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Clinical Sonography & Telecytology
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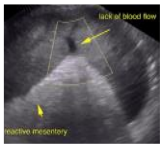
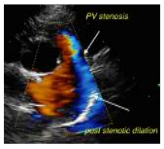
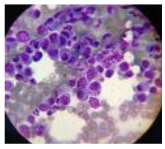
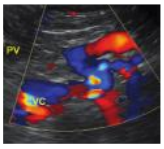

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1-800-838-4268 info@sonopath.com

PATIENT

Maya Gilson

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

9 years

WEIGHT

9.6 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ebersole

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Neat

INVOICE

14779

DATE

9/1/22

PRESENTING CLINICAL SIGNS

Increased respiratory effort on exam. Owner reports normal behavior at home. Significant pleural effusion found on echo, did throacocentesis and removed 90mL from R thorax. Clear/light tan fluid. Starting Lasix.
Abnormal PE/Chem/CBC/UA Results: PE: QAR, increased respiratory effort with abdominal press. RADS (attached, sent out): mild cardiomegaly, borderline pleural effusion, diffuse bronchial pattern. Suspect HCM.

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		NM	0.53	1.2	0.50	47.5	82.4
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	2.8	2.5	2.0			0.89	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 left ventricular wall was remodeled with regions of symmetry. Diffuse mildly hyperechoic endocardium suggestive of fibrosis was noted. Mildly prominent to remodeled papillary muscles were present. LV systolic function was adequate as indicated by the fractional shortening measurement. The LV was overtly normal in volume. The RV was overtly normal in volume. The left atrium exhibited moderate dilation with mild bulbous appearance. No evidence of spontaneous contrast or smoke was noted. The right atrium exhibited concurrent moderate dilation. The mitral valve was overtly normal in appearance. No evidence of obvious MR was noted. The tricuspid valve was overtly normal in appearance. Mild TR was present on doppler. Normal RVOT velocity was evident. Potential for very scant pericardial effusion is noted. Moderate volume primarily anechoic pleural effusion was present. No obvious cardiac tumors were present. Brief sonographic assessment of the cranial abdomen revealed possible mild hepatic congestive pattern with concurrent ascites.

ULTRASONOGRAPHIC FINDINGS

- Unclassified cardiomyopathy
- Moderate biatrial enlargement

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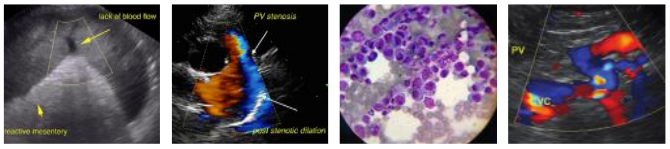

