

**PATIENT**

Emmi Fowler

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Female Spayed

**AGE**

1.19.11

**WEIGHT**

12.7lbs

**INTERPRETED BY**Maggie Machen Lamy,  
DVM, DACVIM  
(Cardiology)**HOSPITAL NAME**Chadwell Animal  
Hospital**REFERRING VET**

Dr. Schaupp

**INVOICE**

25347

**DATE**

7.15.22

**PRESENTING CLINICAL SIGNS**

History: Recheck echo. Asymptomatic.

-Abnormal lab results: None recent.

-Current medications: None listed.

-Blood pressure: 131/103, 130/102, 131/102 and 131/101mmHg.

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

-Pertinent previous ultrasound results (11/9/21 MML): Borderline to mild LVH, no LAE, moderate SAM, trace AI. IVSd: 0.54, LVWd: 0.55, LA: 1.2, AV max: 4.0m/s.

-STAT: Declined.

-Imaging performed by: Stephanie Pearce RDCS, RVT.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is borderline to mildly hypertrophied. There is a diffusely hyperechoic endocardium consistent with fibrosis and ventricular remodeling. Mild papillary muscle remodeling. The right ventricle is subjectively normal in size and morphology. There is mild left atrial enlargement present. No right atrial enlargement present. Normal RVOT velocity. Mild systolic anterior motion (SAM) of the mitral valve present, with an elevated dynamic LVOT velocity. There is mild eccentric mitral regurgitation present secondary to SAM. Mild AI. No other significant valvular regurgitation is present. Scant pericardial effusion noted. No pleural effusion appreciated. 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	5.8	NM	0.58	1.6	0.55	45	80
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	1.6	1.4	2.0	0.72	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

HOCM persists as was previously documented. Compared to the prior study, the only difference is mild left atrial enlargement has developed (previously normal). This likely reflects mildly progressive disease; however, the risk for complication remains low. The LV wall dimensions remain similar and the LVOTO is actually less apparent. Of unknown clinical relevance, there is scant pericardial effusion present. This is certainly noncardiac in origin given only mild left atrial dilation. Consider full systemic evaluation, such as an abdominal ultrasound to assess for additional underlying issues. That being said, the amount is quite small and the patient asymptomatic, and simple monitoring is also reasonable. No additional issues are identified.

Given these findings, no medications remain indicated. While mild left atrial enlargement is somewhat concerning, the LVOTO is mild making Atenolol likely of limited utility.

No cardiac contraindication for general anesthesia. Mild IV fluid restriction is advised. Risk for complication with steroid use typically follows LA dilation, which in this case is low. That being said, any cat can experience unexpected signs of intolerance and monitoring of RR/RE is advised particularly in the initiation phase.

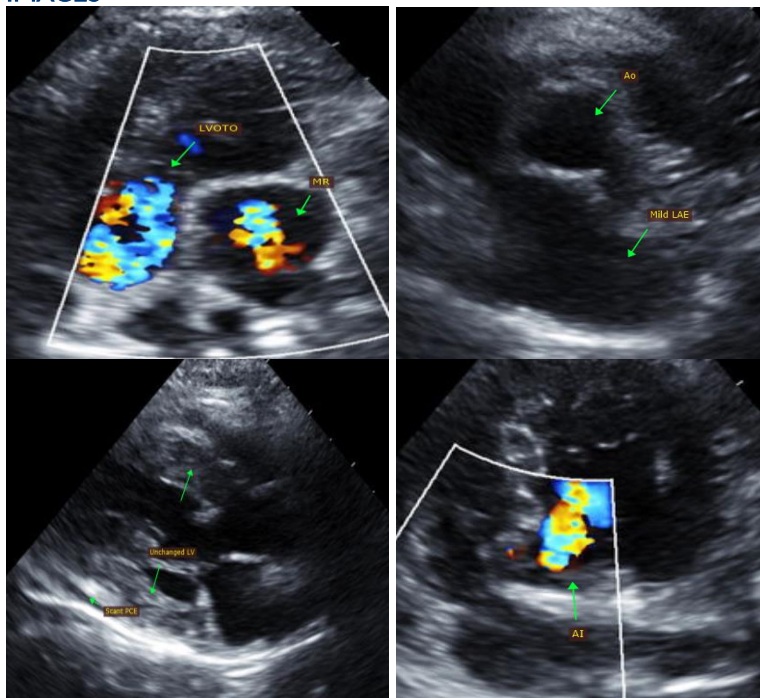
Monitor at home for any respiratory signs or blood clot events (neurologic change, paralysis, etc.). Anesthetic risk is considered mild, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (ketamine, glycopyrrolate, atropine).

## PLAN

Screening BP and T4 every 6 months. Consider full systemic work up as discussed.

Reassess effusion status in 2-3 months, sooner if clinical signs arise. Otherwise, recommend recheck echocardiogram in 6-8 months to assess for progression, sooner if clinical issues arise.

## 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)**  
**info@sonopath.com**