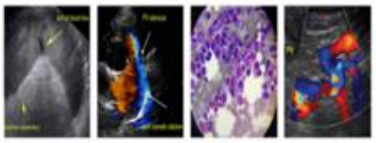
Mass Veterinary Services



SonoPath Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Leo Hamel

SPECIES
Feline

BREED
Siberian

SEX
Male Intact

AGE
2 years

WEIGHT
9.44lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Services

REFERRING VET
Dr. Masloski

INVOICE
32486

DATE
8/22/23

PRESENTING CLINICAL SIGNS

History: Recheck echo. History double chambered right ventricle. Leo is doing well at home but is starting to spray and the owner would like to get him neutered. He is eating well and remains active. On exam: NSR, grade IV/VI parasternal murmur, PSS, lung fields clear, compressible thorax, mm pink, moist, CRT<2. BP: 120-130mmHg. Current medications: Atenolol 25mg 1/4 tab daily *Sedated with propofol for study.
-Pertinent previous echo measurements (5/18/22 MML): LA 1.0 cm; LA:Ao 1.3, LV 1.2 cm.

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. There is a mildly hyperechoic endocardium. The papillary muscles are normal. The endocardium appears mildly remodeled. Subtle septal flattening.
Left atrium: The left atrium is normal in dimension. 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: The RV walls are mild to moderately hypertrophied. Exuberant fibrotic tissue is noted within the mid-RV, creating a significant stenosis through the region; max velocity through region is 4.1m/s.
Right atrium: The right atrium is moderately dilated.
Tricuspid valve: The tricuspid valve appears normal with no significant tricuspid regurgitation. Flow through the MPA is normal.
Pulmonic valve/Pulmonary artery: The pulmonic valve appears normal. No pulmonic insufficiency.
Pericardium/other: No pericardial or pleural effusion noted. No obvious cardiac masses.
Heart rhythm: ECG reveals a sinus rhythm with an average HR of 166bpm.

2-Dimensional Measurements

Ao diam (cm)	0.8
LA diam (cm)	0.8
LA:Ao (Swe)	1.0
IVS thickness (cm)	0.40
LVID diastole (cm)	0.82
PW thickness (cm)	0.46
LVID systole (cm)	0.32
FS (%)	61

Doppler Measurements

PV Vmax (m/s)	0.9
AoV Vmax (m/s)	0.63
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Compared to the prior study, findings are similar. The max velocity through the stenosis is slightly improved, likely due to Atenolol therapy. RA and RV abnormalities are unchanged, suggesting stability overall. No additional issues have developed.

Given these findings, continue Atenolol lifelong. Even with stability seen here, there will always be risk for right-sided CHF, exertional syncope, blood clot events and/or sudden death.

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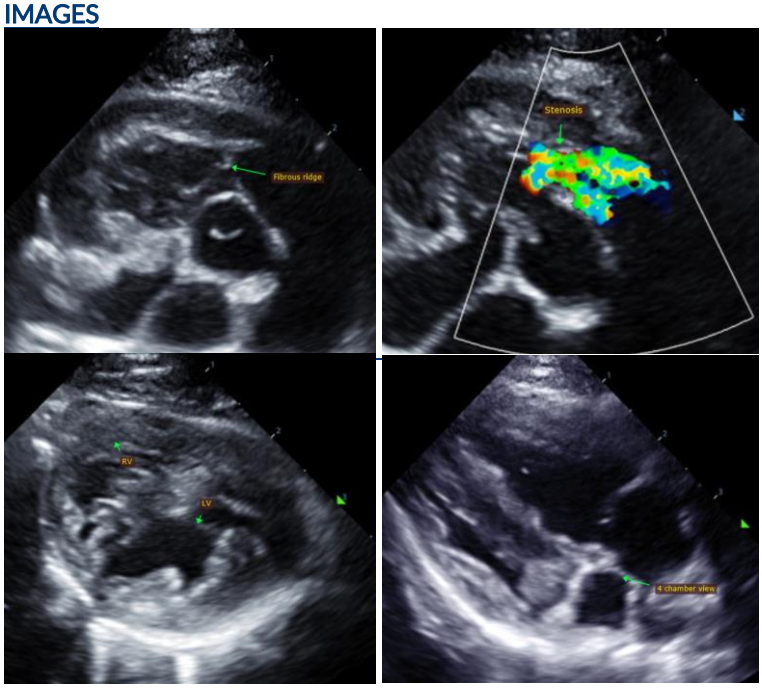
RECOMMENDATIONS

- Continue Atenolol as prescribed.
- If needed, anesthetic risk is considered moderately elevated, and judicious IV fluid rates are advised avoid fluid overload. Pre-oxygenate for 5 minutes prior to induction and recover in O2 if possible. Drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, and isoflurane maintenance. Monitor heart rate, BP, ECG carefully and intervene as necessary.
- Monitor for any clinical evidence of cardiac compromise, including respiratory changes, abdominal distention, syncope, and/or signs of a blood clot event (paralysis, neurologic changes, etc.). Mild lifelong exercise restriction is advised.

PLAN

- Recommend recheck echocardiogram annually, sooner if clinical signs 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

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