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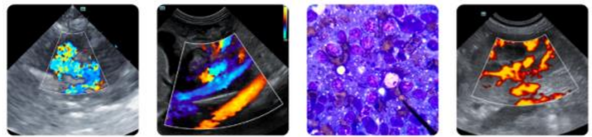


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

Lainie Bagley

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

11/25/2020

WEIGHT

8.3 Pounds

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

IMAGING PERFORMED BY

Stephanie Warga RDCS, RVT.

HOSPITAL NAME

Middle River VC

REFERRING VET

Dr. Hicks

INVOICE

36702

DATE

4/23/26

PRESENTING CLINICAL SIGNS

CLINICAL BACKGROUND & STUDY DETAILS

History: 9/5/26- went to ER for poss. seizure, 2nd episode; BW/rads done- NSF. Vet thought she heard a murmur but thought was physiologic due to stress of visit. 2/20/26- Here for ear infection, treated with Tresaderm; I did here a murmur today and did not seem physiologic; also weight loss of 0.7# since 2/7/2025
4/21/26- present today for abdominal breathing. HR- 220 bpm, arrhythmia RR- 6- bpm; wt loss again of 1 lb (is 8.5#)

Pertinent abnormal PE/Chem/CBC/UA Results: Not attached.
Current medications: None.
Blood Pressure: N/A.
Sedation used: Not required to complete full diagnostic ultrasound.
Pertinent previous ultrasound results: No previous.
STAT: Declined at this time.
Imaging performed by: Stephanie Warga RDCS, RVT.

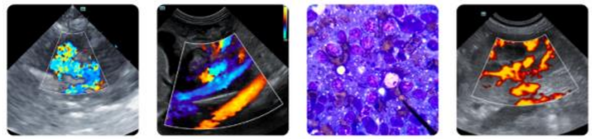
ULTRASONOGRAPHIC EXAMINATION OF THE HEART

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	3.77	NM	0.54	1.78	0.57	48	83
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	NM	1.80	1.94		4.7	0.7	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 mild to moderately enlarged. There are no distinct left atrial thrombi/clots or spontaneous echo contrast appreciated. The left ventricle is normal in dimension as well as 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. The anterior and posterior mitral and tricuspid valve leaflets presented normal linear structure,



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extension in systole, and union in diastole without regurgitation. There is no evidence of systolic anterior mitral valve motion documented. The left ventricular outflow tract demonstrated turbulent flow with significant aortic regurgitation. The aortic valve leaflets are severely thickened with vegetative lesions. The visible aorta is unremarkable. Pulmonary outflow tract assessment revealed normal valve structure, laminar flow, and appropriate diameter and distensibility. There is no evidence of pulmonary hypertension documented. There is no visible pericardial, pleural, or free peritoneal fluid noted, but moderate to severe B-lines are noted in the pulmonary parenchyma.

ULTRASONOGRAPHIC FINDINGS

- These findings identify a vegetative aortic valve lesion in the setting of an enlarged left atrium and ventricle, as well as significant outflow tract obstruction and aortic regurgitation. This is most consistent with infective endocarditis, although this is extremely rare. A congenital aortic stenosis cannot be completely excluded, but the new onset of a heart murmur makes this condition considered less likely. There is also concern for congestive heart failure given the chamber dilation and presence of B-lines. This should be correlated with thoracic radiography.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations/Treatment:

If there is evidence for edema on thoracic radiographs, treatment for CHF is recommended, to include Lasix (2mg/kg BID) and Vetmedin (0.25-0.35mg/kg BID). Paired blood cultures are recommended at multiple draw sites. Additionally, empiric antibiotic therapy after blood culture collection, should include enrofloxacin (5mg/kg SID) and amoxicillin + clavulanic acid (15mg/kg BID). Barring any setbacks or complications, a repeat echo/rads will be recommended in 1-2 months.

Anesthesia considerations:

Anesthesia should be avoided until signs of congestion have resolved. If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. If an ACE inhibitor (enalapril, benazepril) or spironolactone 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. Anesthetic IV fluid use should be limited to < 3 ml/kg/hr and, if IV fluid therapy is administered during the procedure, a 1 mg/kg dose of IM Lasix should be administered when the patient is awake and standing in recovery. 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, or diazepam/etomidate can be used to effect. Maintenance of anesthesia with isoflurane or sevoflurane is reasonable.

Diet:

A high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina that is highly palatable with adequate protein and calories for maintaining optimal body condition with mild dietary sodium restriction (<100 mg/100 kcal) is recommended. Consider omega-3 fatty acid supplementation.

Activity:

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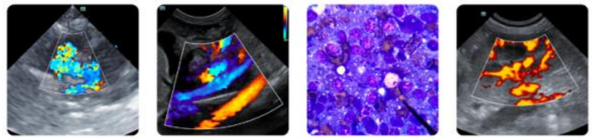
Avoid strenuous activity.



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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