PATIENT

Andre Pepperney

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

15y 8m

WEIGHT

17 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

William Penn VH

REFERRING VET

Dr. Bouzaout

INVOICE

10604

DATE

1/29/26

PRESENTING CLINICAL SIGNS

- Possible syncope, cardiac dz, tachycardia, hyperventilation
- prev. report from 6/2025 attached
- Current Meds: Atenolol 25mg (1/2 t sid)

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

FELINE CARDIAC PARAMETERS	**BODY WEIGHT** (lbs)	**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	17	165	0.62	1.4	0.60	45	78
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	-	1.7	1.75		1.0	0.84	-

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 echocardiogram in this patient demonstrated borderline increased **left atrial** size with mild bulbous structure. Similar LA dimension compared to previous study. No LA spontaneous contrast or thrombus. Chamber volume and blood echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented minor irregular age-related changes that are not clinically significant at this time with adequate extension in systole and union in diastole. Minor eccentric MR was noted on Doppler. The **left ventricle** presented borderline to mild increased free wall and septal thickness with mild alinear contour. The **myocardium** presented some echogenic remodeling consistent with expected age-related change. **Contractility** of the ventricular walls was adequate and in normal range for this breed and patient size. The **left ventricular outflow** tract demonstrated normal laminar flow with subjectively unremarkable structure. Normal measured LVOT velocity was noted. Subjective assessment of the **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted. **Tricuspid** valvular assessment demonstrated expected findings for this age patient. The **right ventricle** was of normal size (1/3 diameter of LV), echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). Normal measured RVOT velocity was noted. No visible **pericardial** or free pleural fluid was noted. The **mediastinum** was free of masses in the visible window. No evidence of overt arrhythmia was noted.

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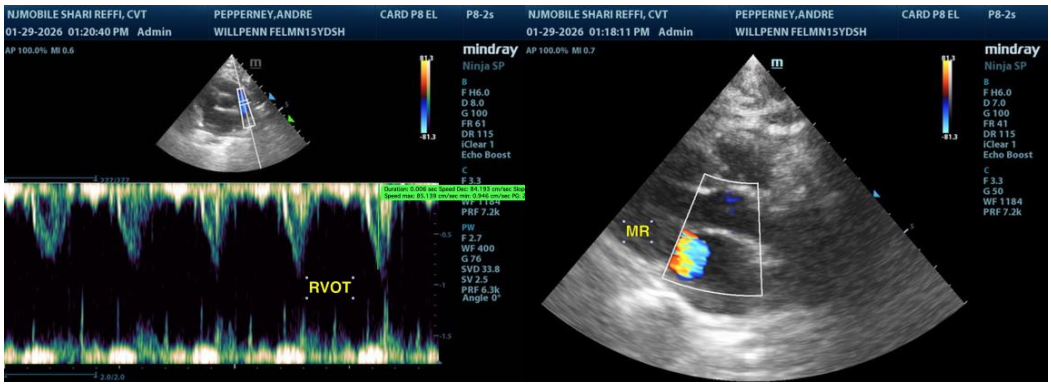
ULTRASONOGRAPHIC FINDINGS

- Static mild LV thickening with myocardial remodeling
- Borderline increased LA dimension – compensated

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Similar cardiac presentation compared to the previous study without evidence of progressive cardiomyopathy. The heart meets mild HCM phenotype criteria, which is a rule-out diagnosis once the patient is deemed euthyroid and normotensive. There is no obvious evidence of clinical cardiomyopathy, given borderline increased LA dimension and lack of additional issues such as LV systolic dysfunction or significant arrhythmia. Correlation with pending ECG consult as well as assessment to determine if Atenolol is required or not, as Atenolol can potentially make it easier for a patient to experience decompensation owing to its negative inotropic properties, although there is no evidence of current cardiac decompensation. There is no indication for additional cardiac medications. Sonographic monitoring is advised with a recheck echocardiogram suggested in 6 months, sooner if clinical signs arise. Anesthetic risk is considered mild to moderate. If required, the following protocol is suggested.

Suggested anesthetic protocol may include opioid or Benzodiazepine pre-med, induction with Propofol or Alfaxalone, and appropriate gas anesthesia with avoidance of alpha 2 agonists.



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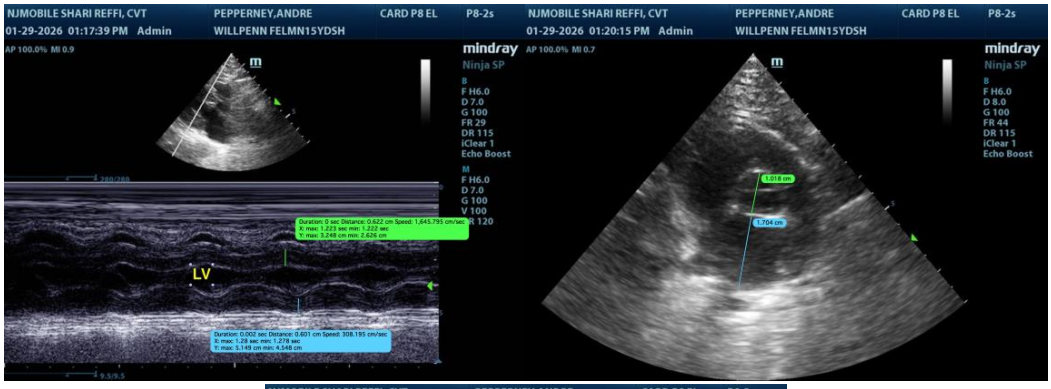

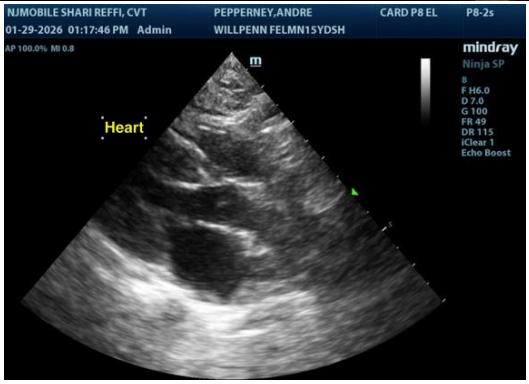

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com