



**PATIENT**

Tristan Konefal

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Male Neutered

**AGE**

6 years

**WEIGHT**

12.9lbs

**INTERPRETED BY**

Maggie Machen  
Lamy, DVM  
DACVIM (Cardiology)

**IMAGING**

**PERFORMED BY**

Pamela Harrigan,  
RDCS

**HOSPITAL NAME**

Mass Veterinary  
Services

**REFERRING VET**

Dr. Masloski

**INVOICE**

32016

**DATE**

7/31/23

**PRESENTING CLINICAL SIGNS**

History: Recheck echo. History HOCM, progressive on prior echocardiogram. Presently, Tristan is doing well at home. Good appetite. On exam: NSR, grade III/VI murmur noted on sternum, PSS, lung fields clear, compressible thorax, mm pink, moist, CRT<2. BP: 100mmHg x 4. Current medications: Atenolol 6.25mg SID, fish oil. \*No sedation for study.  
-Pertinent previous echo findings (1/31/23 MML): LA 1.5 cm; LA:Ao 1.5, IVS 0.69 cm; PW 0.53, moderate septal hypertrophy, asymmetric, mild LAE, LVOT Vmax 4.5 m/s.

**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 asymmetric with borderline septal dimension and a normal free wall. There is a diffusely hyperechoic endocardium consistent with fibrosis. The papillary muscles are mildly remodeled, The endocardium appears mildly remodeled.

**Left atrium:** The left atrium is moderately dilated. Subtle smoke suspected.

**Mitral valve:** The anterior leaflet of the mitral valve appears largely normal. Systolic anterior motion is seen on 2D imaging. Trace MR.

**Aortic valve/Aorta:** The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity. 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.

**Pulmonary 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 160bpm.

**2-Dimensional Measurements**

Ao diam (cm)	1.0
LA diam (cm)	1.7
LA:Ao (Swe)	1.7
IVS thickness (cm)	0.58
LVID diastole (cm)	1.6
PW thickness (cm)	0.53
LVID systole (cm)	0.6
FS (%)	63

**Doppler Measurements**

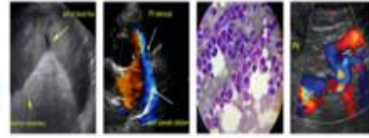
PV Vmax (m/s)	1.2
AoV Vmax (m/s)	1.9
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

**INTERPRETATION OF THE FINDINGS**

Compared to the prior study, the LA is progressively dilated with concern for subtle smoke. In contrast, the LV dimension has actually improved on Atenolol with resolution of the LVOT obstruction. The former finding is clearly concerning, as there may be risk for development of blood clots in the future. No additional issues are identified.

Given these findings, continued Atenolol is recommended with addition of Plavix if able to be medicated.

Prognosis is guarded due to the progression in findings.



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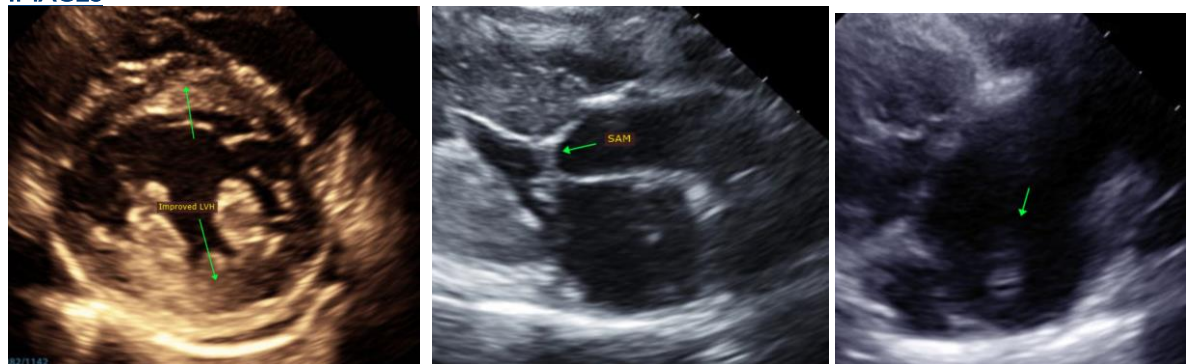
**RECOMMENDATIONS**

- Continue Atenolol as prescribed.
- If able, institute Plavix 75mg tabs; Give ¼ tab by mouth every 24 hours (NOTE: bitter along cut edge, may cause foaming at the mouth; coat in entirety).
- Screening HR, BP/T4 every 6 months.
- Anesthetic risk is considered mildly elevated, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine).
- 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 months to assess rate of progression, sooner if any issues 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  
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)  
info@sonopath.com

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