
**PATIENT**

Buster IFTIGER

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Male Neutered

**AGE**

~11 years

**WEIGHT**

15lbs; 6.8kgs

**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**

21015

**DATE**

9/14/21

**PRESENTING CLINICAL SIGNS**

History: Recheck echo. Presented for vomiting and decreased appetite. No diarrhea. Buster has also been eating less, which means he has not been eating the treats soaked with his heart medications. PPH: HOCM, severe Urethral obstruction with cystotomy and urethrotomy May 2018 Diet: Hills c/d Dental treats

-Current medications: Furosemide 10mg PO BID, Atenolol 6.25mg PO q24h, Benazepril 2.5mg PO BID.

-Pertinent previous echo findings (8/2019 MML): Severe LVH, RVH, moderate RAE, moderate to severe LAE, moderate MR, moderate SAM, mild TR. IVSd: 0.83, LVWd: 1.0, AV max: 3.5, LA; 2.0.

**ECHOCARDIOGRAM FINDINGS**

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is mildly hypertrophied with regions of irregularity. The LVOT flow velocity is normal. No obvious SAM. Mild MR due to annular stretch. There is normal LV diameter in diastole, adequate function. Mild papillary muscle hypertrophy with remodeling. The left atrium is markedly dilated with a horizontal component. Obvious spontaneous contrast seen in both atria. The right atrium is severely dilated as well. The right ventricle is mildly hypertrophied. There is mild to moderate TR. TR velocity consistent with mild to moderate pulmonary hypertension. The flow through the RVOT is normal in velocity. Scant pericardial and pleural effusion. No evidence of cardiac tumors.

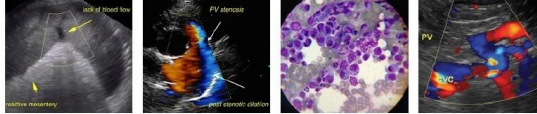
**CARDIAC CHART**

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	6.8	NM	0.6	1.5	0.67	58	92
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	2.5	2.5		1.5	1.7	NM
<i>*Note: All measurements based upon multi-modal images and methods. An average value is reported.</i> 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**

End-stage cardiomyopathy with biventricular involvement persists, with evidence of significant progression. The LV wall continues to decrease, consistent with burnout or end-stage disease. Both atria are severely enlarged with smoke identified; however, no obvious thrombus formation. No obvious LVOT obstruction is seen, and the overall heart rate appears relatively low. Follow up is advised as Atenolol may need to be weaned or discontinued. Finally, and most importantly, scant pericardial and pleural effusion is identified suggesting recurrent congestive heart failure.

Continued full cardiac support is recommended as below. If Lasix has recently been increased and the patient has improved, this should be continued. If no changes have been made, certainly an increase is warranted as below. A heart rate should be evaluated; if &lt;140bpm stressed



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discontinuing Atenolol is recommended going forward. Finally, a baseline blood pressure is strongly recommended as many cases with effusion will present hypotensive. If <130mmHg, Benazepril should also be discontinued. Finally, Plavix is strongly recommended if able to be administered in this patient and Pimobendan could also be considered. As an aside, this patient does appear unstable and if the clinical signs persist or worsen hospitalization is strongly recommended. Long-term prognosis remains poor to grave. If any symptoms of a peripheral thrombus develop, such as paralysis, humane euthanasia should certainly be considered.

The patient will always be at high risk for recurrent episodes of CHF, development of blood clots, and/or malignant arrhythmias/sudden death in the future. Monitoring of sleeping breathing rates at home is recommended as the best way to screen for response to medications and progressing to recurrent CHF at home.

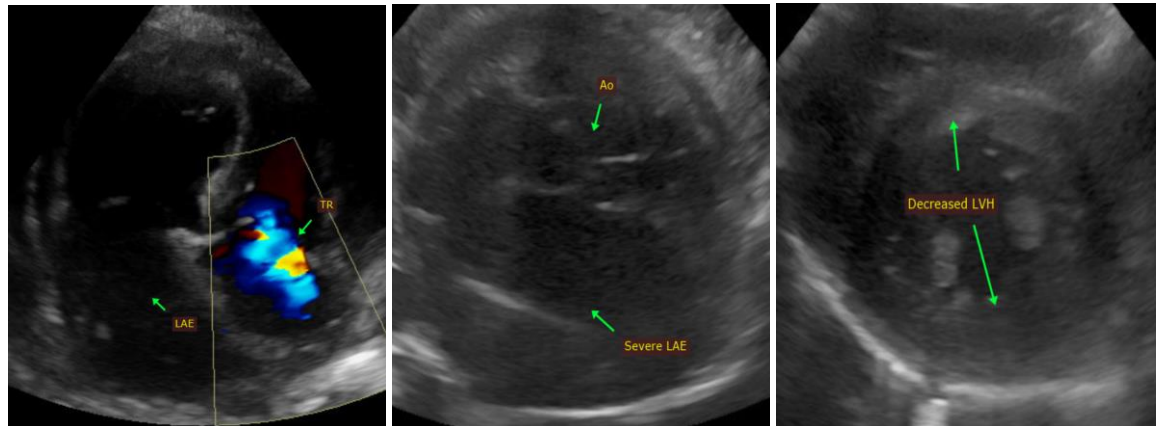
**PLAN**

Consider alter Lasix dose as discussed if not recently performed. If needed, increase to TID dosing. Assess heart rate and blood pressure and wean/discontinue Atenolol and Benazepril as discussed. Consider institute Plavix if possible: 75mg tabs; Give ¼ tab by mouth every 24 hours (NOTE: bitter along cut edge, may cause foaming at the mouth; coat in entirety). Consider institute Pimobendan if possible: 1.25mg PO q12h. Hospitalize if needed.

Recheck renal values and BP in 1-2 weeks, then every 3-4 months lifelong.

Going forward, a recheck echocardiogram is recommended in 6 months to assess progression.

**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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