



PATIENT

Timmy Waddell

SPECIES

Feline

BREED

Tonkinese

SEX

Male Neutered

AGE

16 years

WEIGHT

9.69lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM
DACVIM (Cardiology)

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS

HOSPITAL NAME

Mass Veterinary
Services

REFERRING VET

Dr. Masloski

INVOICE

25823

DATE

8/17/22

PRESENTING CLINICAL SIGNS

History: Recheck echo. History HCM diagnosed on prior echo. Currently: Timmy is doing well overall but does vomit frequently. He is eating well with normal activity. Blood pressure checks at his primary, as well as here, have been within normal limits. On exam: gallop rhythm noted, grade II/VI murmur noted on sternum, PSS, lung fields clear, compressible thorax. BP: 200mmHg x 4. Medications: 1) Probiotic daily 2) Benazepril 5mg 1 tab twice a day 3) Plavix/clopidogrel 75mg 1/4 tab daily *Sedated with propofol for most of study. -Pertinent previous echo findings (2/23/22 Maggie Machen Lamy, DVM, DACVIM-Cardiology): LA 1.7 cm; LA:Ao 2.4; IVS 0.6 cm; PW 0.73 cm; LVOT 0.87 m/s (sedated).

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 mild to moderate generalized thickening. There is a diffusely hyperechoic endocardium consistent with mild fibrosis. The papillary muscles are hypertrophied and hyperechoic. The endocardium appears mildly remodeled. Mild mid-LV obstruction is suspected on color flow imaging.

Left atrium: The left atrial and auricle are severely dilated. Subtle smoke appreciated.

Mitral valve: The mitral valve is normal in structure and mobility. No obvious SAM. Trace 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.

Tricuspid valve: The tricuspid valve appears normal with trace tricuspid regurgitation.

Pulmonary 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.

Heart rhythm: ECG reveals a sinus rhythm with an average HR of 180bpm.

2-Dimensional Measurements

Ao diam (cm)	0.7
LA diam (cm)	1.8
LA:Ao (Swe)	2.5
IVS thickness (cm)	0.58
LVID diastole (cm)	1.3
PW thickness (cm)	0.7
LVID systole (cm)	0.5
FS (%)	62

Doppler Measurements

PV Vmax (m/s)	0.64
AoV Vmax (m/s)	1.0
MR Vmax (m/s)	NM
TR Vmax (m/s)	NM
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Hypertrophic cardiomyopathy (HCM) persists with relative stability. While persistently severe, the left heart dimensions and wall thicknesses are similar to previous. Of great concern, there is now obvious smoke in the left atrium, which raises risk for a blood clot event going forward. No obvious additional issues have developed.

Given these findings, reasonable to continue 2 medications as prescribed. The BP is elevated, although has been previous documented as normal and simple monitoring is recommended. Even with stability seen here, consider addition of Lasix and Pimobendan



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given severity of disease and development of smoke and high risk for complication, if able to be medicated at home.

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Prognosis is guarded to poor long-term; however, it is certainly encouraging the patient continues to do well.

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Tonkinese

RECOMMENDATIONS

- Continue Plavix and ACE-I as prescribed.
- Reassess BP every 4-6 months lifelong.
- If elected, institute low-dose Lasix 1mg/kg PO q12h.
- Consider institute Pimobendan 1.25mg PO q12h.
- Monitor BP and T4 every 6 months as exacerbating issues.
- Anesthetic risk is considered moderately elevated, with high 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.
- Risk for complication with steroid use follows left atrial dilation, which in this case is certainly elevated. Ideally, avoid steroids in this patient given the risk for fluid overload. If elected for systemic wellness, close monitoring of RR/RE particularly during the initiation phase is recommended.
- Monitor for any clinical evidence of cardiac compromise, including respiratory changes and/or signs of a blood clot event (paralysis, neurologic changes, etc.).

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PLAN

- Recommend recheck echocardiogram in 6 months, sooner if clinical issues arise.

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IMAGES



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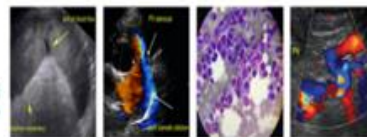
The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

DATE
8/17/22

Maggie Machen Lamy, DVM
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com



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Echocardiogram performed by:

Pamela Harrigan, RDCS
Pet Animal Ultrasound Service (4paus.com)

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