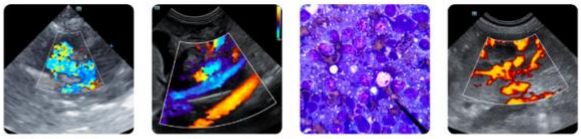


PATIENT

Caymus Safianow

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

5.3 kg

INTERPRETED BY

Sara Brethel, DVM, DACVIM (Cardiology)

IMAGING PERFORMED BY

Andrea Nicastro, DVM, DACVIM

HOSPITAL NAME

Blue Pearl Summerville

REFERRING VET

Dr. Kelsey Harris

INVOICE

36262

DATE

3/17/26

PRESENTING CLINICAL SIGNS

- Patient presented for strange breathing, lethargy and decreased appetite
- Pleural effusion
- Meds: Torbugesic, Furosemide, Cerenia, Ondansetron, Gabapentin
- Abnormal PE/Chem/CBC/UA Results: No murmur, decreased heart sounds on the right side; pulses were strong and synchronous. Intermittent arrhythmia BP - 160 HR/ 36 RR/ BP 100 mmHg HCT - 57% Leukocytosis: neutrophilia, monocytosis Chloride - 110 (L) Globulins - 5.3 (H)

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	5.3	NM	0.71	1.23	0.58	39.02	--
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	1.23	1.3	--		1.0	0.8	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							

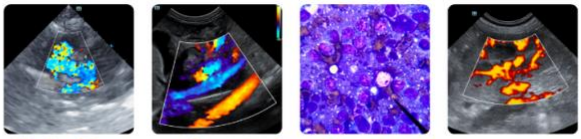
LVIDS 0.75

Chest Radiographic Interpretation

The images are dated 3/15. There is prominent pulmonary vasculature, an interstitial to coalescing alveolar pattern, and scant pleural effusion. There's concern for cardiogenic pulmonary edema and pleural effusion based upon the thoracic radiographs.

ECG Interpretation

There is significant baseline artifact, and the ECG is non-diagnostic. From what is visible, there appears to be a primarily sinus rhythm and one aberrant heartbeat consistent with a possible ventricular premature complex.



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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. Aortic and pulmonic outflow velocities are within normal limits. The aorta and PA are normal along with the associated PA branches. There is scant pleural and pericardial effusion. There are no intracardiac masses.

ULTRASONOGRAPHIC FINDINGS

- Scant pleural effusion
- Scant pericardial effusion
- Normal left atrial size
- Concentric left ventricular hypertrophy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based upon the chest radiographs provided from the 15th, there is concern for congestive heart failure, however, the echocardiogram shows a normal left atrial size. Depending on the amount of diuretic therapy the patient has received, you can see normalization of left atrial size, and despite having had an episode of heart failure. However, if the x-rays and echo were on the same day and less than 4.0 mg/kg of furosemide therapy has been given to the patient, then the echo findings are not supportive of congestive heart failure despite there being evidence of changes to the left ventricle. Therefore, if the patient has been receiving diuretic therapy, I would recommend continuing that diuretic therapy. Typically, furosemide for first time heart failure doses, I would recommend about 1.5 mg/kg twice daily, along with clopidogrel despite the normal left atrial size. However, if the echo and chest radiographs were done the same day, then I do not recommend continued diuretic therapy, and clopidogrel does not appear to be indicated, and I would continue to investigate other differentials causing the changes to the pulmonary parenchyma, pericardial and pleural effusion.

Recommend ensuring the patient is euthyroid. The reported blood pressure is low/normal at 100. The cause for the elevated globulins is unknown, and that may require additional evaluation.

The client should start monitoring respiratory rate and effort at home if not already doing so. The resting respiratory rate should be < 35-40 breathes/minute when the patient is resting or sleeping. If the breathing rates are increasing, then chest radiographs are recommended.

Recommend rechecking kidney values and electrolytes in 7-10 days if the patient remains on diuretic therapy, and then a recheck echo in 4-6 months, sooner if the patient is decompensating. If the patient remains on diuretics, and again the echo is done after the chest x-rays were obtained, then I would also add in ACE inhibition, enalapril versus benazepril, at a dose of 0.3 to 0.5 mg/kg once to twice daily. 2-3 weeks after starting enalapril or other ACE inhibitors, recheck blood work, assessing

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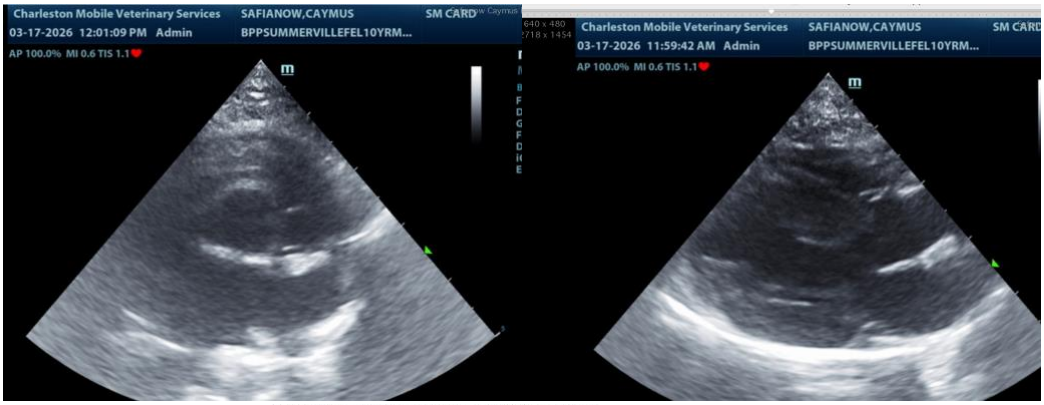
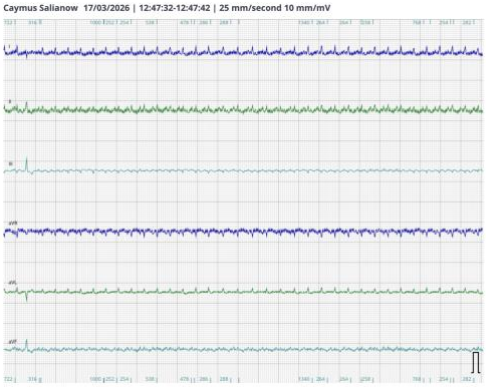
the kidneys and electrolytes is also recommended.





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)

info@SonoPath.com