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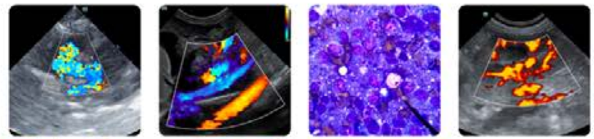


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Lavender Madden

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years

WEIGHT

10.16 lbs

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Jenni Tudini, MRCVS, SDEP Cert (Abd)

HOSPITAL NAME

Fetch the Vet Mobile Veterinary Practice

REFERRING VET

Dr. Megan Dudek

INVOICE

75586

DATE

5/31/26

PRESENTING CLINICAL SIGNS

Patient was recently seen for a routine annual physical exam and was noted to have an intermittent gallop rhythm during that exam. Patient is asymptomatic and displays no changes historically.

Abnormal PE/Chem/CBC/UA Results: Cardiovascular Notes from 05/15 : - Gallop rhythm heard when heart rate is slower. When pet begins to struggle and heart rate increases, the rhythm is normal and a grade II/VI parasternal systolic murmur is heard. This is consistently repeatable - Femoral pulses were synchronous and of good quality. Exam on 05/27: Unremarkable cardiac exam but soft Grade 2/6 systolic murmur ausc. - Bloodwork: CBC - Eosinophilia 2.31 (0.2-1.214) Basophilia 0.22 (0-01) - Biochem: unremarkable - Pro BNP: 142 (0-100) - Blood Pressures: Sys - 127 Dia - 88 MAP 92 HR145 - no evidence of hypertension

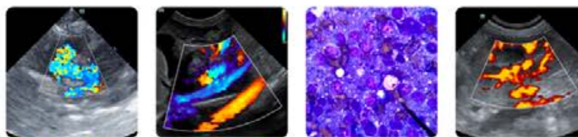
ULTRASONOGRAPHIC EXAMINATION OF THE HEART

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	4.62	120	0.45	1.42	0.59	38	72
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	1.26	1.76		0.8	1.0	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, prominent and irregular papillary muscles and a suspected false tendon. 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. There is turbulence at the level of the mitral valve in end diastole/early systole, but no overt 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 no evidence of semilunar valve insufficiency or pulmonary hypertension documented. There is no visible pericardial, pleural, or free peritoneal fluid noted.



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ULTRASONOGRAPHIC FINDINGS

- These findings identify borderline/equivocal left ventricular wall measurements with a prominent and irregular papillary muscle, which may represent an early manifestation of hypertrophic cardiomyopathy; however, may also represent a variation of normal for this patient. It is unlikely that any of the clinical/radiographic signs are related to underlying heart disease at this time.

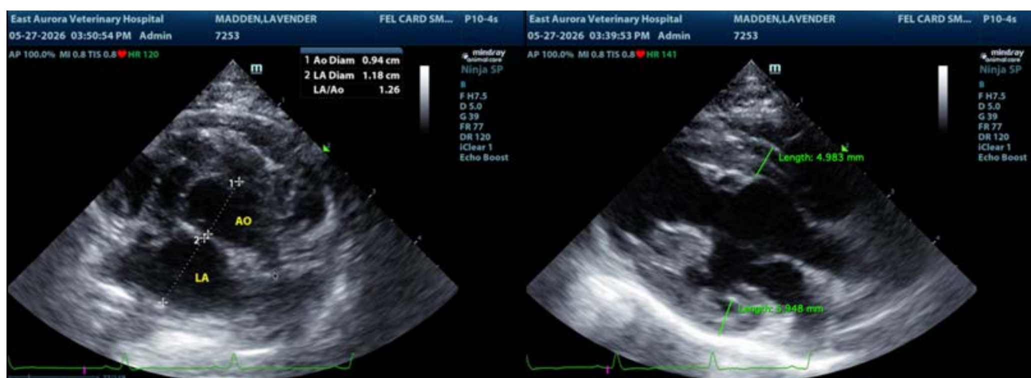
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

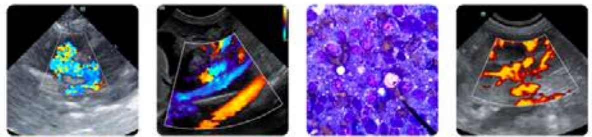
Given the absence of any underlying heart disease, no cardiac therapy will be recommended. In addition, there are no cardiac objections to fluid therapy or steroid use. Owing to the presence of a equivocal wall thickness, a follow up echo is recommended in another 6-12 months to make sure no progression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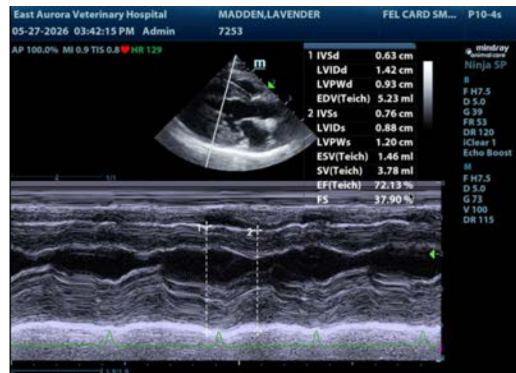

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com