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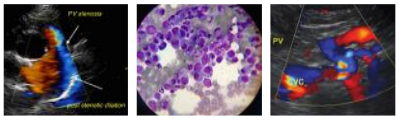

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Ernest Angerosa

SPECIES
Feline

BREED
DLH

SEX
Male Neutered

AGE
6.24.12

WEIGHT
17.3lbs

INTERPRETED BY
Maggie Machen Lamy, DVM, DACVIM (Cardiology)

HOSPITAL NAME
Cat Hospital at Towson

REFERRING VET
Dr. Brunt

INVOICE
26622

DATE
9.29.22

PRESENTING CLINICAL SIGNS

History: Cardiomegaly. Overweight. Chronic vomiting.
-Radiographs: A large heart shadow with an apparent enlarged left atrium and lung vessels.
-Current medications: Proviable SID.
-Sedation used: Patient sedated with Alfaxone.
-Pertinent previous ultrasound results: No previous.
-STAT: Not requested
-Imaging performed by: Andi Parkinson, BS, RDMS.

ECHOCARDIOGRAM FINDINGS

2D, m-mode, color flow and doppler imaging is available. The left ventricular wall is asymmetric with moderate septal thickening and severe free wall hypertrophy. Obliteration of the chamber in systole. There is a diffusely hyperechoic endocardium consistent with fibrosis. Symmetric papillary muscle hypertrophy. There is severe left atrial enlargement present. No smoke visualized; no obvious blood clots. The RA is moderately enlarged. The RV also appear affected with RV hypertrophy. There is no obvious systolic anterior motion (SAM) of the mitral valve present, with a normal LVOT velocity. Mild MR. Mild TR. No other obvious valvular regurgitation is present. The MPA and branches are normal. There is no pericardial effusion noted. No pleural effusion appreciated. No obvious 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	3.5-0.55	<2 (mean 1.5)	3.5-0.55	35-67	80-100
PATIENT	7.8	210	0.73	1.25	1.0	38	72
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	2.1	2.1		1.0	0.9	NM

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

Hypertrophic cardiomyopathy (HCM) is a rule out diagnosis for LV hypertrophy once a patient is confirmed euthyroid and normotensive. Both should be ruled out as contributing issues in this case. Both atria are severely enlarged, indicating high risk for spontaneous CHF and/or blood clot events going forward.

Given these findings and exceedingly high risk for decompensation, recommend full cardiac support as below including low dose Lasix therapy even without respiratory signs. With this degree of disease, prognosis is guarded to poor long term. The patient will always be at high risk for 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 recurrent CHF at home.

Anesthesia, fluid or steroid therapy is not advised.

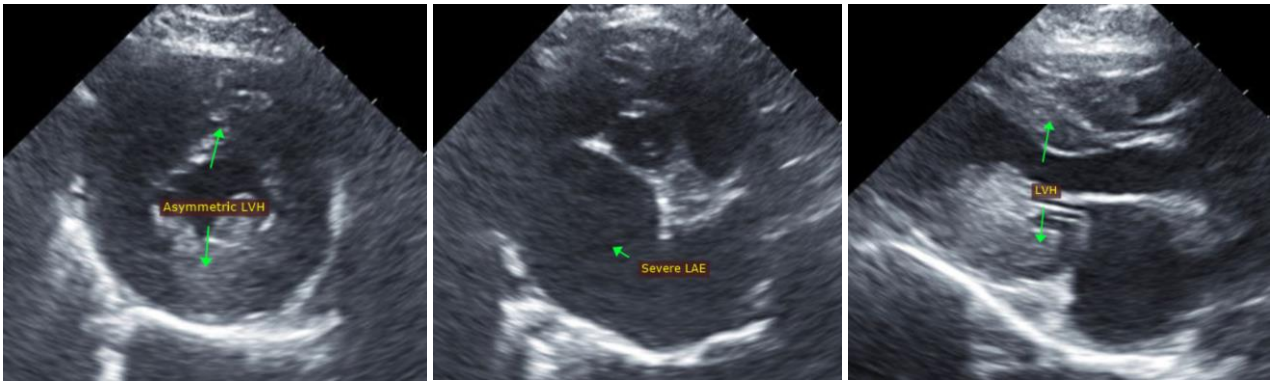
PLAN

Administer Lasix 1mg/kg PO q12h. Administer Plavix to decrease risk of thrombi formation: Plavix 75mg ¼ tab SID (NOTE: bitter on cut edge, coat in entirety or administer in a gel cap). Administer Pimobendan 1.25mg PO q12h.

Monitor BP and kidney values in 1-2 weeks, then every 4-6 months lifelong. If BP >130mmHg and patient is eating well at home and able to be medicated, consider addition of an ACEI 0.5mg/kg PO q12h.

A recheck echocardiogram is recommended in 6 months to assess for progression, sooner if clinical signs 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.

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