



PATIENT

Whiskey Taylor

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

9 years

WEIGHT

11.8lbs

INTERPRETED BY

Maggie Machen Lamy,
DVM, DACVIM
(Cardiology)

IMAGING PERFORMED BY

Dana Alterman,
RDMS, LVT

HOSPITAL NAME

Eubank Animal Clinic

REFERRING VET

Dr. Warrick

INVOICE

26560

DATE

9/26/22

PRESENTING CLINICAL SIGNS

History: Grade 2/6 heart murmur.

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; 50mm/s, 20mm/mV. The average heart rate is 165bpm (range 158-176bpm). The rhythm is sinus in origin, with a p for every QRS complex and vice versa. The P and QRS morphologies are positive. Occasional VPCs (singles only) occasionally followed by suspected aberrant conduction (cannot rule out alternative explanation without a six-lead tracing). No supraventricular premature beats, pauses or other dysrhythmias observed. ECG diagnosis: Normal sinus rhythm with VPCs. Occasional aberrant conduction (Ashman phenomenon).

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is largely normal in dimension with regions of irregularity. There is a diffusely hyperechoic endocardium consistent with fibrosis. The papillary muscles are remodeled. The mitral valve is normal with no MR. The left atrium is mildly dilated and bulbous in appearance. No obvious smoke. The right atrium is normal. Tricuspid valve is normal with no TR. The right ventricle appears normal. Blood flow through both the LVOT and RVOT is normal in velocity. No pericardial effusion seen. No pleural effusion. No obvious cardiac tumors.

CARDIAC CHART

FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm) (Moise, Pipers)	LVIDd (cm) (Moise, Pipers)	LWVd (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	5.4	NM	0.50	1.3	0.50	47	82
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	1.4	1.6	1.5		0.94	0.7	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

The finding of mild left atrial enlargement in the face of normal LV dimensions is most consistent with Unclassified Cardiomyopathy (UCM); however, some prior infectious or inflammatory issues cannot be ruled out. Mild left atrial dilation is present, which may suggest risk for progression going forward. No additional structural issues are identified. No cause for the murmur is seen in this study.



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Additionally, there is an arrhythmia present on the ECG with isolated VPCs identified. The abnormal beats are singles only with low markers of malignancy. There are also suspect wide complex sinus beats, which are most likely due to aberrant conduction. A six-lead tracing would be necessary to confirm; however, this is largely benign. What is seen here in cat with mild disease, does not warrant anti-arrhythmic therapy; however, systemic screening is advised to assess for any additional underlying issues. It is important to note that anti-arrhythmics in cats are difficult to use and should only be institute if sustained arrhythmias or syncope are noted in the future.

Given what is seen here, no indication for medications at this time. Follow up is certainly advised, as any progressive left atrial enlargement will warrant medical management.

The long-term prognosis given the totality of the findings is guarded; however, there is a highly variable rate of progression in cats with subclinical disease. There will always remain risk for progression to CHF and development of blood clots and/or sudden death in the future. Monitoring is certainly advised, particularly should any respiratory signs, collapse or significant lethargy be noted in the future.

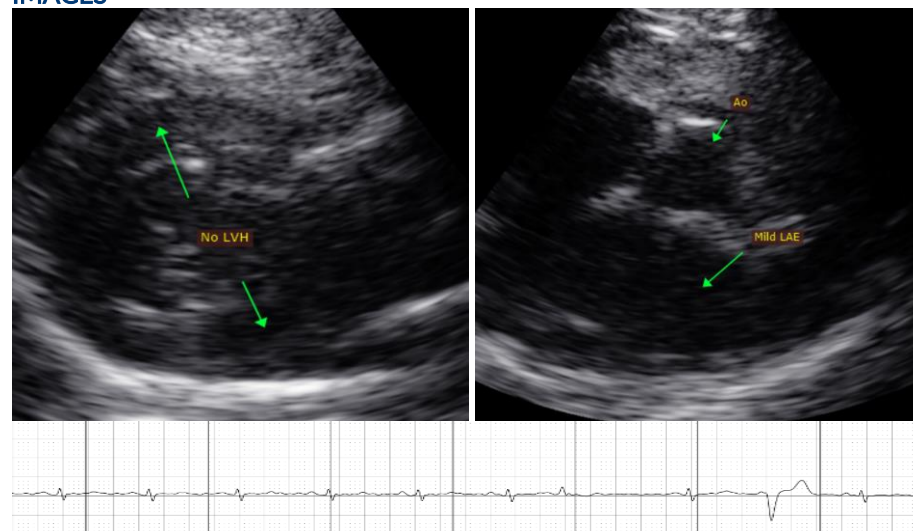
Anesthetic risk is considered moderately elevated due to a combination of mild LAE and VPCs. Drugs that stimulate heart rate should be avoided unless clinically necessary (glycopyrrolate, atropine). Avoid ketamine, telazol, alpha 2 agonists. A reasonable protocol includes opioid/benzodiazepine premedication, propofol induction, isoflurane maintenance. Monitor ECG intra and post-operatively, with careful intervention if ventricular arrhythmias are sustained (i.e., sustained VT) and lead to hemodynamic compromise.

PLAN

Consider systemic evaluation as discussed.

A recheck echocardiogram and ECG is recommended in 6 months, sooner if any clinical signs arise.

IMAGES





PATIENT

Whiskey Taylor

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.

SPECIES

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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.

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DSH

Maggie Machen Lamy, DVM
Diplomate of the American College of Veterinary Internal Medicine (Cardiology)
info@sonopath.com

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