

PATIENT

Dominic Werner

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

12 years

WEIGHT

11.5lbs

INTERPRETED BY

Maggie Machen
Lamy, DVM, DACVIM
(Cardiology)

HOSPITAL NAME

Cat Hospital at
Towson

REFERRING VET

Dr. Fitzgerald

PRESENTING CLINICAL SIGNS

History: Patient presented for hyporexia and decreased defecation that started after second cat in home passed away 1 month prior. When O takes P to beach house symptoms resolved for entire week, when brought back symptoms returned. P has lost 3# in 5 months but otherwise normal on examination - no palpable stool or abdominal pain, normal TPR, strong pulse and no murmur. Blood pressure normal.

-Pertinent abnormal PE/Chem/CBC/UA Results: Elevated ProBNP: 499 and suspect stress leukogram that has been historic vs inflammation.

-Current medications: Mirtazapine 1.5inch TD SID, Gabapentin 10mg PO BID

-Sedation used: Not needed.

-STAT: Declined by Dr

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is irregular, with a focal thinning of the apical free wall. The remainder of the wall dimensions are normal without obvious hypertrophy. There is a diffusely hyperechoic endocardium consistent with fibrosis. The papillary muscles are remodeled. Systolic function is depressed, with an akinetic free wall. The left atrium is normal. The mitral valve is normal. No MR. The right atrium appears normal. The right ventricle appears normal. No TR. Blood flow through the LVOT and RVOT is normal. Scant pleural and pericardial effusion are seen. No obvious cardiac tumors.

CARDIAC CHART

FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm) <small>(Moise, Pipers)</small>	LVIDd (cm) <small>(Moise, Pipers)</small>	LVWd (cm) <small>(Moise, Pipers)</small>	FS (%)	EF (%)
NORMAL PARAMETER	-----	150-240	3.5-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	5.2	175	0.44	1.6	0.34	24	52
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	1.2	1.1		0.7	1.2	NM

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.

INVOICE

20421

DATE

8/9/21

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Restrictive/unclassified cardiomyopathy (R/UCM) is suspected, with potentially an infarcted free wall. The diagnosis is based upon LV dysfunction and irregularity of the wall morphology. It is also possible that this patient has essentially a normal cardiac structure with simply a previous infarcted for an unknown reason. Regardless, both atria are normal indicating relatively low risk for complication at this time. Many cats with this presentation will remain occult/asymptomatic for extended periods of time, however there is a subset that will experience more rapid progression. No additional issues are identified.

Given the appearance of the LV with overall systolic dysfunction, it may be reasonable to institute cardiac supportive Pimobendan in this case (off label use). That being said, both atria are normal indicating there is relatively low risk for complication at this time. If this cat is difficult to medicate, an alternative would be to monitor closely for progression in the next 6 months. No additional medications are indicated at this time.

Despite these findings, **bicavitary effusion is unlikely to be cardiogenic in origin** as prior to atrial enlargement there is low risk for CHF. Further systemic evaluation is advised and obtaining a sample of the effusion would be highly useful from a diagnostic standpoint.

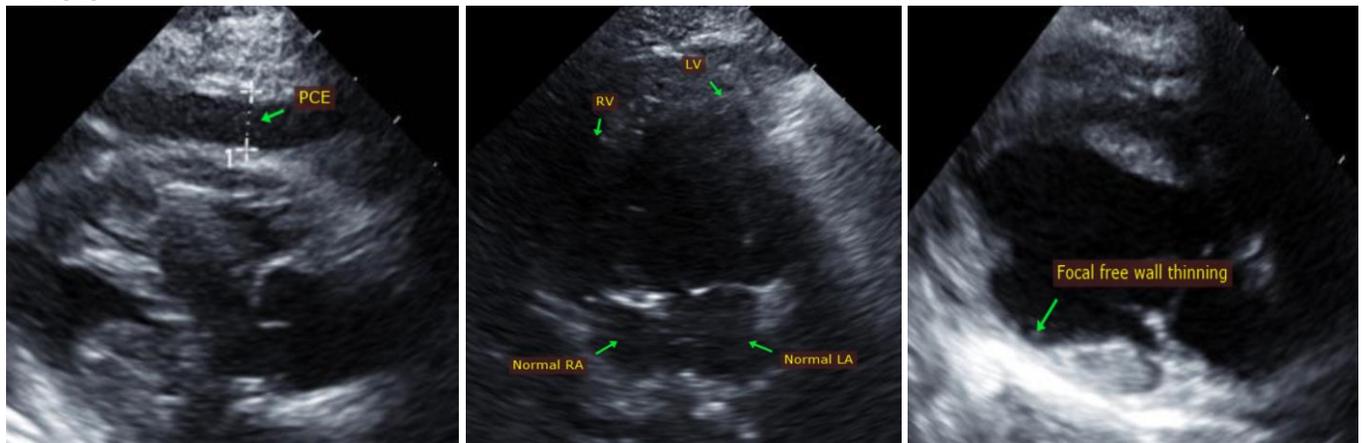
Anesthetic risk is considered mildly elevated, with risk for fluid overload, spontaneous CHF, hypotension, etc. Judicious IV fluid rates are advised to avoid fluid overload. Drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Avoid ketamine, telazol, acepromazine and Dexdomitor. A reasonable protocol would include opioid/benzodiazepine pre-medication, propofol induction, isoflurane gas.

PLAN

Consider Pimobendan as discussed: 1.25mg PO q12h. Further systemic evaluation of bicavitary effusion including sampling, internal medicine consultation, etc.

Recommend recheck echocardiogram in 6 months to assess for progression and need for medications, 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)