



PATIENT

Cheddar Centanni

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

4 Years

WEIGHT

7 kg

INTERPRETED BY

Brad Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Sarah Burns

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Sarah Burns

INVOICE

72458

DATE

1/25/26

PRESENTING CLINICAL SIGNS

1 week history of lethargy and decreased appetite. Seen on 1/23/26 at SVEC where constipation was the main concerns as per O. Received an enema and cerenia injection and later that evening had a bowel movement. O reports that his lethargy continued/worsened over the next 48 hours and he had not eaten for 203 days. Indoor outdoor cat that frequently hunts rodents, and has full access to the neighborhood.

Abnormal PE/Chem/CBC/UA Results: CBC: HCT 36.5 (N), WBC 18.76 (H), Neut 15.20 (H), Lymph 2.11 (N), Mono 1.18 (H)- suspect machine error reading bands, inflammatory leukogram, Plt 175 (N) Chem10: all values WNL AFAST: no ff in the abdomen, subjectively normal abdomen otherwise TFAST: moderate pleural fluid present in the left hemithorax, with scant pericardial fluid, marked pleural fluid present in the right hemithorax Pleural fluid: TS: 3 g/dl Clear/yellow fluid, low cellularity Pericardial fluid: TS 3.2 g/dl Clear/yellow fluid, low cellularity PRO BNP - 916.8 pmo l/L

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm)	LVIDd (cm)	LVWd (cm)	FS (%)	EF (%)
NORMAL PARAMETER	-----	150-240	0.3-0.6	1.0-2.1	0.25-0.6	35-67	80-100
PATIENT	7.0	NM	0.63	1.51	0.64	38	NM
FELINE CARDIAC PARAMETERS	LA/AO (M-mode)	LA/AO HEART BASE (Sisson)	LAD LA MAX 4 Chamber		LVOT VEL. (m/s)	RVOT VEL. (m/s)	IVRT (m/)
NORMAL PARAMETER	< 1.5	1.6	0.7-1.7		< 1.6	< 1.3	40-60
PATIENT	1.48	1.08	1.4		1.1	1.1	NM
Adapted from June Boon, Veterinary Echocardiography, 1998 Sisson D et al. JVIM 1991; 5: 232, Jacobs et al. Am J Vet Res 1985; 46:1705							

Cardiac Presentation

The left atrium is normal in dimension. There are no distinct left atrial thrombi/clots or spontaneous echo contrast appreciated. The left ventricle is normal in dimension, with mild to moderate concentric hypertrophy, and no evidence of restriction. Left ventricular systolic function is normal. The right atrium and ventricle are subjectively normal in dimension and systolic function. There is no systolic anterior motion of the mitral valve; however, the left ventricular outflow tract narrows during systole with a mid-ventricular pinch. The tricuspid valve leaflets presented normal linear structure, extension in systole, and union in diastole. The left ventricular outflow tract demonstrated subjective structural valvular integrity. The visible aorta is unremarkable. Pulmonary outflow tract assessment revealed normal valve structure, and appropriate diameter and distensibility. There is mild pericardial effusion noted with hyperechoic pericardial fat in the periaortic region. No overt intra-pericardial or heart based mass is identified.



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ULTRASONOGRAPHIC FINDINGS

- These findings identify left ventricular hypertrophy in the setting of an outflow tract obstruction and absence of any chamber dilation, consistent with occult hypertrophic obstructive cardiomyopathy (HOCM). Additionally, pericardial/pleural effusion in the absence of any obvious mass lesion is noted. Given the absence of any identifiable neoplasia, idiopathic disease is a possibility. However, the inability to document a mass does not exclude the potential for a neoplastic or infectious/inflammatory (FIP) effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given these findings, no cardiac therapy is recommended. The results of fluid cytology may provide an etiologic diagnosis (especially if there is neoplasia present). Long term management may require a pericardiectomy. If the effusion is idiopathic in origin, surgery may be curative. However, the added value of surgery is to better evaluate the heart base in an effort to identify mass lesions that can be missed by ultrasound. If surgery is being considered, an abdominal ultrasound is recommended to evaluate for potential mass lesions.

Additionally, the presence of hypertrophy and an outflow tract obstruction make the use of a beta blocker worth considering. However, the challenge of treating these cats is the lack of any real data to support a meaningful benefit (most of the rationale for their use is theoretical), coupled with the potential for adverse effects (low BP, renal impairment, potential exacerbation of CHF). If atenolol is used, the atenolol dose would be 1-2mg/kg once daily (with the potential of increasing to BID if well tolerated after the first week). A recheck heart rate, BP, and chemistry would be indicated 1-2 weeks after starting therapy; at that time the need for higher doses of atenolol can be assessed. A repeat echo is warranted in another 6 months, regardless of whether or not therapy is started. Ultimately, a conversation with the owner is necessary to determine what course of therapy is most suitable for them. Regardless, owners should monitor resting respiratory rate at home. Values above 30 breaths/minute or an increase in respiratory rate 10% above baseline should prompt veterinary re-evaluation.

