



PATIENT

Clifford Hoskins

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

13 Years

WEIGHT

12.22 Pounds

INTERPRETED BY

Sara Brethel DVM,
DACVIM (Cardiology)

IMAGING PERFORMED BY

Dr. Andrea Nason

HOSPITAL NAME

Caravan Vet

REFERRING VET

Dr. Andrea Nason

INVOICE

35893

DATE

12/15/25

PRESENTING CLINICAL SIGNS

History: Clifford has a history of HCM/SAMM, previous echo report from May attached. He's currently having unintentional weight loss and waxing and waning soft/liquid stools. He had an abdominal scan done as well (report pending). GI and diarrhea panel in June of this year unremarkable. Recheck cardiac work up to assess if heart disease is potentially part of the cause. He also needs a dental procedure, so assessing his safety for anesthesia.

Abnormal PE/Chem/CBC/UA Results: CBC - mild eosinophilia Chem - Crea 1.9, BUN 25 T4 2 USG 1.014, UPC 0.3 Blood Pressure 152 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	0.38	1.24	6.12	--	--
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	--	1.01	--		~2.0		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							

MR VMAX: ~5.0

Chest Radiographic Study

Of the chest radiographs provided, the cardiac silhouette is within normal limits. The pulmonary vasculature is normal and there is no evidence of cardiogenic pulmonary edema.

ECG Interpretation

Sinus rhythm with periods of occasional ventricular premature complexes and an accelerated idioventricular rhythm.

Cardiac Presentation

The mitral valve leaflets are normal and there is mild mitral regurgitation. There is no prolapse of the mitral valve leaflets. The left atrial size is within normal limits. Left ventricular systolic function appears preserved. Left ventricular diastolic dimensions are within normal limits. There is evidence of systolic anterior motion of the mitral valve and there is a discrete step up in velocities through the left



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ventricular outflow tract There is evidence of a kissing lesion at the level of SAM and the left ventricular myocardium appears hyperechoic in some regions. Left ventricular walls measure hypertrophied. There is normal right atrial size without evidence of tricuspid regurgitation. There is no prolapse of the tricuspid valve leaflets and no evidence of pulmonary hypertension on the images provided. The right ventricle appears normal in structure and function subjectively. The aortic and pulmonic valves have normal morphology and the corresponding outflow velocities are within normal limits. There is no evidence of pulmonic or aortic insufficiency. The aorta appears normal. The pulmonary artery and associated branches appear normal. There is no evidence of pleural effusion, pericardial effusion, or intracardiac masses.

ULTRASONOGRAPHIC FINDINGS

- Hypertrophic changes to the left ventricle
- Normal left atrial size
- Mild mitral regurgitation
- Systolic anterior motion of the mitral valve
- Subclinical left ventricular outflow tract obstruction, that is mild

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient continues to have hypertrophic obstructive cardiomyopathy, stage B-1, with normal left atrial size. Given the ECG changes and the prominent accelerated idioventricular rhythm, I suspect this is secondary to whatever underlying systemic disease is causing the patient's weight loss and clinical signs and does not appear to be primarily related to cardiac disease. No cardiac therapies are recommended. Consider rechecking an ECG in 2-3 weeks, sooner if the patient is developing any cardiovascular clinical signs, such as weakness, lethargy, collapse, etc. Recommend ensuring the patient is normotensive and euthyroid.

Once the gastrointestinal signs and weight loss are worked up, from a cardiac standpoint, as long as the rhythm is stabilized, the patient can undergo elective anesthetic procedures. Recommend continuous ECG monitoring during the procedure. 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.

A recheck echocardiogram is recommended in 10-12 months, sooner if other signs are developing.



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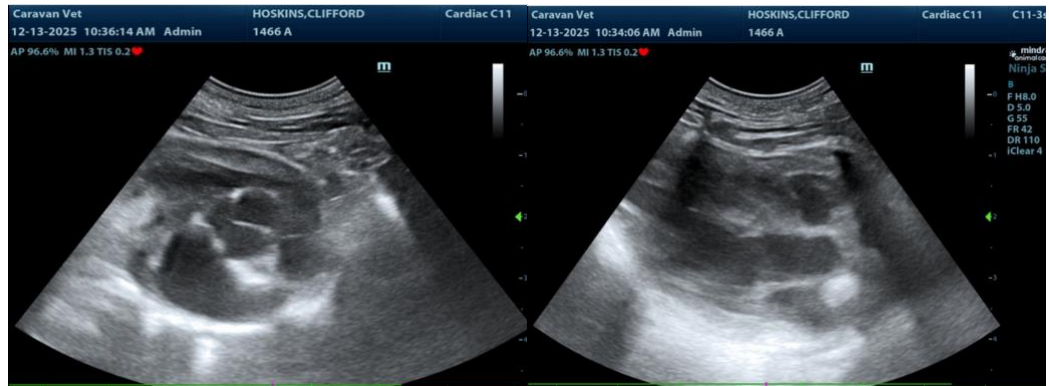
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sara Brethel DVM, DACVIM (Cardiology)

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