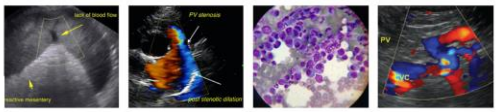
Mass Veterinary Specialty Services
1-413-734-1292



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

PATIENT
Rosco Wadkins

SPECIES
Feline

BREED
DSH

SEX
Male Neutered

AGE
8 years

WEIGHT
19lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Mass Veterinary Specialty Services

REFERRING VET
Dr. Masloski

INVOICE
21032

DATE
9/15/21

PRESENTING CLINICAL SIGNS

History: Recheck echo. History end-stage HOCM. Current presentation: Rosco is doing well at home with no concerns. His appetite and activity level remain normal. CV/RESP: NSR grade II/VI murmur best noted on sternum, PSS, lung fields clear. BP: 110mmHg.
-Current medications: 1) Atenolol 25mg 1/4 tab twice a day 2) Plavix 75mg 1/4 tab daily.
*Sedated with propofol.
-Pertinent previous echo findings (11/18/20 MML): LA 2.7; LA:Ao 2.7; OVS 0.66 cm; PW 0.89 cm; LVOT 1.1 m/s; LVH with extensive remodeling; severe LAE with spontaneous contrast.

ELECTROCARDIOGRAPHIC FINDINGS *Note: Single lead ECGs are evaluated as a rhythm strip. Morphology/MEA cannot be definitively commented on.

A single lead ECG is available; 25mm/s, 20mm/mV. The underlying rhythm is sinus in origin with a p for every QRS complex and vice versa. Frequent APCs throughout. Periods of atrial bigeminy. No couplets, triplets, or runs of SVT are appreciated.
ECG diagnosis: Normal sinus rhythm with frequent isolated APCs.

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 marked free wall hypertrophy and borderline septal thickening. There is a diffusely hyperechoic endocardium with extensive remodeling. The papillary muscles are hyperechoic and hypertrophied.
Left atrium: The left atrium is markedly dilated with obvious spontaneous contrast.
Mitral valve: The mitral valve appears normal with **no obvious** systolic anterior motion noted. Mild to moderate eccentric MR secondary to SAM.
Aortic valve/Aorta: The aortic valve is normal in morphology and mobility. Normal aortic outflow velocity. Trace aortic insufficiency is seen.
Right ventricle: Normal right ventricular diameter and morphology indicating no overt evidence of pulmonary arterial hypertension.
Right atrium: The right atrium is normal in dimension.
Tricuspid valve: The tricuspid valve appears normal with no 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.

2-Dimensional Measurements

Ao diam (cm)	1.0
LA diam (cm)	2.8
LA:Ao (Swe)	2.8
IVS thickness (cm)	0.6
LVID diastole (cm)	1.26
PW thickness (cm)	1.1
LVID systole (cm)	0.6
FS (%)	45

Doppler Measurements

PV Vmax (m/s)	0.6
AoV Vmax (m/s)	1.0
MR Vmax (m/s)	NA
TR Vmax (m/s)	NA
TR PG (mmHg)	NA

INTERPRETATION OF THE FINDINGS

Hypertrophic Obstructive Cardiomyopathy (HOCM) persists with evidence of progression. Severe left atrial enlargement has become marked with remarkable spontaneous contrast

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seen. SAM can be seen through the mitral valve motion; however, the aortic outflow velocity is normal indicative of LV failure. No obvious additional issues are identified.

The ECG shows frequent isolated APCs which is not surprising given this degree of atrial dilation. Isolated APCs are largely benign; however, this patient is at high risk for atrial fibrillation. Monitor for signs of this development including acute collapse or lethargy.

Given the severity of changes seen here, recommend institute low dose Lasix due to extremely high risk of imminent CHF. Additionally, the overall heart rate is relatively slow and LVOTO is not apparent, suggesting myocardial failure. Based upon this, recommend decrease Atenolol dose to once daily with close monitoring of heart rate going forward.

Prognosis is poor to grave long term with high risk for CHF, malignant arrythmias and/or sudden death going forward.

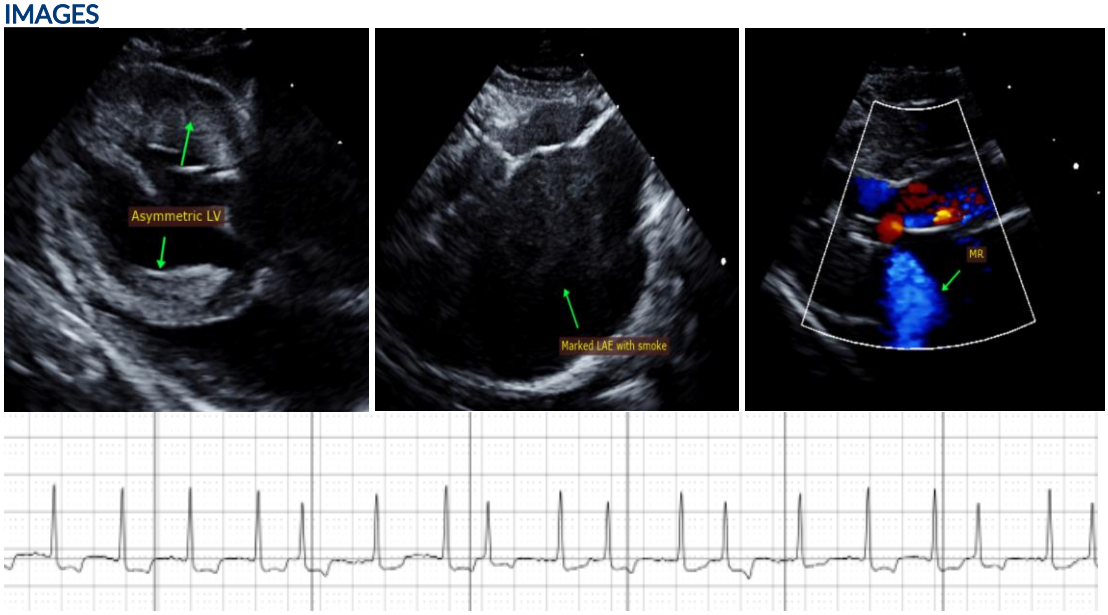
RECOMMENDATIONS

- Continue Plavix as prescribed.
- Decrease Atenolol to ¼ tab SID.
- Institute low dose Lasix 1mg/kg PO q12h.
- Close monitoring of breathing rates at home.
- Monitor at home for any respiratory signs and/or evidence of blood clot event.
- Elective anesthesia is not advised.

PLAN

- Monitor renal values in 1-2 weeks, then every 3-4 months lifelong.
- Recommend recheck echocardiogram in 6 months to continue to screen for progression, sooner if clinically signs arise.

IMAGES



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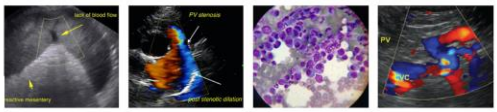

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)