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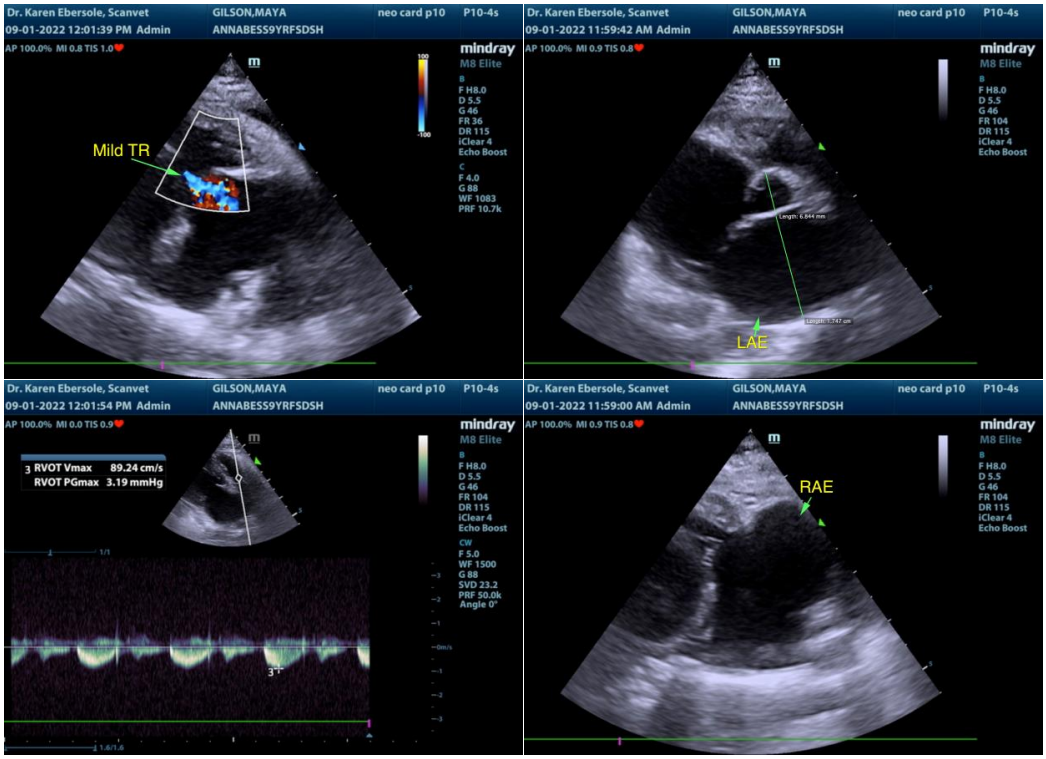
- LV myocardial remodeling
- Pleural scant pericardial and concurrent peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cardiac presentation, given biatrial enlargement in the face of overtly normal wall thickness, is most consistent with unclassified cardiomyopathy. Burn-out or end-stage HCM can also have this appearance. Regardless of categorical classification, the degree of atrial enlargement combined with at least bicavitary effusion confirms the diagnosis of congestive heart failure.

Going forward, increased risk of continued episodes of CHF, development of blood clots and malignant arrhythmias are possible. Consider hospitalization with injectable Lasix if the patient is exhibiting respiratory distress or until stabilized. Once stabilized, Lasix 1.0-2.0 mg/kg PO BID, Clopidogrel 75 mg tab, 1/4 tab, PO SID, and off-label Pimobendan 1.25 mg PO BID is recommended. Serial monitoring of renal parameters, BP, +/- ECG, if an arrhythmia is detected, is advised.

Long-term prognosis is likely poor, yet Immediate prognosis is dependent upon response to medial therapy. Recheck echocardiogram is recommended in 3-4 months, sooner if progressive evidence of CHF.



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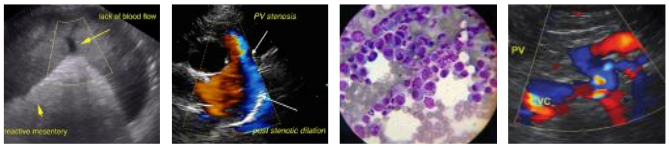

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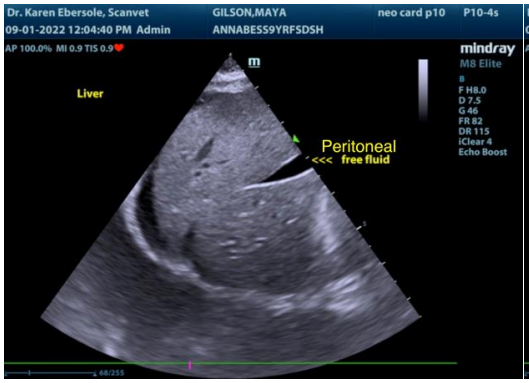

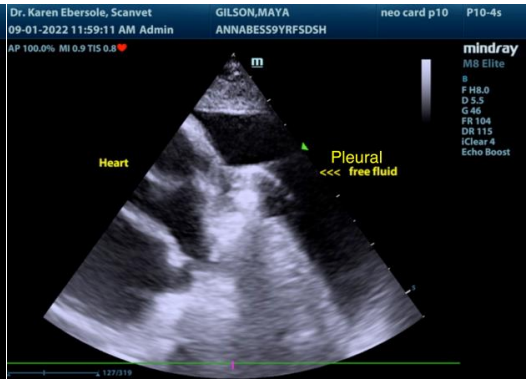

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com