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Echocardiographic Final Report

Name: SAMPLE, PATIENT Date: 03/07/2011 13:38 Sonographer: Sample Sonographer, RDCS,RVT, RDMS
DOB: 06/19/1959 Age: 51 BSA: 2.9 BP 100 / 71 Location: SAMPLE LOCATION
Sex: M Ht: 72.9 Wt: 349 Ordering Physician: MD, Doctor 999-999-9999

Indications: new onset of Congestive Heart Failure, Idiopathic/Constrictive/Restrictive, Cardiac Dysrhythmia, unspecified, Tachycardia, Shortness of Breath, Tobacco Use Disorder, Morbid Obesity

2D/Doppler Measurements:

RVd	4.0	cm(0.9-2.6)	Est. EF:	40	(>55%)	PVa		(<30)
LVd:	6.6	cm(3.5-5.7)	Simpsons EF:		(>55%)	E Prime Vel	6.6	(>10)
LVs:	4.8	cm(1.5-3.9)	AO	2.3	cm (2.0-3.7)	E/ E Prime	11.9	(<8)
IVS:	1.3	cm(0.6-1.1)	AV Peak Vel:	189.6	cm/s (100-170)	PVR		
LVPW	1.3	cm(0.6-1.1)	MV Peak Vel:	78.8	cm/s(60-130)	LVOT Peak Vel	85.9	cm/s (80-120)
LA s:	5.0	cm(1.9-4.0)	TV Peak Vel:	64.2	cm/s(30-70)	LVOT Diameter	2.2	cm(1.8-2.2)
LA V	201		PV Peak Vel:	39.1	cm/s(60-90)	LVOT VTI	18.7	
LA V I	69	< 29 ml/m2	PAP:		mmHg	AV VTI		
						AV Area:		cm ² (4.0-6.0)

Hemodynamic Analysis

HR: 118 bpm(60-100) Stroke Vol: 71 cc(50-90) Cardiac Out: 8.7 l/min(4-7) CI: 2.9 l/min/m²(2.5-4.5)

Conclusions:

Follow Up Recommendations:

1 year, If clinically indicated

PRINCIPAL FINDINGS: Systolic and diastolic congestive heart failure. Dilated left ventricle with severe diastolic dysfunction and reduced systolic function. Tachycardia was noted during exam (118 bpm).

FINDINGS:

1. Severe Diastolic Dysfunction: Moderate elevation of resting filling pressure. Severe increase in left atrial volume consistent with a history of elevated LV filling pressures.
2. Systolic Dysfunction: Mildly reduced LVEF 40%; Dilated left ventricle; Mild LV hypertrophy. Ill-defined regional wall motion abnormalities suggestive of possible resting ischemic heart disease.
3. Aortic valve sclerosis, a marker of atherosclerotic cardiovascular risk and future risk for MI, CVA, CHF and aortic stenosis.
4. Unable to estimate pulmonary artery systolic pressure. Normal RV size with reduced systolic function. Dilated IVC with reduced respiratory collapse.

KNOWLEDGE-BASED INFORMATION:

1. Further cardiovascular attention may be indicated. Cannot exclude coronary artery disease.
2. Considerations: Aggressive physiologic optimization irrespective of BP; normalization of resting LV filling pressure. Highest tolerable dose ARB or ACEI; calcium channel blocker (dihydropyridine class); thiazide-like diuretic; Statin with a goal of LDL cholesterol <70mg/dl; non-selective beta-blocker.
3. Extreme Obesity (BMI: 46) is associated with severely increased risk of Cancer, Coronary Artery Disease, Type II Diabetes and Hypertension.
4. Follow-up: Echo/Doppler to assist in management of CV dysfunction in 1 year or sooner is appropriate if there is a documented change in clinical status or symptoms.

Final 2D Interpretation:

Severe left atrial enlargement. Right atrial enlargement. The aortic valve is not well seen, cusp number is indeterminate, is sclerotic, but appears to open well. Mild mitral valve thickening. Structurally normal pulmonary and tricuspid valves. Dilated inferior vena cava (2.1 cm) with little or no respiratory collapse (<50%), consistent with elevated mean right atrial pressure. Normal aortic root and ascending aorta dimensions. No intracardiac mass or thrombus. No pericardial effusion.

Final Doppler Interpretation:

No significant valvular stenosis. No significant valvular regurgitation. Trivial mitral valve regurgitation. No evidence for shunt by color Doppler interrogation.

Reading Physician MD FACC

CARDIOLOGIST