

PATIENT

Rosie Michelman

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

13.10 years

WEIGHT

7lbs

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

IMAGING PERFORMED BY

Melinda Persson, DVM

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Melinda Persson

INVOICE

47497

DATE

4/9/26

PRESENTING CLINICAL SIGNS

History: Hyporexia, weight loss and lethargy. New grade 1-2 murmur and intermittent gallop sound. Elevated BNP. Controlled hyperthyroid x 2 years. BP: 155mmHg.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall thickness is normal to slightly decreased with thinning of the free wall. There is a diffusely hyperechoic endocardium consistent with fibrosis. The LV is slightly dilated with marked dysfunction and specifically a hypokinetic free wall. The papillary muscles are mildly remodeled. The left atrium is markedly dilated. No obvious spontaneous contrast; no obvious thrombus. Moderate MR. The right ventricle is also affected, with diffuse fibrosis and remodeling. Moderate RA dilation. No TR. Trace AI. Scant pericardial effusion. Large volume pleural effusion seen. 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	3.2	NM	0.38	1.5	0.32	20	35
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	2.5	2.2		0.8	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

Unfortunately, this patient has end-stage cardiomyopathy and systolic dysfunction. The exact diagnosis of DCM v RCM v other could be argued, although the differentiation is academic. There is significant dilation and overload of all 4 chambers with marked biatrial enlargement. The LV has an asymmetric appearance, which may suggest an infarct of the posterior wall. Regardless, what is seen here is severe and has resulted in biventricular effusion, most consistent with CHF. An ECG should be obtained.

Systolic failure can be primary in nature (DCM); however, this is relatively uncommon. An advanced form of restrictive cardiomyopathy (RCM) with development of systolic dysfunction is also possible, however the differentiation is purely academic. Finally, systolic failure can develop secondary to taurine deficiency, myocarditis, or infiltrative disease such as lymphoma. Taurine deficiency is highly uncommon in cats on commercially prepared cat foods; however, diet should



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be addressed and can consider taurine supplementation in case of an absorption issue. Further systemic evaluation for underlying infiltrative contribution such as neoplasia or myocarditis may be reasonable (abdominal ultrasound, fluid cytology, etc.).

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Full cardiac support is recommended as below. Centesis should be performed if the patient is or becomes unstable. Hospitalization should also be considered in this acute phase.

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Even if we are able to stabilize the patient through this crisis, given the totality of the findings, prognosis is poor to grave at this stage in the disease process, with an average survival time of <6 months. High risk for recurrent CHF, development of blood clot events and/or malignant arrhythmias/sudden death at home should be discussed. Most cats are able to maintain a good QOL for some time however on oral medications.

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Monitor for development of labored breathing, limb paralysis/neurologic changes and/or collapse episodes in the future. Monitoring of sleeping breathing rates at home is recommended to assess response to medications and recurrence of CHF in the future.

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Elective anesthesia is not advised.

PLAN

Consider hospitalization, centesis, etc. as discussed. A baseline ECG is recommended. Institute Lasix ASAP 1-2mg/kg PO q8-12h. Institute Pimobendan ASAP 1.25mg PO q12h. Initiate Clopidogrel (Plavix) 75mg tabs, ¼ tab PO q24h (NOTE: This medication is bitter on the cut edge; coat in entirety). Consider supplement taurine 500mg daily if able to be easily medicated. Full diet and systemic history is advised.

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Maggie Machen Lamy,
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(Cardiology)

Recheck renal panel, HR/ECG, BP and clinical response in 5-7 days. If doing well and BP >130mmHg at that time, consider institute ACEI 2.5mg PO q24h at that time. Recheck echocardiogram/ECG in 6 months to assess for progressive issues.

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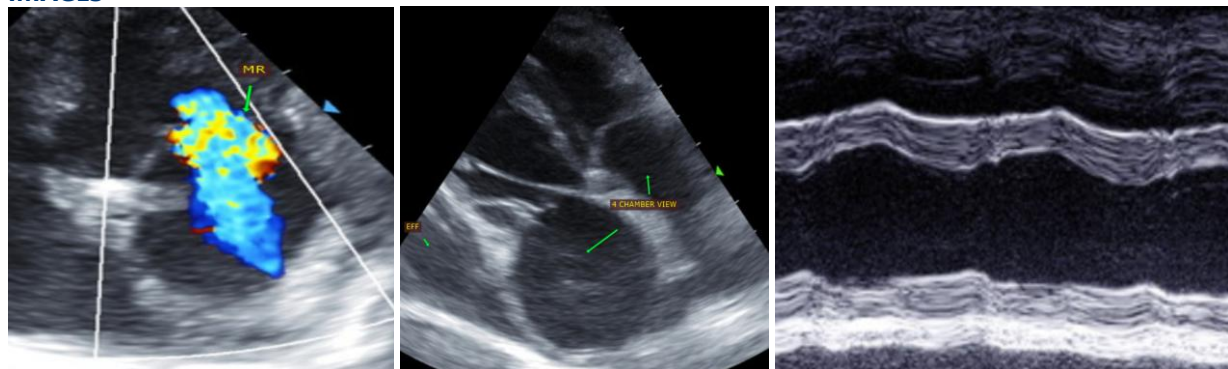
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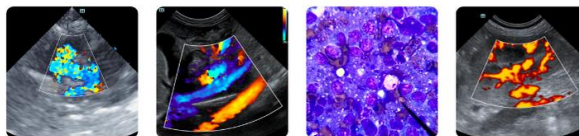
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IMAGES



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.



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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.

Maggie Machen Lamy, DVM

Diplomate of the American College of Veterinary Internal Medicine (Cardiology)

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