrhythmia is present with suspicion for atrial fibrillation. A single lead tracing with significant artifact is difficult to interpret and sinus node activity is suspected. Regardless, A-fib and/or supraventricular arrythmias typically do not require rate control therapy in cats with CHF; however, reassessing the underlying rate and rhythm once the patient is stabilized is recommended. Rare VPCs are also noted, which are not surprising given the severity of the findings. Patient is at risk for maglinant arrythmias and sudden death and this should be expressed to the owner.

The mean survival time for cats once CHF is diagnosed is <8-12 months; however, most cats are able to maintain a good quality of life on medications. Patient will always be at high risk for recurrent episodes of CHF and development of blood clots in the future. Monitoring of sleeping breathing rates at home is recommended as the best way to screen for recurrent CHF at home.

Avoid anesthesia, steroids and fluid therapy unless absolutely necessary in the future.

PLAN

Consider injectable Lasix dose/hospitalization if indicated. Administer Lasix to 1-2mg/kg PO q12h. Institute Plavix 75mg tabs; Give ¼ tab by mouth every 24 hours (NOTE: bitter along cut edge, may cause foaming at the mouth; coat in entirety). Institute Pimobendan 1.25mg PO q12h.

Monitor renal values, ECG, BP in 1-2 weeks, then every 3-4 months lifelong. The repeat ECG is intended to confirm the suspected diagnosis and determine if additional anti-arrhythmic therapy is warranted. Submitting for evaluation is recommended. If doing well and BP >130mmHg, institute an ACE-I 0.5mg/kg PO q12h.

A recheck echocardiogram is recommended in 6 months to assess progression.

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Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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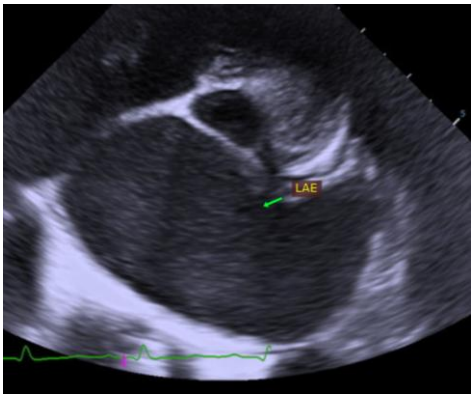
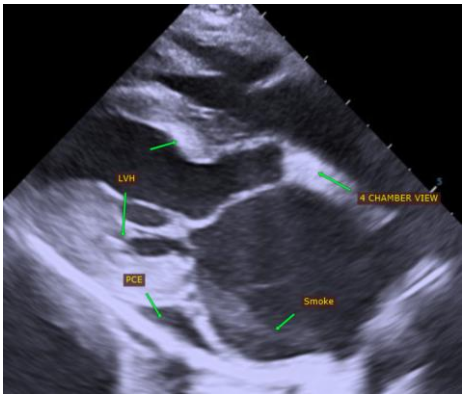
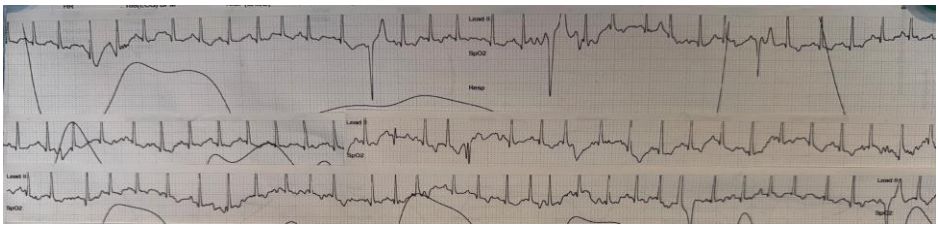
IMAGES







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