



**PATIENT**

Leo Ramsundar

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Male Neutered

**AGE**

12.19.13

**WEIGHT**

10lbs

**INTERPRETED BY**

Maggie Machen Lamy,  
DVM, DACVIM  
(Cardiology)

**HOSPITAL NAME**

Homeward Bound  
Veterinary

**REFERRING VET**

Dr. Vance

**INVOICE**

31510

**DATE**

6.23.23

**PRESENTING CLINICAL SIGNS**

History: Presenting for not eating for the last 2 months. Is a chronic URI cat. History of a heart murmur. Dyspnea noted upon exam.

-Current medications: None listed.

-Sedation used: Not required to complete full diagnostic ultrasound.

-Pertinent previous ultrasound results: No previous.

-STAT: Requested/Approved.

-Imaging performed by: Stephanie Warga RDCS, RVT.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is normal in dimension. The LV is mildly dilated with adequate myocardial function. There is a diffusely hyperechoic endocardium consistent with fibrosis. The papillary muscles are remodeled. The left atrium is moderate to severely dilated. No smoke seen in the LA. The left auricle is dilated as well. Mild to moderate mitral regurgitation. The right atrium is mildly enlarged. The right ventricle appears normal. Mild tricuspid regurgitation. Scant pericardial effusion. No pleural effusion. No obvious cardiac tumors.

**CARDIAC CHART**

FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm) <small>(Moise, Pipers)</small>	LVIDd (cm) <small>(Moise, Pipers)</small>	LVWd (cm) <small>(Moise, Pipers)</small>	FS (%)	EF (%)
NORMAL PARAMETER	-----	150-240	3.5-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	4.5	NM	0.46	1.8	0.45	52	86
FELINE CARDIAC PARAMETERS	LA/AO <small>(Boon)</small>	LA/AO HEART BASE (Swe) <small>(Abbott)</small>	LA 2D short axis Base view (cm) <small>(Abbott)</small>		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	1.85	1.8		1.7	0.8	NM

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

The finding of biatrial enlargement in the face of normal LV wall thickness is most consistent with Unclassified Cardiomyopathy (UCM); however, some prior infectious or inflammatory insult to the myocardium cannot be definitively ruled out. Regardless of categorical classification, the finding of this degree of atrial dilation is concerning for development of CHF. Pericardial effusion is noted in a dyspneic patient, likely supporting early decompensation. Baseline CXR are strongly recommended with hospitalization if the patient is or becomes unstable. No additional structural issues are identified in this study.

If able to be stabilized, prognosis is guarded to poor long term with risk for recurrence going forward. There will always be risk for progression to CHF, malignant arrhythmias, development of blood clots and/or sudden death in the future. Monitoring of sleeping breathing rates at home is recommended as the best way to screen for progression to CHF at home.

Anesthesia, steroid or fluid therapy should be avoided in this case.

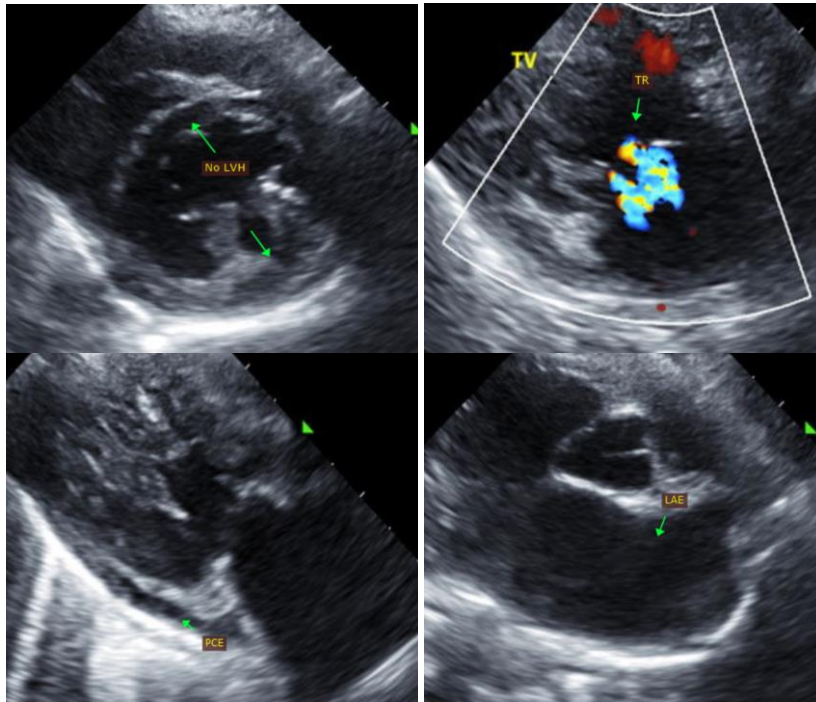
## PLAN

Screening BP and CXR are recommend. Consider hospitalization if indicated. 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) 1.25mg PO q12h. Institute Lasix 1mg/kg q12h.

Renal values and BP in 1-2 weeks, then ever 3-4 months lifelong. If doing well and BP is >130mmHg, institute ACE-I 0.5mg/kg PO q12h.

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

## 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.

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