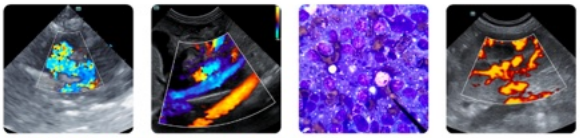

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PATIENT

Knut Williams

SPECIES

Feline

BREED

Sphynx

SEX

Neutered male

AGE

4 years

WEIGHT

9.9 lbs

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Eugene AH

REFERRING VET

Dr. Matsuoka

INVOICE

74147

DATE

4/3/26

PRESENTING CLINICAL SIGNS

- Clinical Exam Findings: Grade 2/6 left parasternal murmur, history of HCM
- ABNORMAL Labwork Values None recent
- HR/RR/BP: 230/50/ to follow
- Current Medications Atenolol 25mg tabs 1/4 tab PO SID, Clopidigrel 75mg tabs 1/4 tab PO SID

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is moderately to severely enlarged. There are no distinct left atrial thrombi/clots or spontaneous echo contrast appreciated. The left ventricle is normal in dimension, with moderate to severe concentric hypertrophy, and no evidence of restriction. Left ventricular systolic function is marginal, 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, extension in systole, and union in diastole without 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 no visible pericardial, pleural, or 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	4.5 kg	NM	0.78	1.66	0.82	28	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	2.78	2.31	2.48		1.2	1.4	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

EKG

The underlying rhythm is sinus in origin with an average rate of 210bpm. The R-R intervals are regular, with a uniform P-R interval that is within normal limits. There are rare single premature complexes with a wide QRS (>40ms), consistent with a ventricular origin. There are no ventricular couplets or runs of tachycardia documented. There is no evidence of atrioventricular block or atrial ectopy documented.

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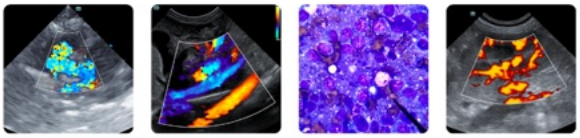

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ULTRASONOGRAPHIC FINDINGS

These findings identify left ventricular hypertrophy in the absence of an outflow tract obstruction, consistent with hypertrophic cardiomyopathy (HCM). As a consequence of the heart disease, the left atrium is also enlarged.

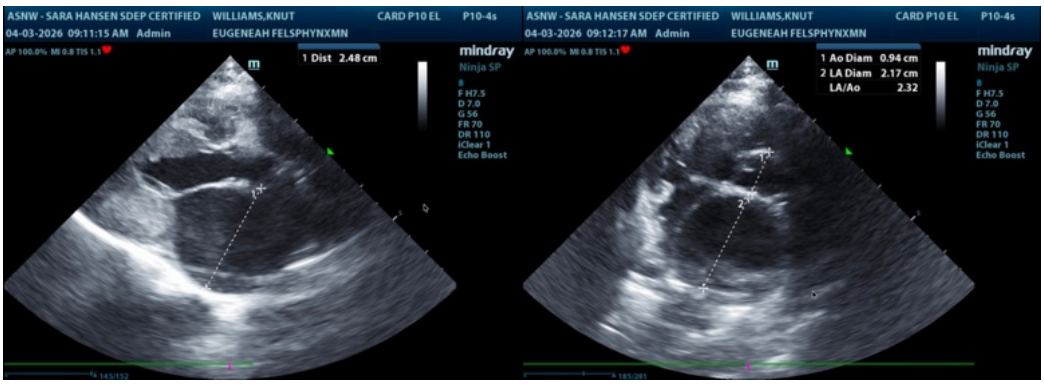
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the degree of chamber dilation, the addition of enalapril (0.5mg/kg SID) is recommended. Continued atenolol (1-2mg/kg BID) and clopidogrel (18.75mg SID) is also indicated at this time. A recheck of blood pressure and renal values are indicated in one week and three months, especially if enalapril is added. A recheck echocardiogram is recommended in 6 months to monitor for progression, or sooner, if clinical signs are noted. Owners should begin monitoring the resting respiratory rate. A normal respiratory rate is less than 30 breaths per minute; however, the trend in breathing rate is most important. If a progressive increase in respiratory rate is seen, then evaluation by a veterinarian is necessary.

Anesthesia considerations:
While there is no CHF present, there is likely an increased anesthetic risk which must be considered prior to any anesthetic procedure. 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. Fluid therapy during anesthesia should be considered at a reduced rate (e.g., 2-3 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, or diazepam/etomidate 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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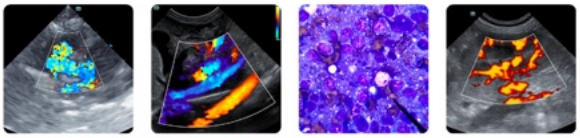

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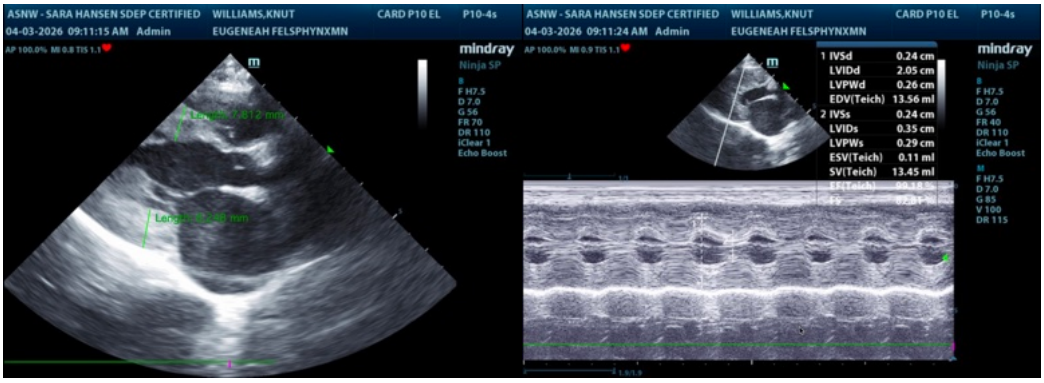

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com