



PATIENT

Cleopatra Magers

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13

WEIGHT

12.22

INTERPRETED BY

Sara Brethel DVM,
DACVIM (Cardiology)

IMAGING PERFORMED BY

Dr. Andrea Nason

HOSPITAL NAME

Caravan VS

REFERRING VET

Dr. Andrea Nason

INVOICE

35486

DATE

11/11/25

PRESENTING CLINICAL SIGNS

History: Cleopatra was diagnosed with hyperthyroidism in July of this year. At that time, her proBNP was 119 and she was started on felinorm. As of October, her thyroid has normalized and the proBNP is 135. Her blood pressure is normal, no kidney disease. Cardiac work up to evaluate for any underlying heart disease prior to anesthesia for dental procedure.

Abnormal PE/Chem/CBC/UA Results: July 2025 - proBNP 119, T4 6.9, Crea 0.7, BUN 22, blood pressure 160 systolic, USG 1.041 Oct 2025 - T4 1.6, Crea 0.9, BUN 21, SDMA 11, USG 1.041 At time of echo - blood pressure 135 systolic.

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	5.55	NM	0.62	1.1	0.54	51.81	--
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	--	1.42	--		NM	NM	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							

LVIDs: 0.53

ECG Interpretation

Sinus rhythm

Cardiac Presentation

The left atrium is within normal limits. The mitral valve leaflets are normal and there is no mitral regurgitation. There is no evidence of systolic anterior motion of the mitral valve and no evidence of a left ventricular outflow tract obstruction. There is concentric hypertrophy of the left ventricle. The right atrium is normal. The tricuspid valve is normal without evidence of tricuspid regurgitation. The right ventricle appears to have preserved systolic function subjectively. The aortic and pulmonic valves are normal without evidence of insufficiency. The aorta and PA are normal along with the associated PA branches. There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses.

ULTRASONOGRAPHIC FINDINGS



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- Left ventricular concentric hypertrophy of the interventricular septum
- Normal left atrial size

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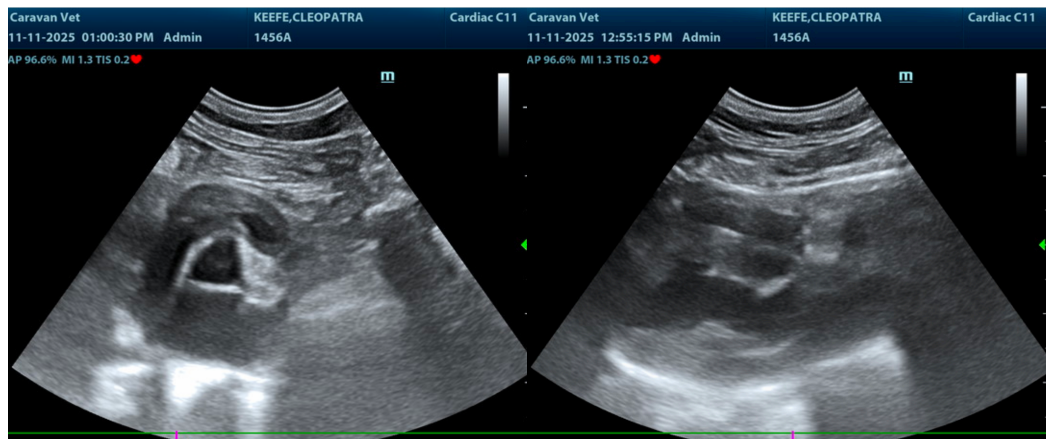
DATE

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient has evidence of left ventricular concentric hypertrophy and is classified as a stage B1 due to the normal left atrial size. With the patient's history of now being euthyroid, if the thyroid hormone has not been controlled for at least 2-3 months, this still could represent changes secondary to hyperthyroidism, however, if the thyroid hormone has been controlled for that long, and the patient is normotensive, then the patient also likely has some underlying primary cardiac disease, such as hypertrophic cardiomyopathy. No cardiac medications are indicated at this time as the patient is at a low risk for complications associated with this condition. Since this can be a progressive condition, serial monitoring is recommended. It's recommended to recheck an echocardiogram in 6 months, sooner if the patient develops cardiovascular clinical signs.

Standard perioperative fluid rates should be well-tolerated. Medications like dexmedetomidine and other alpha 2 agonists are best avoided. Ketamine is also best avoided. Anticholinergics can be used in the case of a clinically significant bradyarrhythmia (i.e., bradycardia with concurrent hypotension). If the patient is on an ACEi, recommend not giving this therapy the day of anesthesia.





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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.

Sara Brethel DVM, DACVIM (Cardiology)

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