



**PATIENT PRESENTING CLINICAL SIGNS**

Laksmi Ray

History: Newly found gallop rhythm. Sedated with Torbugesic and Alfaxan IM.  
-Abnormal PE/Chem/CBC/UA Results: PE: WNL aside from gallop rhythm.

**SPECIES ECHOCARDIOGRAM FINDINGS**

Feline

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is asymmetrically hypertrophied with moderate septal dimension and mildly increased free wall. There is a diffusely hyperechoic endocardium consistent with fibrosis and ventricular remodeling. Mild papillary muscle remodeling. The right ventricle is subjectively normal in size and morphology. There is no left atrial enlargement present. No right atrial enlargement present. Normal RVOT velocity. Mild systolic anterior motion (SAM) of the mitral valve is seen on 2D and color flow imaging crating an elevated dynamic LVOT velocity (not captured on doppler). There is mild eccentric mitral regurgitation present secondary to SAM. No other significant valvular regurgitation is present. There is no pericardial effusion noted. No pleural effusion appreciated. No obvious cardiac tumors.

**BREED**

DSH

**SEX**

Female Spayed

**AGE**

~6 years

**CARDIAC CHART**

**WEIGHT**

8.6lbs

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	3.9	NM	0.71	8.8	0.63	55	94
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	1.3	1.1	1.1		0.82	0.96	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.*

**INTERPRETED BY**

Maggie Machen Lamy, DVM, DACVIM (Cardiology)

**IMAGING PERFORMED BY**

Dr. Karen Ebersole

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**HOSPITAL NAME**

Scanvet

The diagnosis is hypertrophic obstructive cardiomyopathy (HOCM). This indicates LV thickening (moderate in this case) with a dynamic LVOT obstruction (SAM) and secondary mitral regurgitation as the cause of the heart murmur. The hypertrophy is significant; however, the LA is normal, indicating the risk of spontaneous CHF and/or a thrombotic event is currently low. My suspicion is the LVOTO may be more apparent when not sedated, although this is debatable if no murmur is appreciated. No additional issues are identified.

**REFERRING VET**

Dr. Kaltsas

**INVOICE**

21273

While no medications have been shown to definitively alter long term outcome at this stage of disease, atenolol is often initiated to decrease the outflow obstruction. If the patient is easily medicated, it is reasonable to initiate at this time as below. If there is difficulty medicating at home, an alternative approach would be closely monitoring for progression in the next 6-12

**DATE**

9/29/21



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months. Discussion with the owner is advised. No additional medications are indicated prior to significant atrial dilation.

Monitor at home for any respiratory signs or blood clot events (neurologic change, paralysis, etc.). Anesthetic risk is considered mild, however judicious IV fluid rates are advised to avoid fluid overload. Additionally, drugs that stimulate heart rate should be avoided unless clinically necessary (ketamine, glycopyrrolate, atropine).

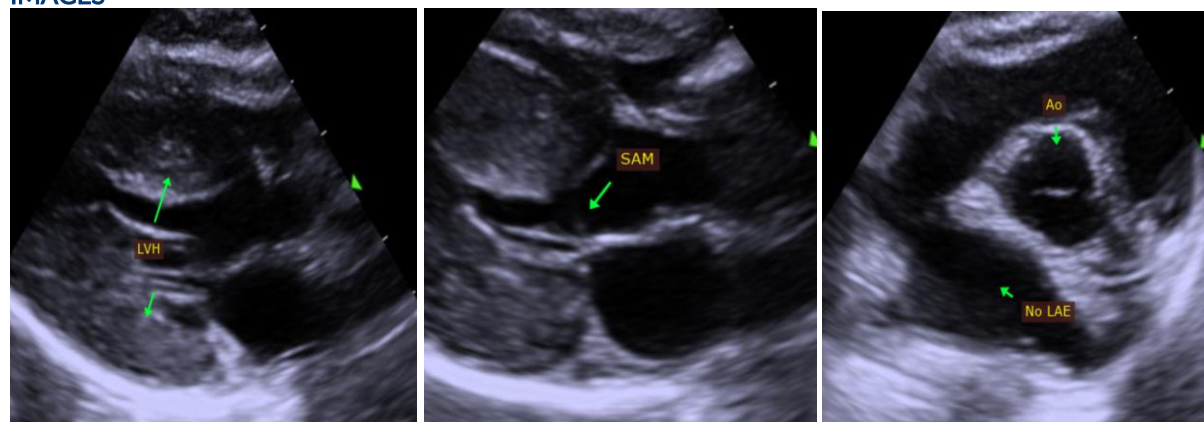
**PLAN**

If elected, administer titrating dose of atenolol: 25mg tablets; Give ¼ tab once daily. Recheck heart rate in 1-2 weeks with target stressed rate of 140-160bpm 12-24 hours post-administration. Increase as needed until target reached.

Screening blood pressure and T4 are recommended every 6 months.

Recommend recheck echocardiogram in 6 months to assess for progression, sooner if clinical issues 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.

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