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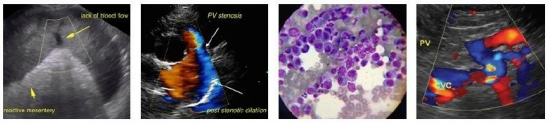


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT
Dotty Ortiz

SPECIES
Feline

BREED
DSH

SEX
Female Spayed

AGE
12 years

WEIGHT
11.5lbs; 5.2kgs

INTERPRETED BY
Maggie Machen Lamy, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY
Loetitia St-Jacques, LVT/RVT

HOSPITAL NAME
VCA Feline Animal Hospital

REFERRING VET
Dr. Fleming

INVOICE
32243

DATE
8/8/23

PRESENTING CLINICAL SIGNS

History: Chronic vomiting. History of hypertensive. No murmur or arrhythmia. BP improved from 180 to 156mmHg. Screen for causes of SHT.
-Current medications: Diet: Hills K/D Med: Amlodipine 0.625mg PO q24.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is mildly increased in dimension with a small internal chamber. There is a mildly hyperechoic endocardium consistent with fibrosis. Mild symmetric papillary muscle hypertrophy and remodeling. The right ventricle is subjectively normal in size and morphology. There is no left atrial enlargement present. No right atrial enlargement present. Normal RVOT velocity. Trace TR. Normal LVOT velocity. There is no obvious systolic anterior motion (SAM) of the mitral valve present. No MR. There is no pericardial effusion noted. No pleural effusion appreciated. No obvious cardiac tumors.

CARDIAC CHART

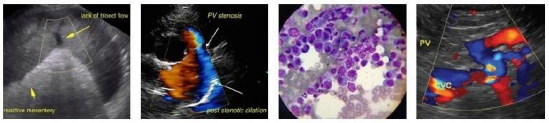
FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm) (Moise, Pipers)	LVIDd (cm) (Moise, Pipers)	LVWd (cm) (Moise, Pipers)	FS (%)	EF (%)
NORMAL PARAMETER	------	150-240	0.35-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	5.2	214	0.68	0.95	0.67	65	94
FELINE CARDIAC PARAMETERS	LA/AO (Boon)	LA/AO HEART BASE (Swe) (Abbott)	LA 2D short axis Base view (cm) (Abbott)		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	1.3	1.2		1.5	1.0	NM

**Note: All measurements based upon multi-modal images and methods. An average value is reported.*
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

Hypertrophic cardiomyopathy (HCM) is a rule out diagnosis once a patient is deemed normotensive and euthyroid. Pseudohypertrophy must also be considered, given a small LV chamber. Regardless, the degree of disease is mild, with only mild LVH and no LA dilation. This would indicate the risk for clinical issues is low at this time. No additional issues are identified.

It is important to note that primary cardiac issues do not cause systemic hypertension, rather the inverse is true with secondary hypertrophy developing due to chronically elevated blood pressure. What is seen here may be related to historical hypertension, although a reported BP of 156mmHg would suggest relatively good control. Continue Amlodipine +/- additional vasodilator therapy as dictated by Internal Medicine Screening for causes of SHT is recommended, such as PLN, Cushing's, etc.



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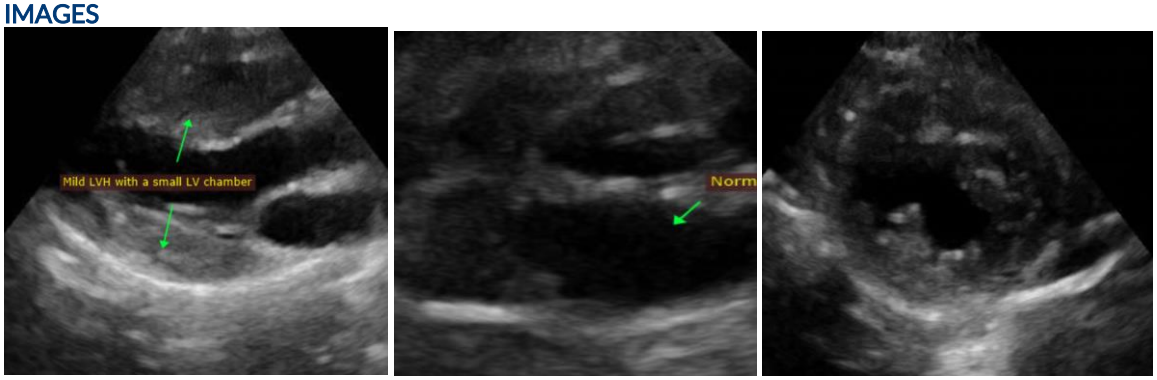
Monitor at home for any respiratory issues or signs of blood clot events (neurologic change, paralysis, etc.). Anesthetic risk is considered mild, however judicious fluid administration is advised if needed with careful RR/RE monitoring to screen for fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Risk for complication with steroid use typically follows LA dilation, which in this case is mildly elevated. If needed, monitoring of RR/RE is advised particularly in the initiation phase.

PLAN

A screening blood pressure and T4 are recommended every 6 months lifelong. Consider underlying causes of SHT as discussed. Consider further vasodilator therapy if indicated

A recheck echocardiogram is recommended in 6-12 months to assess for 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
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