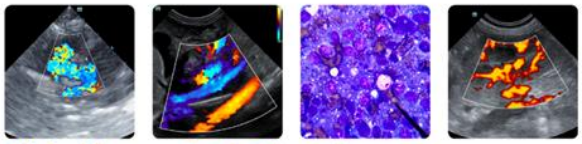




**PATIENT**

KC Parker

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

11yr

**WEIGHT**

9.3lb

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Ryan Leal

**HOSPITAL NAME**

Wellesley Animal Hospital

**REFERRING VET**

Dr. Cecelia Dean

**INVOICE**
24066

**DATE**
03/02/2026

## PRESENTING CLINICAL SIGNS

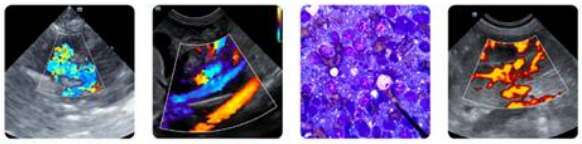
- Pt presented for thoracocentesis today. During thoracocentesis, concern for left atrial enlargement. Echocardiogram was recommended and approved.
- Pt originally presented on 2/24 for coughing. TXR revealed pleural effusion. Thoracocentesis recommended and declined at that time.
- Pt sedated, thoracocentesis performed - removed ~150mL pink tinged transudate. Echo performed after thoracocentesis
- Abnormal PE/Chem/CBC/UA Results: PE: BCS 4/9, RR44, RE 2+, no murmurs auscultable, NSR CBC: HCT 32%, WBC 22k, Neut 18k, Mono 0.7k Chem: NSF UA: USG 1.051, 2+ protein T4: 2.5 HWT: negative BP: pending until after sedation

## ULTRASONOGRAPHIC EXAMINATION OF THE HEART

| **FELINE CARDIAC PARAMETERS** | **BODY WEIGHT** | **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** | 9.3lb | NM | 0.43 | 1.7 | 0.43 | 25 | 50 |
| **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** | -- | 2.1 | 2.5 | | 0.8 | 0.6 | NM |
| 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 enlarged left atrial size and increased bulbous LA appearance based on 2 separate LA measurements. Mild swirling LA spontaneous contrast. The cranial and caudal mitral valve leaflets presented mild irregular thickening with normal kinetics. No obvious MR on Doppler. The left ventricular septum and free wall revealed normal thicknesses, subnormal contractility and mildly increased left ventricular volume with echogenic remodeling with septum and free wall consistent with myocardial fibrosis /remodeling. The left ventricular outflow tract demonstrated normal laminar flow and subjective structural integrity. Mild decreased measured LVOT velocity and minor aortic valve insufficiency. The right atrium and auricle revealed increased size and normal content. No evidence of masses was noted or right atrial spontaneous contrast. Tricuspid valvular assessment demonstrated adequate linear morphology and kinetics. The right ventricle was enlarged in size with normal chordae structure, myocardial echogenicity and thickness. Pulmonic tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). Minor volume pericardial and moderate volume free pleural fluid present. No extra cardiac pathology in the visible planes. The cranial mediastinum and pericardial regions were free of masses in the visible window. Subjective bradycardia. Emerging to mild prominent hepatic vasculature.





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## ULTRASONOGRAPHIC FINDINGS

### Primary

- Bilateral enlargement with LA spontaneous contrast
- LV myocardial remodeling / fibrosis with decreased LV contractility
- Mild volume pericardial and moderate volume pleural effusion
- Subjective bradycardia

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Unclassified cardiomyopathy given biatrial enlargement with normal LV wall thickness with potential for burnout or end stage HCM or restrictive cardiomyopathy possible. Regardless of classification, the degree of biatrial enlargement in combination with bradycardia and decreased LV systolic function is consistent with congestive heart failure. Going forward this patient will remain at significant increased risk for progressive CHF, malignant arrhythmia, thrombotic events, or possible sudden death.

