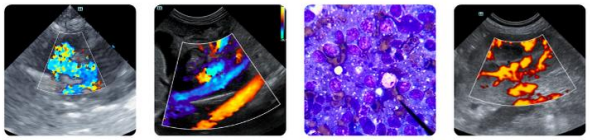

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Saffy Brandon

SPECIES

Feline

BREED

Siamese

SEX

Female Spayed

AGE

9.9 years

WEIGHT

8.2lbs

INTERPRETED BY

Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Greg Kuhlman, DVM

HOSPITAL NAME

Red River Animal Emergency Hospital & Referral Center

REFERRING VET

Dr. Kuhlman

INVOICE

47864

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Dx with IRIS Stage 2 CKD 10/2025.
Seen by AERC 4/27/26 for susp. complete/third degree AV block. They identified the following:
-High-grade second to periods of complete AV block
-Historic VPCs/PVCs - None seen (on atenolol)
-Normal heart size/function, with hyperechoic spot in the region of the AV node
AERC recommendations included: recheck echo in 6 months, d/c Atenolol, recheck EKG
4/13/26 MML- Recheck echo, BP, and ECG. Concern for complete AV block (ventricular escape rhythm and atrioventricular dissociation.)
11/6/25 ECG submitted. Sinus tachycardia (HR 285 bpm) with frequent monomorphic VPCs. Started Atenolol
10/30/25 - consult/ecg for murmur and hx of pericardial effusion. Dx with IRIS Stage 2 CKD. Discontinued plavix and furosemide
10/30/25 - Echo: normal cardiac structure and function with some age-related fibrosis. significant arrhythmia with frequent ventricular beats was noted. No cause for murmur. CHF ruled out. BP: 150
Current Meds: Gaba, solensia, lactulose. D/C atenolol
Update 5/13: doing well. Seems to be doing better off the Atenolol. No gaba today
Abnormal PE/Chem/CBC/UA Results: Previous Lab Work: 4/24/26 - Tropin-1 WNL 2/11/26 - Chem: Chol 313, SDMA 16 ug/dL T4 WNL. CBC WNL 11/25/25 - UA: SpG 1.018, pH 5, protein 30 mg/dL, WBC >50/HPF, RBC >50/HPF, no bacteria detected 11/24/25 - Total T4 WNL.

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, 10mm/mV. The sinus/P wave rate is 188bpm. No P:QRS correlation is seen, The ventricular rhythm is likely junctional, with a HR of 100bpm. VPCs are seen; singles and rapid couplets.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The good news is this ECG is far more diagnostic than the previous tracing. The diagnosis at this time is complete/3rd degree AV block with a junctional escape rhythm. Of additional concern in this case is there also relatively frequent VPCs present, with both singles and rapid couplets. Given a lack of significant structural disease in this case, certainly the arrythmia is extra-cardiogenic in origin. While an idiopathic progressive disorder is possible, consider ruling out ancillary issues that may be contributing. This includes a neoplastic or malignant process that may be present elsewhere in the body, electro-abnormalities, etc. Full systemic evaluation is advised, including abdominal ultrasound. A cardiac troponin level may be telling in this case, although will not change treatment options or plan.

The history in this case is extensive and complicated, with an initial SVT documented as well. Ideally evaluation by a Cardiologist should be sought, as ultimately pacemaker implanation may have to be discussed. Treating the ventricular arrhythmias is now contraindictated with confirmed AV block, and any heart rate stimulation may worsen the ventricular arrhythmias. If referral is declined, simple monitoring is also reasonable approach, particularly given that the cat is doing relatively well at home. If any decline or collapse is seen, referral or ultimately euthanasia may have to be considered.

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Anesthesia is not advised.

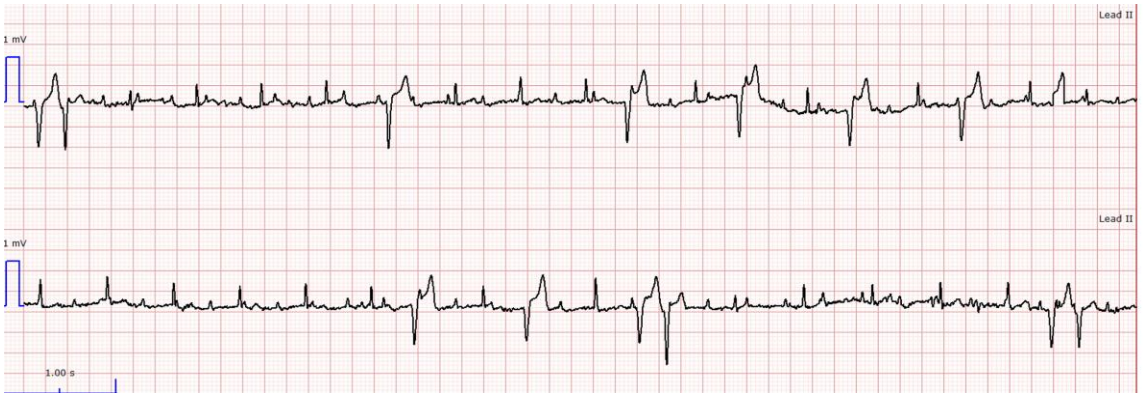
Monitor at home for signs of cardiac compromise, including respiratory changes and/or signs of a blood clot event (paralysis, neurologic changes).

PLAN

Consider referral v monitoring. Full systemic screening.

Recommend recheck echocardiogram in 6 months to assess for any progressive issues or development of disease the pre-existing murmur may mask.

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)
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