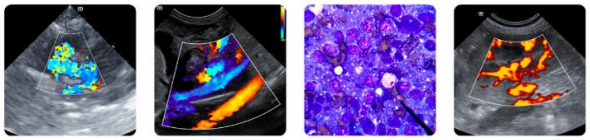

PATIENT

Simba Doerr

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

12 years

WEIGHT

13lbs

INTERPRETED BY

Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Robert Nack, DVM

HOSPITAL NAME

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Dr. Nack

INVOICE

47466

DATE

4/7/26

PRESENTING CLINICAL SIGNS

History: Grade 3/6 systolic heart murmur. HR 80bpm, RR 30bpm. Distended abdomen with fluid wave. Respiratory effort mildly increased. BP 100mmHg (Doppler). ~1L of fluid drained from abdomen

ELECTROCARDIOGRAPHIC FINDINGS

A six lead ECG is available at 12.5mm/s; 5mm/mV. The ventricular rate is 75bpm, with a regular rhythm. The QRS is inverted and prolonged. No P waves are seen consistent with atrial standstill/asystole.
ECG diagnosis: Asystole/atrial standstill with a ventricular escape rhythm.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, spectral doppler and color flow imaging is available. The left ventricular wall is normal with no hypertrophy identified. There is a mildly hyperechoic endocardium consistent with fibrosis. Borderline LV dilation with depressed myocardial function. The papillary muscles are mildly remodeled. The left atrium is severely dilated with a horizontal component. No spontaneous contrast or thrombi noted. No MR. The right ventricle is markedly dilated. Marked RA dilation. Mild TR. Flow through both great vessels is decreased. Trace PI. No pericardial or pleural effusion seen. No obvious cardiac tumors. Bradycardia noted throughout.

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	5.9		0.49	1.6	0.48	37	70
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	2.2	2.0		1.0	0.5	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

Unusual case. The most striking finding is there is 4 chamber dilation and mild dysfunction. The right heart is massively enlarged, and confirms right-sided CHF is the cause of the ascites. The left heart is also affected albeit to a slightly lesser extent. No LV hypertrophy is seen ruling out typical hypertrophic disease. The categorical diagnosis for these findings could be argued. With marked bradycardia, a secondary phenomenon is possible although considered less likely given the severity. It is more likely that an RV cardiomyopathy or similar is present which led to

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dysfunction of the sinus node over time.

The ECG does confirm a significant bradyarrhythmia is present with asystole/atrial standstill (ie no P wave/sinus node activity). In response to bradycardia, a ventricular escape rhythm is firing as a rescue mechanism at a very low heart rate (75bpm). Atrail standstill is extremely rare in small animals. Severe electrolyte derrangements should be ruled out as a possible causative issue (ie hyperkalemia). Aside from this, this is likely a primary issue and the only treatment would be pacemaker implantation. Given the severity of the structural disease, this is likely not a reasonable option in a senior cat as we will still be left with severe structural disease and congestive heart failure. Consider referral in this complicated case should the owner elect to go forward. If the heart rate is not corrected, it will be extremely difficult to keep this patient out of active CHF and quality of life will likely suffer. Our goal is to stabilize the situation for the short term understanding this is a terminal issue. If medications are attempted without improvement at home, euthanasia should be elected.

Patient will always remain risk for recurrent episodes of CHF, development of blood clots, arrhythmias, and/or sudden death in the future. Monitoring of sleeping breathing rates at home is recommended as the best way to screen for recurrent CHF at home.

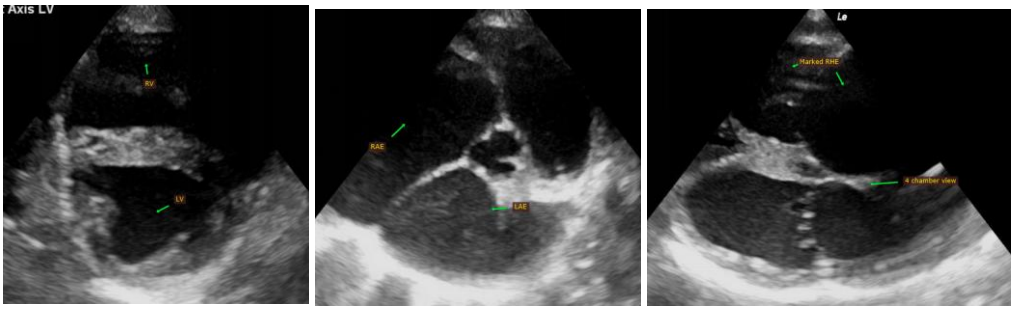
PLAN

Referral versus euthanasia should be considered. If declined, consider hospitalization, oxygen, IV diuretic in hospital if needed stabilization. Electrolyte assessment is recommended to ensure hyperkalemia is not the cause. Full cardiac support should be instituted as follows: Furosemide 1-2mg/kg PO q12h. Institute blood thinner Clopidogrel (Plavix) 75mg tablets; give ¼ tab orally once daily (NOTE: this medication is very bitter on the cut edges). Institute Pimobendan (off label use) 0.625mg PO q12h**. If medications do not improve patient stability and quality of life suffers, euthanasia should be elected.**

If patient stabilizes, recheck renal values, BP, ECG in 10-14 days, then every 3-4 months lifelong.

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

IMAGES



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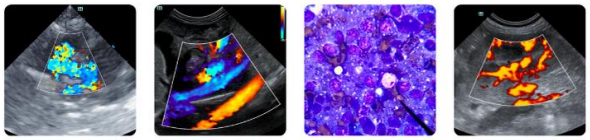

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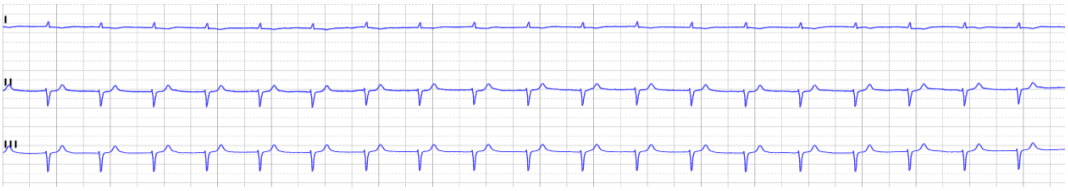

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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