

PATIENT

Samson Crawford

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

8.87 pounds

INTERPRETED BY

Sara Brethel, DVM,
 DACVIM (Cardiology)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Q Street Animal Hospital

REFERRING VET

Dr. Rensema

INVOICE

14582

DATE

03/24/26

PRESENTING CLINICAL SIGNS

September 2025 - vomiting followed by acute paralysis of a hindlimb that was diagnosed as a saddle thrombus. Went to OSU for evaluation, ruling-out current saddle thrombus, heart disease, and any other abdominal issues. Furthermore, oral exam and swallowing appeared normal. Kidney values were also remarkably elevated but are getting better. Late July 2025 - Vomiting, mildly elevated kidney values, potential pancreatitis. January 2025 - presented to rDVM for URI signs; diagnosed with feline asthma. Started on Flovent which resolved clinical signs. 2022-2024 - intermittent focal seizures reported

ABNORMAL Labwork Values: SDMA 16 ug/dL. CREATININE 1.7 mg/dL. BUN 32 mg/dL. SPECIFIC GRAVITY 1.036. ProBNP 24

HR/RR/BP: 160/24/xx

Is there a Heart Murmur? If so, please grade: No

Current Medications: Clopidogrel transdermal; fluticasone PRN

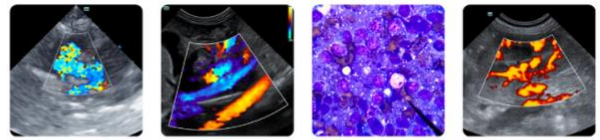
Notes to Specialist (if any): Honestly, I'm doubtful if this patient ever had a thromboembolic event or at least didn't have a saddle thrombus. I don't know of any true contraindication for clopidogrel use without overt heart disease. Also, patient was noted as having kidney failure, but I believe this is not as horrible as initially thought (stage 1 at worst)

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	4.03	NM	0.36	1.3	0.4	--	--
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	0.96	1.0	NM	0.99	--	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 mitral valve leaflets are normal and there is no mitral regurgitation. The left atrial size is normal. There is no evidence of systolic anterior motion of the mitral valve and no evidence of a left



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ventricular outflow tract obstruction. Left ventricular systolic and diastolic function is within normal limits. There is no evidence of left ventricular concentric hypertrophy. 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.

ECG

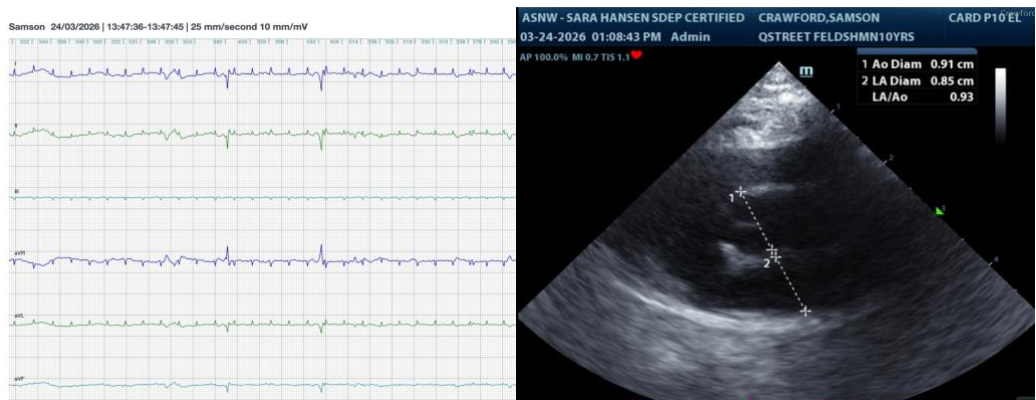
Sinus rhythm with occasional isolated monomorphic ventricular premature complexes.

ULTRASONOGRAPHIC FINDINGS

- Structurally normal heart.
- VPCs.

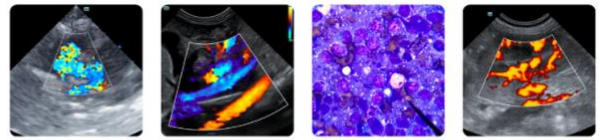
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient's heart is structurally normal. A cause for the previous episode of paralysis is not identified. Clopidogrel therapy does not appear to be indicated at this time. As far as long-term complications with clopidogrel, if not needed, none are known, but if any surgeries are needed in the future, clopidogrel should be discontinued prior to elective procedures. The cause of the VPCs is unknown. Stress, anxiety can cause them, other diseases of the liver, spleen, infectious, inflammatory, etc. can all cause these. No therapy is indicated at this time. Can consider a recheck ECG in 6 months. Alternatively, can perform a Holter monitor on the patient. A recheck echo can be considered in 10-12 months, otherwise a recheck echo would not be needed unless the patient develops a murmur or an abnormal proBNP.



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.



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