



PATIENT

Ginger Pelland

SPECIES

Feline

BREED

Maine Coon Cat

SEX

Female Spayed

AGE

3 years

WEIGHT

16.63lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

HOSPITAL NAME

Mass Veterinary Services

REFERRING VET

Dr. Masloski

INVOICE

24481

DATE

5/31/22

PRESENTING CLINICAL SIGNS

History: Ginger presented to rDVM for a dental in early March. She was given Alfaxalone and Sevoflurane and developed a bradycardia with concurrent pulse deficits and absent heart sounds. A ProBNP level was normal at 36. Good appetite. On exam: NSR, no murmurs noted, PSS, lung fields clear, compressible thorax. BP: 140mmHg. No medications. *Sedated with propofol for study (after ECG was performed).

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 166bpm with a regular rhythm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. P and QRS morphologies are positive. ST segment elevation. No ectopic beats, pauses or dysrhythmias observed.
ECG diagnosis: Normal sinus rhythm.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.

Left ventricle: The LV diameter is normal with adequate myocardial function. The LV wall thicknesses are normal. There is a diffusely hyperechoic endocardium consistent with fibrosis. False tendon. The papillary muscles are hyperechoic.

Left atrium: The left atrium is mildly dilated; however, bulbous in appearance. No obvious smoke or thrombi seen.

Mitral valve: The mitral valve is normal in structure and mobility. No obvious systolic anterior motion is seen. No MR.

Aortic valve/Aorta: The aortic valve is normal. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.

Right ventricle: Normal RV.

Right atrium: Mild right atrial enlargement.

Tricuspid valve: The tricuspid valve appears normal with no tricuspid regurgitation.

Pulmonic valve/Pulmonary artery: The pulmonic valve is normal in morphology and mobility. No pulmonic insufficiency. Normal RVOT velocity; laminar flow.

Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.

2-Dimensional Measurements

Ao diam (cm)	1.0
LA diam (cm)	1.5
LA:Ao (Swe)	1.5
IVS thickness (cm)	0.46
LVID diastole (cm)	1.6
PW thickness (cm)	0.43
LVID systole (cm)	0.9
FS (%)	63

Doppler Measurements

PV Vmax (m/s)	0.62
AoV Vmax (m/s)	1.2
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

The finding of biatrial enlargement in the face of normal LV wall thickness and LV fibrosis, is most consistent with Restrictive Cardiomyopathy (RCM). This is largely unexpected in a young cat, and likely reflects silent congenital disease. Some prior infectious or inflammatory insult to the myocardium is also possible. No additional issues are identified, and the ECG shows no obvious dysrhythmias.



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The finding of atrial dilation confers risk for progression in the future and use of Pimobendan (off label use) should be considered. No additional medications are indicated at this time; however, close follow-up is advised.

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The long-term prognosis is guarded; however, there is a highly variable rate of progression in cats with subclinical disease. There will always remain risk for progression to CHF and development of blood clots in the future. Monitoring is certainly advised, particularly should any respiratory signs, collapse or significant lethargy be noted in the future.

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These findings do not necessarily explain an anesthetic event, particularly in light of no obvious arrhythmias on the ECG. Consider a drug reaction as a possible issue, particularly given that cardiac-protective agents were used. This patient is at risk for fluid overload; however, arrhythmias would be largely unexpected. The ST segment is elevated; however, this is of unknown significance in a single lead tracing. A 6 lead tracing should be considered, particularly if further issues are identified.

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RECOMMENDATIONS

- If able, recommend institute Pimobendan (off label use) 1.25mg PO q12h.
- Consider a 6 lead ECG is possible.
- Given prior anesthetic event, consider referral to facility with an Anesthesiologist if possible. If declined, anesthetic risk is considered moderately elevated, and judicious IV fluid rates are advised to avoid fluid overload. Avoid vasodilators as this may worsen the obstruction. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, isoflurane maintenance. Additionally, steroids and/or fluid therapy should be avoided lifelong unless absolutely necessary.
- Monitor for any clinical evidence of cardiac compromise, including respiratory changes, collapse and/or signs of a blood clot event (paralysis, neurologic changes, etc.).

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PLAN

- Recheck echocardiogram in 6 months, sooner if clinical signs arise.

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

IMAGES



HOSPITAL NAME

Mass Veterinary
Services

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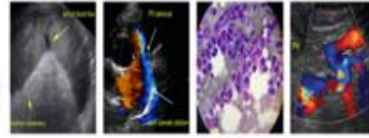
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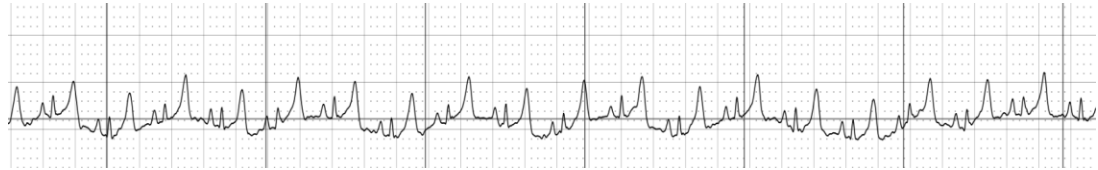
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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Echocardiogram performed by: Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)