



PATIENT

Althea Connor

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

12 Years 9 Months

WEIGHT

7.8 lbs

INTERPRETED BY

R. McKenzie Daniel,
 DVM, DABVP (Canine
 / Feline Practice)

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Rondout Valley
 Veterinary Associates

REFERRING VET

Dr. Page

INVOICE

16264

DATE

05/15/26

PRESENTING CLINICAL SIGNS

Heart murmur- prev. echo 3/23 consistent with HCM, no LA dilation. Grade 3/6 L parasternal systolic murmur

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	7.8	NM	0.6	1.15	0.41	40	74
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	NM	1.36	1.3	1.1	1.0	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

Cardiac Presentation

The echocardiogram in this patient demonstrated normal **left atrial** size and structure. No evidence of LA spontaneous contrast or thrombus. 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. No overt systolic anterior motion (SAM) of the mitral valve or definitive MR. The **left ventricle** presented mild thickened IVS with normal free wall dimension and mild alinear contour. The **myocardium** presented some variably echogenic remodeling consistent with expected age-related change/fibrosis. Mildly prominent remodeled papillary muscle. **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. 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. Mild TR on doppler measuring 2.4 m/s. 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. No visible **pericardial** or free pleural fluid was noted. The **mediastinum** was free of masses in the visible window. No evidence of arrhythmia.

ULTRASONOGRAPHIC FINDINGS

- LV myocardial remodeling with mild thickened intraventricular septum and remodeled papillary muscle.
- Normal LA.



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- Normal RA/RV.
- Mild tricuspid insufficiency.

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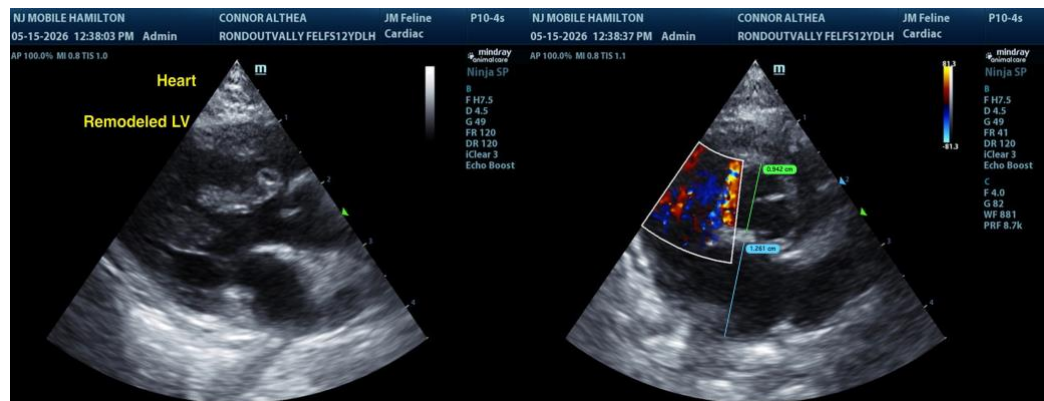
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left ventricle may indicate chronic HCM phenotype given the patient's history in conjunction with myocardial remodeling and fibrosis. Aside from the tricuspid insufficiency, no obvious additional contributing factor to the murmur, although concurrent mild mitral valve insufficiency is not definitively excluded.

Regardless, the hemodynamic effects of the murmur appear low given no evidence of left or right cardiac chamber enlargement. No evidence of pulmonary hypertension. No indication for cardiac medication at this stage. Conservative monitoring of the murmur going forward is advised with recheck echo suggested in six months, sooner if clinical signs arise. Correlation with pending lab work including T4 level and assessment of systemic BP to rule out potential complicating factors.

If required, anesthetic risk is considered mild. Assuming no evidence of hypertension, if required, the following protocol is recommended. 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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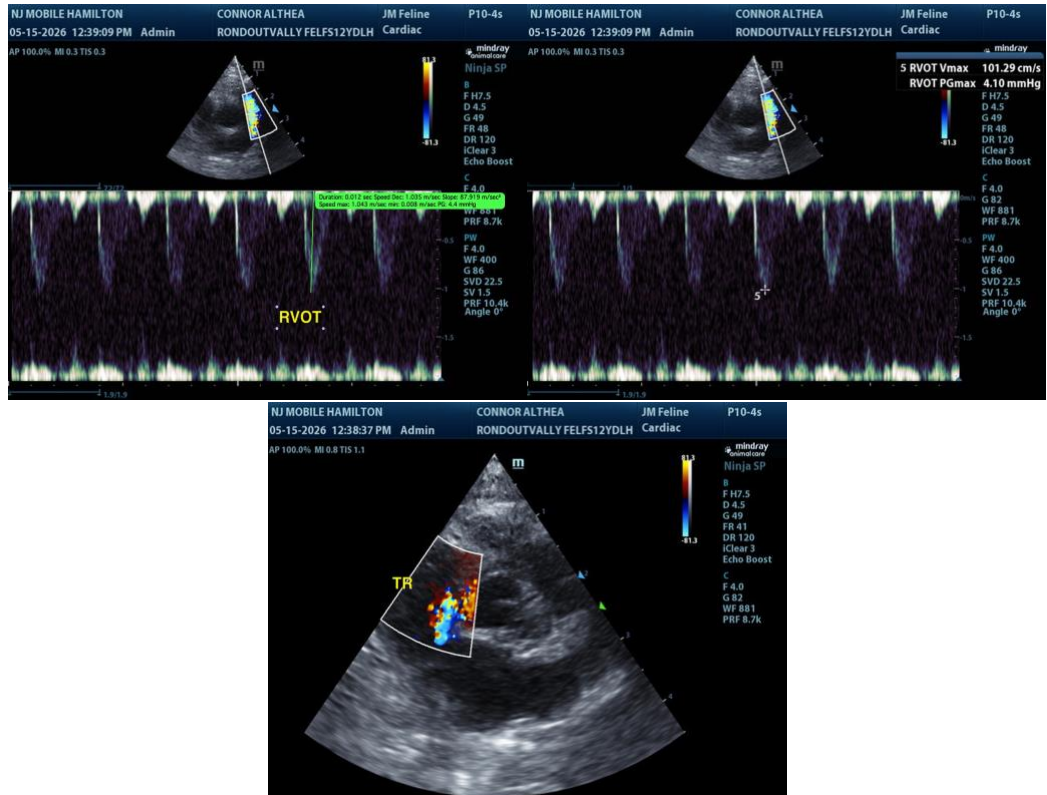
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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