Assessment of T4 level and systemic BP to rule out complicating factors and ECG assessment is recommended. Hospitalization with respiratory support and IV diuretic therapy until patient is stabilized is recommended. If stable, Lasix 1-2 mg per kg PO BID, Clopidogrel 75 mg tab 1/4 tab PO SID and Pimobendan 1.25 mg PO BID is recommended. Monitoring of renal parameters on diuretic therapy is recommended. An extremely guarded to potentially unfavorable long-term prognosis is indicated. Elective anesthesia is not advised. Recheck echo is suggested in 4-6 months, sooner if clinically indicated.

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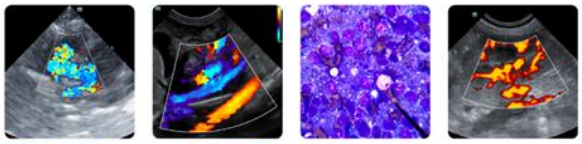

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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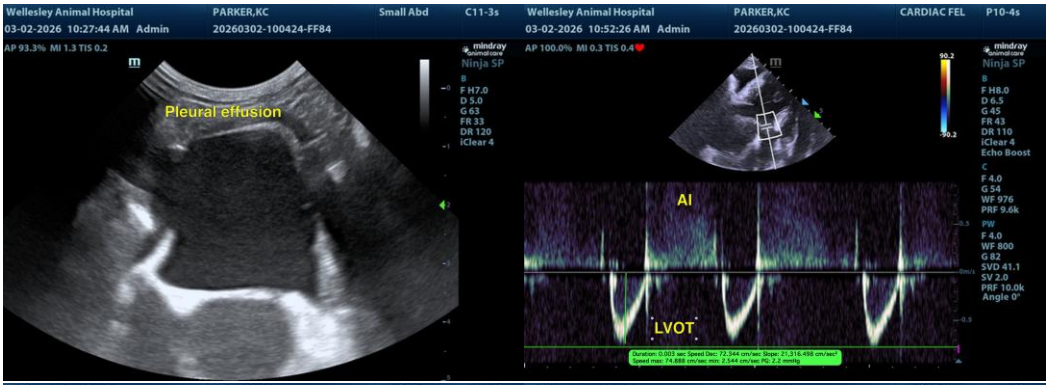


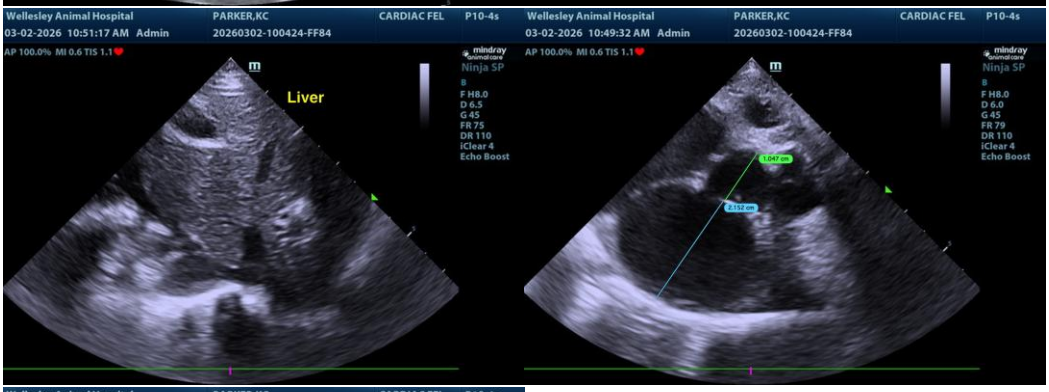


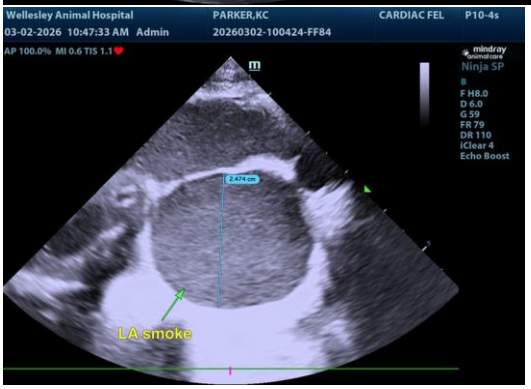


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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