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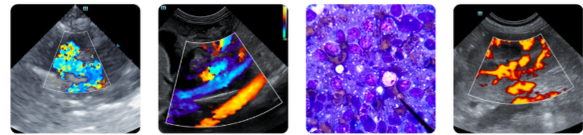


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Major Wesley Rostal

SPECIES

Feline

BREED

Selkirk Rex

SEX

Neutered male

AGE

17 years

WEIGHT

8.6 lbs

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Willakenzie AC

REFERRING VET

Dr. Kairis

INVOICE

68772

DATE

11/18/25

PRESENTING CLINICAL SIGNS

History: Clinical Exam Findings: Labored breathing on 11.15.25 - Thoracocentesis - ~ 150cc of fluid extracted Hyperthyroid (Y/D - toxically allergic to Methimazole) Corona virus CKD ABNORMAL Labwork Values Can be provided For ECHO Only: Blood Pressure Last BP on 11.05.25 = ~ 163 mm HG HR/RR/BP: Resting HR ~ 125/min., Resting Resp. ~ 25-30/min. Is there a Heart Murmur? If so, please grade. None noted Current Medications Mirataz transdermal - as needed, 1/4 Furosemide 12.5 BID (began pm of 11.17.25), 0.25ml B12 injections (began ~ 11.14.25), Denamarin began again 11.8.25 and suspended 11.15.25) Radiographic Findings Can provide from 11.15.25 if needed

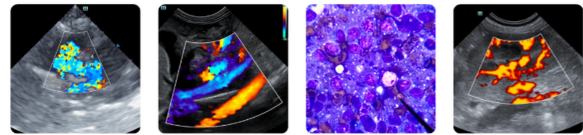
ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is severely enlarged. There are no distinct left atrial thrombi/clots or spontaneous echo contrast appreciated. The left ventricle is moderately with normal wall thickness, and no evidence of restriction. Left ventricular systolic function is reduced, with diminished 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, extension in systole, and union in diastole. There is mild mitral and tricuspid valve regurgitation. There is no evidence of systolic anterior mitral motion documented. 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 trace pericardial, moderate pleural, but no free peritoneal fluid noted.

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	3.91 kg	140	0.55	2.8	0.53	35	67
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	1.64	1.73	2.3		1.1	0.8	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

ECG:
There is a six-lead ECG available for review. There is significant artifact present. The underlying rhythm is regular at an average rate of 140bpm. The rhythm appears to be sinus in origin (PQ 80ms) with narrow QRS complexes (<40ms). There is no atrial or ventricular ectopy and no conduction delay or block identified. This is most consistent with a normal sinus rhythm.



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ULTRASONOGRAPHIC FINDINGS

- These findings identify significant atrial dilation in the absence of any LV hypertrophy or outflow tract obstruction. In the presence of concurrent hyperthyroidism, that could represent a volume load, an underlying cardiomyopathy cannot be definitively diagnosed. Regardless of the underlying cause (thyrotoxic cardiomyopathy vs myocardial form of restrictive cardiomyopathy (RCM, previously considered UCM)), the degree of atrial dilation makes CHF a likely explanation for the clinical/radiographic signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations/Treatment:
An additional thoracocentesis may be indicated if respiratory signs are still present. Treatment for CHF is recommended, to include Lasix (2 mg/kg q24-BID), enalapril (0.5 mg/kg q24, assuming normal BP and kidney function), and Vetmedin (0.25-0.35 mg/kg BID). A repeat chest X-rays, chemistry, and BP is recommended prior to discharge, and again in 1-2 weeks. Additionally, Plavix/clopidogrel (1/4 of a 75 mg tablet, or 18.75 mg PO q 24 h) +/- rivaroxaban (2.5mg q24) should be initiated as an anti-thrombotic. Due to the bitter taste of this medication, it may be best to place it in an empty gelatin capsule or use products such as a Pill Pocket. Barring any setbacks or complications, a repeat echo/rads will be recommended in 3-6 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:
Avoid strenuous activity.

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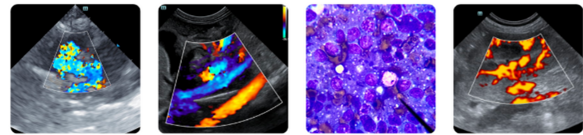

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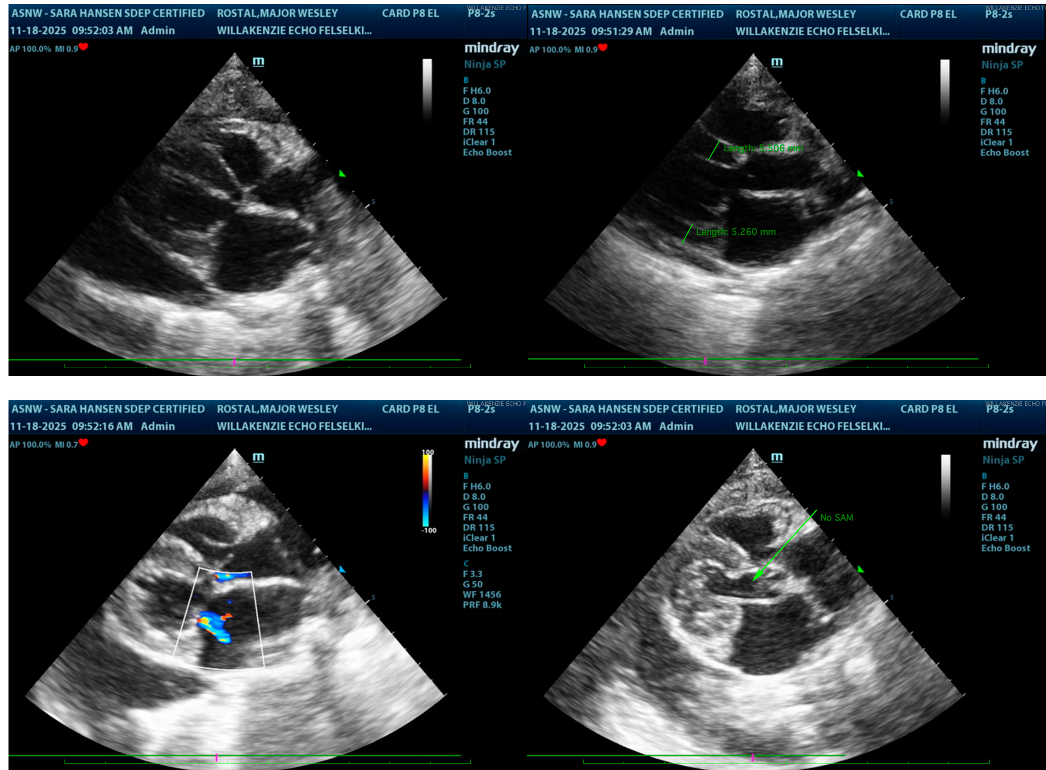

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

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