



**PATIENT**

Stinky Randal

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Female Spayed

**AGE**

11 years

**WEIGHT**

11lbs

**INTERPRETED BY**

Maggie Machen  
Lamy, DVM  
DACVIM (Cardiology)

**IMAGING**

**PERFORMED BY**

Pamela Harrigan,  
RDCS

**HOSPITAL NAME**

Compassionate Care  
Veterinary Clinic

**REFERRING VET**

Dr. Farrington

**INVOICE**

25508

**DATE**

7/22/22

**PRESENTING CLINICAL SIGNS**

History: History heart murmur, borderline hyperthyroidism, arthritis, dental disease. Seen at Tufts for hypertension in Nov 2021 - did not continue medications. Presents for acute onset ataxia, lethargy. PE= generalized atrophy and poor body condition, but weight stable from previous visit in February 2022. On exam: grade III/VI systolic murmur; bounding femoral pulses and gallop rhythm. Ataxia, weakness to right side, normal retinal appearance. r/o hypertensive crisis vs stroke vs primary neuro disease. Started back on Amlodipine 2.5mg, 1/4 q24h. Pro BNP 254, SDMA 20.

**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 with a focal septal thickening. There is a diffusely hyperechoic endocardium consistent with significant fibrosis. The papillary muscles are mildly remodeled and hyperechoic.

**Left atrium:** The left atrium is normal. No obvious spontaneous contrast 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 in morphology and mobility. Normal aortic outflow velocity; laminar flow. No aortic insufficiency.

**Right ventricle:** Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.

**Right atrium:** The right atrium is normal in dimension.

**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.

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

**Heart rhythm:** ECG reveals a sinus rhythm with an average HR of 210bpm.

**2-Dimensional Measurements**

Ao diam (cm)	1.0
LA diam (cm)	1.1
LA:Ao (Swe)	1.1
IVS thickness (cm)	0.64
LVID diastole (cm)	1.5
PW thickness (cm)	0.51
LVID systole (cm)	0.30
FS (%)	76

**Doppler Measurements**

PV Vmax (m/s)	0.8
AoV Vmax (m/s)	1.0
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

**INTERPRETATION OF THE FINDINGS**

The only abnormality identified is mild focal septal hypertrophy with an irregular LV appearance. This may simply be secondary to reported systemic hypertension; however, follow up is advised. Hyperthyroidism can also contribute to this finding and should continue to be monitored. Regardless, the LA is normal, which suggests low risk for complication. No cause for the murmur is identified, making it likely physiologic in origin.

These findings would suggest the episode is unrelated to structural disease. Systemic hypertension is considered more likely; however, a blood pressure is not reported. Follow up is dictated by IM evaluation/BP.



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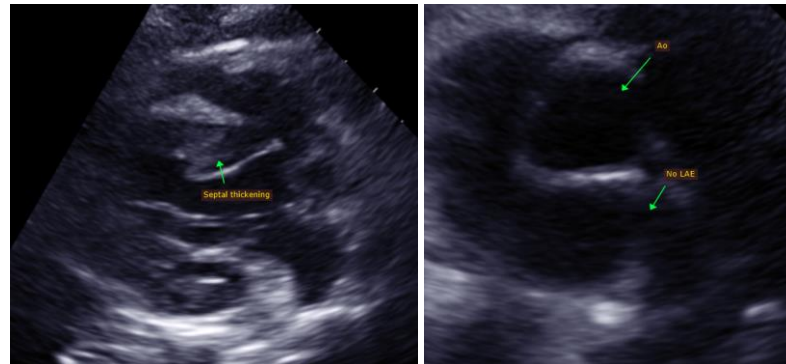
**RECOMMENDATIONS**

- Given these findings, no medications are indicated.
- Monitor BP and T4 every 6 months.
- Anesthetic risk is considered mildly elevated, with risk for fluid overload, spontaneous CHF, hypotension, etc. Judicious IV fluid rates are advised to avoid fluid overload. Drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Avoid ketamine, telazol, acepromazine and Dexdomitor. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, isoflurane maintenance.
- Monitor for any clinical evidence of cardiac compromise, including respiratory changes and/or signs of a blood clot event (paralysis, neurologic changes, etc.).

**PLAN**

- Recommend recheck echocardiogram in 6 -12 months to screen for progression, sooner if any clinical signs arise in the interim.

**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**  
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 info@sonopath.com