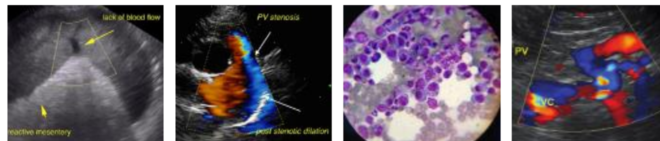

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1-800-838-4268 info@sonopath.com

PATIENT

Tinky Kittler

SPECIES

Feline

BREED

Tabby

SEX

MN

AGE

10yr

WEIGHT

16.1lb

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Jessica Miller

HOSPITAL NAME

Newton VH

REFERRING VET

Dr. Kim

INVOICE

12693ag

DATE

01/16/2023

PRESENTING CLINICAL SIGNS

Congestive heart failure. Blood pressure 134. Previous U/S 4/10/21 at VC Hardyston.

Current meds: lasix

Abnormal PE/Chem/CBC/UA Results: WBC 24.69, Neuts 23.08, HCT 53.6, BUN 34.5, TP 9, Alb 4.1, K 3.3, Cl 102, BNP abnormal

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		220	0.47	1.72	0.44	30	60
FELINE CARDIAC PARAMETERS	**LA/AO** (Boon)	**LA/AO HEART BASE** (Sisson)	**LA** 2D 4-chamber long axis AS to FW (Sisson) (cm)		**LVOT VEL.** (m/s)	**RVOT VEL.** (m/s)	**IVRT** (m/)
NORMAL PARAMETER	<1.5	0.88-1.79	0.7-1.7		<1.6	<1.3	40-60
PATIENT	2.0	1.95	2.1		0.75	0.7	
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 ventricular wall exhibited normal thickness with evidence of myocardial remodeling and areas of mild myocardial asymmetry. Concurrent mildly hyperechoic LV endocardium suggestive of LV myocardial fibrosis and mildly prominent papillary muscles were present. LV systolic dysfunction is decreased as evidenced by the FS measurement above. The LV is borderline dilated. The RV appeared to exhibit normal volume. The LA exhibited moderate dilation with mild bulbous appearance contained anechoic content without evidence of LA spontaneous contrast or formed thrombus. The RA exhibited concurrent mild dilation without evidence of spontaneous contrast. The mitral valve was overtly normal with trace MR present on Doppler. No obvious TR was present. Blood flow through the LVOT/RVOT was subjectively laminar on Doppler with possible mild subnormal measured LVOT/RVOT velocities. No evidence of pericardial or pleural effusion was present. No overt cardiac tumors. Possible tachycardiac was noted. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

ULTRASONOGRAPHIC FINDINGS

- Unclassified cardiomyopathy
- Moderate LA/RA enlargement
- Borderline dilated LV with myocardial remodeling and decreased LV systolic function

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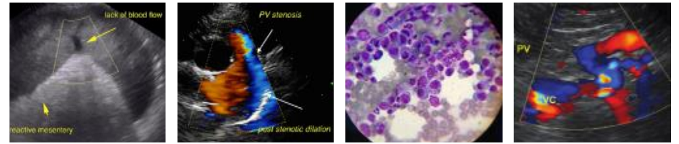

