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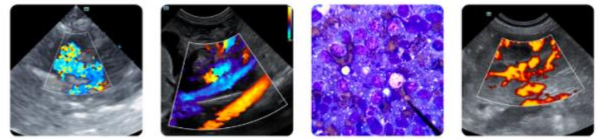


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™
www.carolinavetmobile.com
info@carolinavetmobile.com
800.808.5948

PATIENT
Mochi Martinez

SPECIES
Feline

BREED
Ragdoll Mix

SEX
Neutered Male

AGE
5 Years

WEIGHT
8.4 kg

INTERPRETED BY
Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

IMAGING PERFORMED BY
Kathleen Byrnes

HOSPITAL NAME
Animal Emergency Clinic of the High Country

REFERRING VET
Dr. Phipps

INVOICE
15245

DATE
04/20/26

PRESENTING CLINICAL SIGNS

P presented to ER clinic for dyspnea that started about a week ago. Owners report an abdominal component last night. e/d decreased, fever on and off, hiding and vocalizing one month. On Thursday P received a steroid injection from rDVM. P has history of FIC. On exam harsh lung sounds present. ProBNP abnormal. 3 view rads, rad report mild bronchial pattern. Started on Albuterol and Aerokat inhaler, Cerenia and Doxycycline. Owner reports no improvement

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

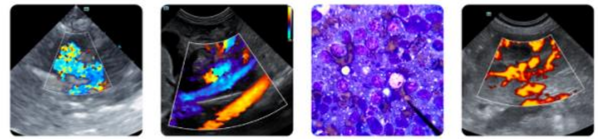
FELINE CARDIAC PARAMETERS	BODY WEIGHT (kg)	HR (BPM)	IVSd (cm)	LVIDd (cm)	LVWd (cm)	FS (%)	EF (%)
NORMAL PARAMETER	------	150-240	0.3-0.6	1.0-2.1	0.25-0.6	35-67	80-100
PATIENT	8.4	190	0.59	1.71	0.57	67	97
FELINE CARDIAC PARAMETERS	**LA/AO** (M-mode)	**LA/AO HEART BASE** (Sisson)	**LAD** LA MAX 4 Chamber		**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	1.5	1.26	1.32		1.0	0.9	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 equivocal wall thickness, and no evidence of restriction. Left ventricular systolic function is normal, with adequate contractility. The right atrium and ventricle are subjectively normal in dimension and systolic function. There is no evidence of systolic anterior motion of the mitral valve or other valve abnormalities with no mitral regurgitation. The tricuspid valve leaflets presented normal linear structure, extension in systole, and union in diastole with trace regurgitation. The left ventricular outflow tract demonstrated normal laminar flow and subjective structural valvular integrity. The visible aorta is unremarkable. Pulmonary outflow tract assessment revealed normal valve structure, laminar flow, and appropriate diameter and distensibility. There is an aneurysmal defect on the lateral aspect of the right ventricular outflow tract at the level of the pulmonary valve. There is no significant flow within this defect. There is no evidence of semilunar valve insufficiency or pulmonary hypertension documented. There is no visible pericardial, pleural, or free peritoneal fluid noted.

ULTRASONOGRAPHIC FINDINGS

- These findings are consistent with an essentially normal echocardiogram. The borderline/equivocal left ventricular wall measurements may represent an early manifestation of hypertrophic cardiomyopathy; however, may also represent a variation of normal for this



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patient. The defect/dropout at the level of the pulmonary valve is of unknown significance. It is unlikely that any of the clinical/radiographic signs are related to underlying heart disease at this time.

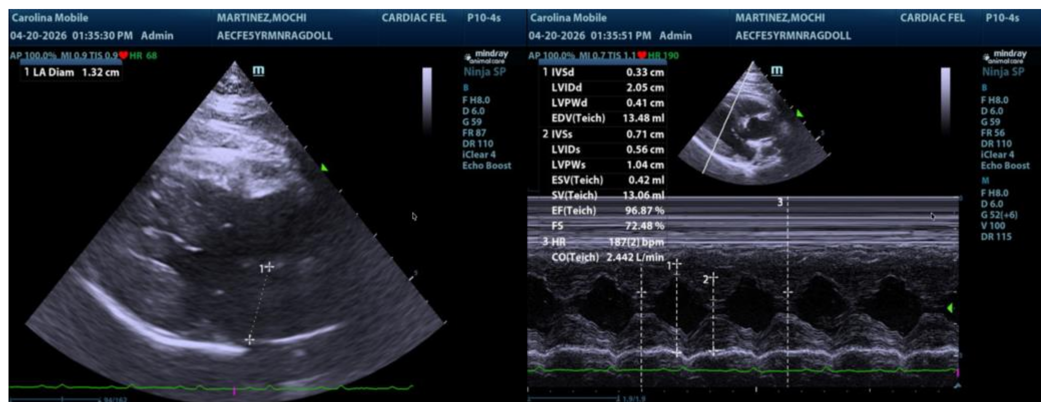
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

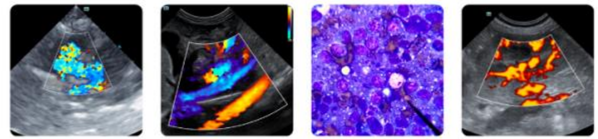
Given the absence of any underlying heart disease, no cardiac therapy will be recommended. In addition, there are no cardiac objections to fluid therapy or steroid use. Owing to the presence of a equivocal wall thickness, a follow up echo is recommended in another 6-12 months to make sure no progression has occurred.

Anesthesia considerations:
If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a reduced 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, 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:
No special considerations are necessary.





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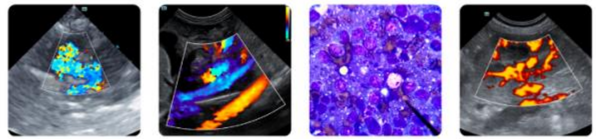
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

info@SonoPath.com



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