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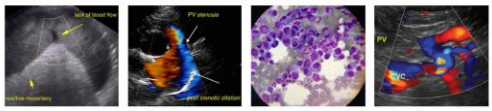

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PATIENT
Butchie Kosmark

SPECIES
Feline

BREED
DSH

SEX
Male Neutered

AGE
10 years

WEIGHT
16lbs

INTERPRETED BY
Maggie Machen Lamy, DVM DACVIM (Cardiology)

IMAGING PERFORMED BY
Pamela Harrigan, RDCS

HOSPITAL NAME
Wood River Animal Hospital

REFERRING VET
Dr. Schuelke

INVOICE
26528

DATE
9/23/22

PRESENTING CLINICAL SIGNS

History: History HCM. History of CHF. History of VPCs. Mycoplasma positive. Had echocardiogram 1/7/22 (measurements not available). Tx: Pimobendan 1.25mg, 1 q12h; Plavix 75mg, 1/4 q24h; Furosemide 20mg, 1/2 q12h. Presented again in March 2022 in CHF. Lasix changed to Torsemide 5mg/ml 0.25mg/ml PO q12h, other medications continued as prescribed. Butchie doing fairly well clinically.

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 average heart rate is 170bpm with a largely regular rhythm. The rhythm is sinus in origin, with a p for every QRS complex and vice versa. P morphology is positive. The QRS is isoelectric. Isolated VPCs are seen throughout; singles only. No atrial premature beats, pauses or other dysrhythmias observed.
ECG diagnosis: Normal sinus rhythm with isolated VPCs.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and Doppler imaging is available.
Left ventricle: The LV dimeter is mildly increased. The LV wall thicknesses are highly asymmetric with significant apical free wall thinning. No significant hypertrophy is identified. The endocardium appears remodeled. The papillary muscles are hypertrophied. Systolic function is depressed.
Left atrium: The left atrium is severely dilated. No obvious thrombus or spontaneous contrast.
Mitral valve: The mitral valve is normal in structure and mobility. No systolic anterior motion is seen. Mild central mitral regurgitation.
Aortic valve/Aorta: Aortic valve is normal. Normal outflow velocity, laminar flow. Trace AI.
Right ventricle: Right ventricular appears normal.
Right atrium: The right atrium is normal.
Tricuspid valve: Tricuspid valve is normal with no obvious TR.
Pulmonic valve/Pulmonary artery: The pulmonic valve appears normal in morphology and mobility. Decreased pulmonic outflow velocities with laminar flow. No PI.
Pericardium/other: Scant pericardial effusion. No obvious pleural effusion. No obvious cardiac tumors.

2-Dimensional Measurements

Ao diam (cm)	0.9
LA diam (cm)	2.1
LA:Ao (Swe)	2.4
IVS thickness (cm)	0.49
LVID diastole (cm)	1.9
PW thickness (cm)	0.26
LVID systole (cm)	1.6
FS (%)	15

Doppler Measurements

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

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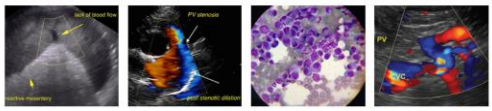

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INTERPRETATION OF THE FINDINGS

Significant cardiomyopathy persists with end-stage disease. The categorical diagnosis of HCM versus U/RCM could be argued in his case; however, a history of HCM would suggest hypertrophy was identified previously. What is seen here is considered end-stage based upon apical thinning and persistent hypertrophy. As well as significant LV dysfunction. The LA is severely enlarged, with risk for complication. No additional issues are identified.

Given that the patient is doing well no changes to the medications are warranted at this time; however, Torsemide is a potent diuretic and close monitoring of renal values is advised. Routine blood pressure monitoring is recommended, as an ACE-I may be utilized if >130mmHg.

Prognosis remains poor long-term; however, it is encouraging the patient continues to do well at home. There will always be at high risk for recurrent episodes of CHF, development of blood clots, malignant arrhythmias and/or sudden death in the future.

The ECG shows isolated VPCs, which are not surprising given the severity of LV pathology. Only single isolated VPCs are appreciated, and no treatment is warranted at this time. Follow up is advised should any collapse or acute exercise intolerance be noted in the future.

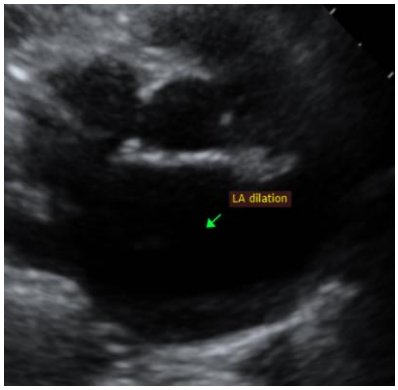
RECOMMENDATIONS

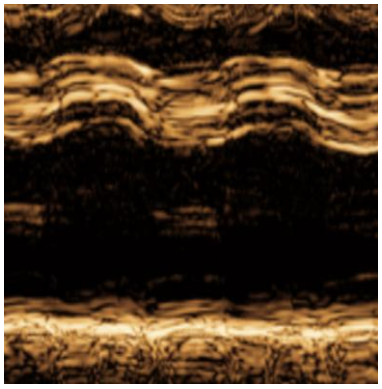
- Continue Torsemide, Pimobendan and Plavix at current dosages.
- Pending BP assessment, consider an ACE-I 0.5mg/kg PO q12h.
- Monitor for signs of sustained arrythmias, such as syncope.
- Monitoring of sleeping breathing rates at home is recommended as the best way to screen for recurrent CHF at home.
- Avoid anesthesia, steroids and/or fluid therapy unless absolutely necessary in the future.

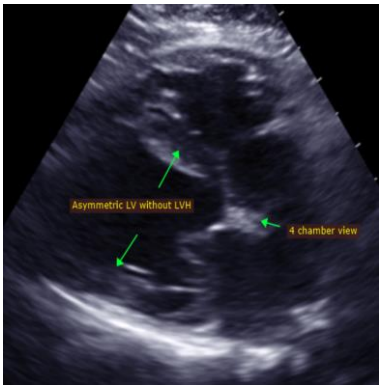
PLAN

- Monitor renal values/BP every 6 months lifelong.
- A recheck echocardiogram is recommended in 6 months to assess for progression, sooner if issues arise in the interim.

IMAGES







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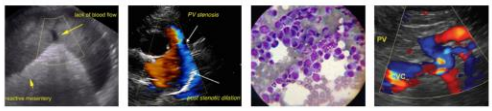

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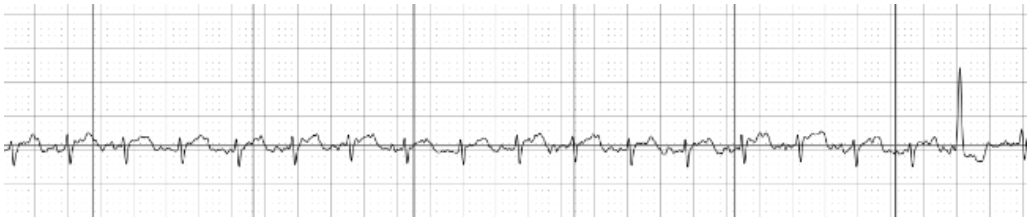

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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