Anesthesia considerations:

If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. If a beta-blocker (atenolol) is being given, it should not be administered on the morning of general anesthesia. Other cardiac medications should be administered per the normal dosing schedule. Fluid therapy during anesthesia should be considered at a conservative rate (e.g., 5 ml/kg/hour) if possible (i.e., if not hypotensive). A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is advised. Premedication with an opioid (i.e., butorphanol, hydromorphone, oxymorphone) with or without a benzodiazepine is generally the safest protocol. An induction agent such as Propofol or alfaxalone can be used to effect. Maintenance of anesthesia with isoflurane or sevoflurane is reasonable.

Diet:

No special considerations are necessary. Any high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina is reasonable.

Activity:

Avoid overly strenuous activity.



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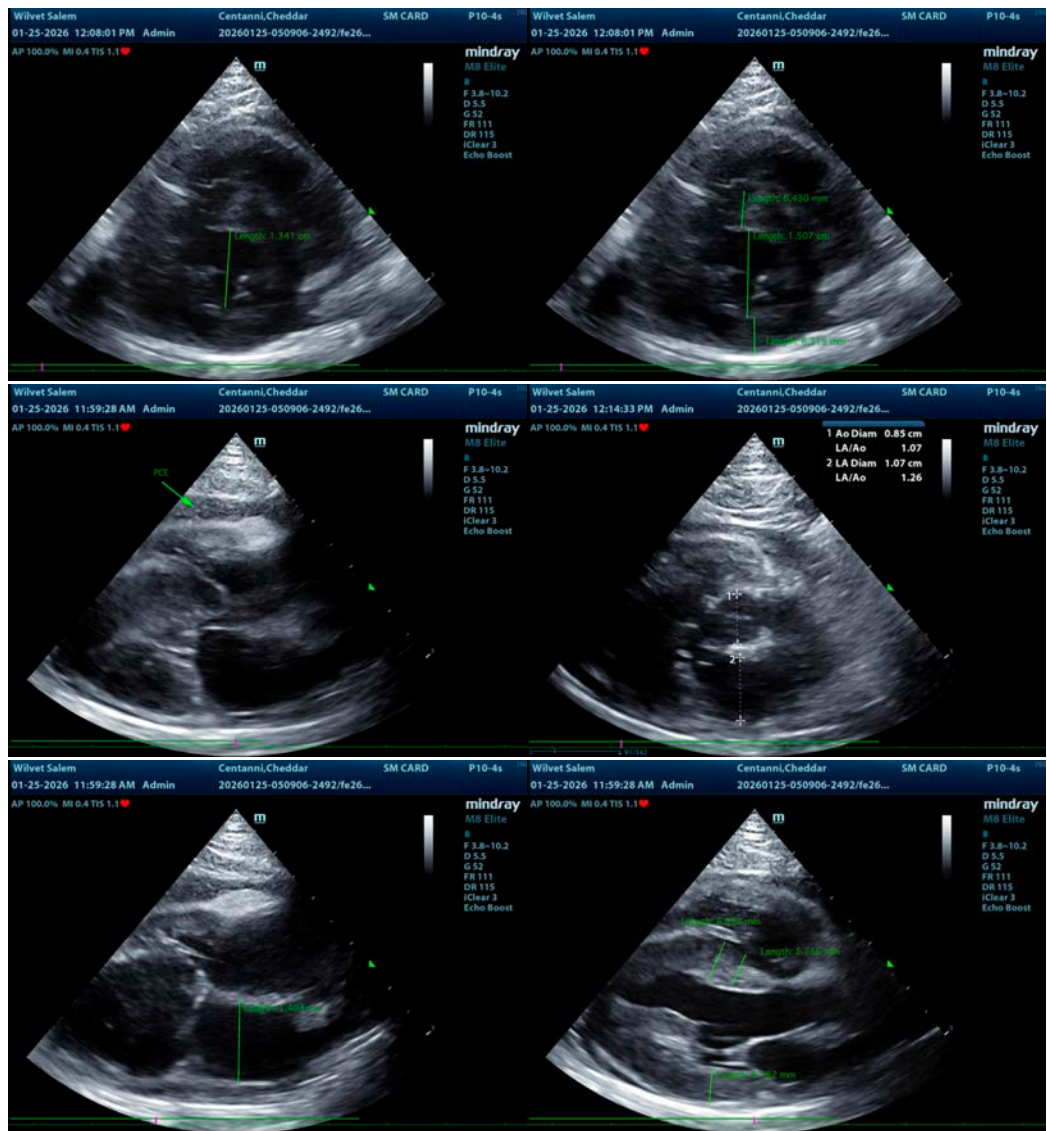
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

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