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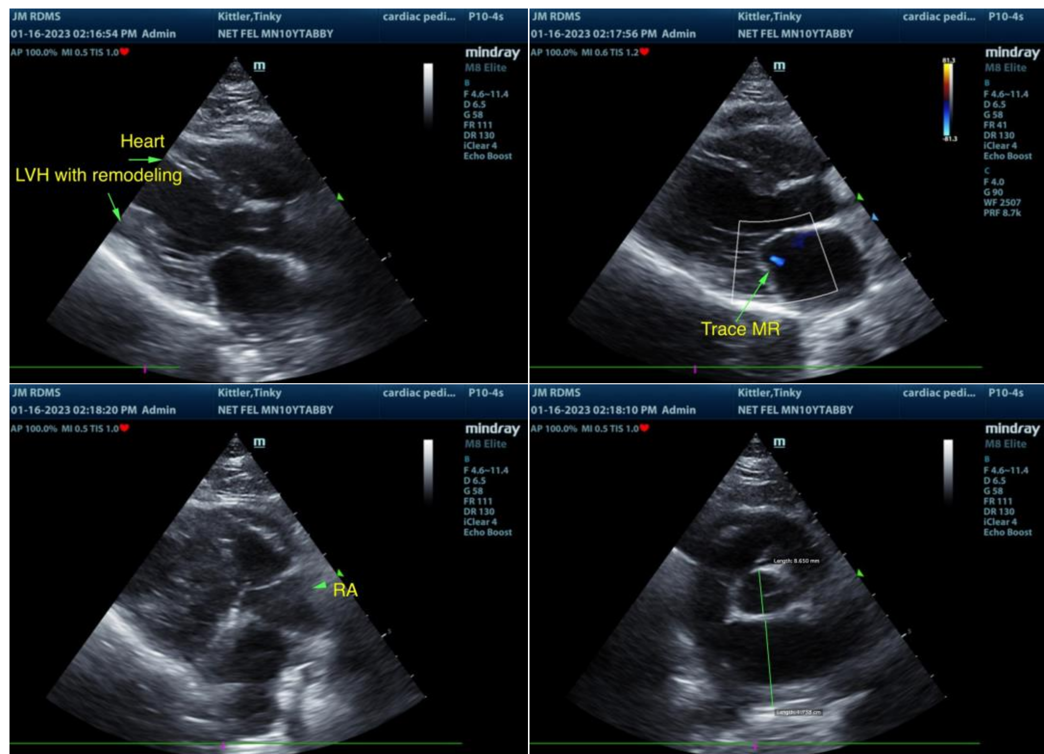
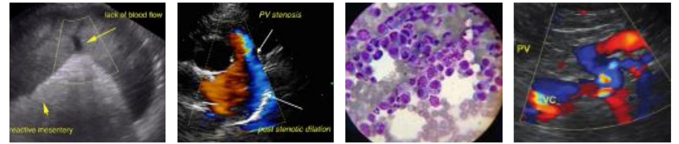
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The finding of atrial enlargement with normal LV wall thickness is most suggestive of unclassified cardiomyopathy however burn out or end stage HCM can also have this appearance. LV systolic dysfunction and likely diastolic dysfunction were present. Subjectively the degree of atrial enlargement was not severe. The combination of atrial enlargement, possible tachycardia and LV systolic dysfunction is most likely consistent with a diagnosis of CHF. If the patient is currently in respiratory distress, some degree of lower airway disease as a contributing factor cannot be definitively excluded.

Hospitalization with injectable Lasix and supplemental O2 is recommended if clinically indicated until patient is stable. Lasix 1-2 mg-kg PO BID, off label Pimobendan 1.25 mg PO BID and clopidogrel ¼ 75 mg tab PO SID given the LA enlargement is recommended with assessment of clinical response. ECG if possible is suggested to assess for potential tachyarrhythmia as a contributing factor. Close monitoring of renal values given the mildly elevated BUN and systemic BP going forward is recommended. Monitoring of resting respiration rate is also suggested.

A recheck echocardiogram suggested in 4-6 months, sooner if clinically indicated. A guarded long term prognosis is indicated.





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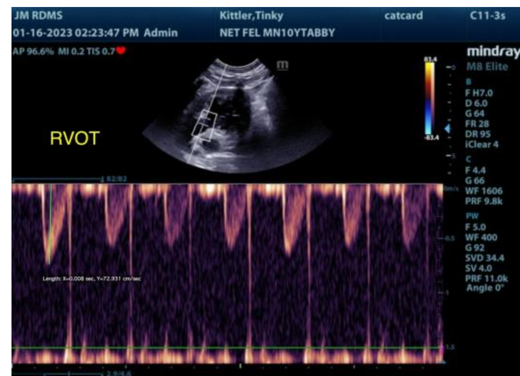

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com