



PATIENT

Moscow Lewis

SPECIES

Feline

BREED

Ragdoll

SEX

Neutered Male

AGE

12 Years 4 Months

WEIGHT

11.9 Pounds

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(Cardiology)

IMAGING PERFORMED BY

Graham Sager-Gellerman, DVM

HOSPITAL NAME

BackBayVC

REFERRING VET

Graham Sager-Gellerman, DVM

INVOICE

35734

DATE

12/2/25

PRESENTING CLINICAL SIGNS

History: Primary cause of presentation: Decreased Appetite Got home from traveling on Sunday, P was with sitter for 5 days. Will lead owners to food bowl like normal, though will not eat and just sit at bowl and meow. Social eater and likes to eat with O's company, now not interested in food beyond a few bites of Churu. Current diet: RC P/D, in last 48 hours, only taken two bites of food (when O was making appointment this morning). Drinking water normally, had one instance of diarrhea on Sunday with some hairballs, unsure if defecated since. Has been more cuddly at home (actively seeking out comfort from O). Patient has had 11% weight loss since February 2025 Labwork today supportive of pancreatitis. New heart murmur auscultated today (Grade II/VI sternal), previous ProBNP (2023) 36 pmol/L (0-100 pmol/L) Patient has high FAS, difficult to perform thorough exam/administer treatments without sedation/PVP. Treating supportively for pancreatitis unless image sets suggest alternative etiology of clinical signs.

Abnormal PE/Chem/CBC/UA Results: Labwork today (12/2/25): CBC: wnl except mild eosinopenia (stress?) CHEM: chem wnl except for pancreatic lipase (8.0 U/L, reference range 0-4.4 U/L).

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

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	5.41	200	0.45	1.16	0.53	53	99
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	1.05	1.02	1.0		1.0	1.9	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 left atrium is normal in dimension. There are no distinct left atrial thrombi/clots or spontaneous echo contrast appreciated. The left ventricle is normal in dimension as well as wall thickness, and no evidence of restriction. Left ventricular systolic function is normal, with adequate contractility based on fractional shortening and systolic left ventricular dimensions. The right atrium and ventricle are subjectively normal in dimension and systolic function. There is evidence of systolic anterior motion of the mitral valve with trace mitral regurgitation. The tricuspid valve leaflets presented normal linear structure, extension in systole, and union in diastole without regurgitation. The left ventricular outflow tract demonstrated turbulent flow and subjective structural valvular integrity. The visible aorta is



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unremarkable. Pulmonary outflow tract assessment revealed normal valve structure, laminar flow, and appropriate diameter and distensibility. There is no evidence of semilunar valve insufficiency or pulmonary hypertension documented. There is no visible pericardial, pleural, or free peritoneal fluid noted.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic urine and there is a mild to moderate amount of suspended mobile echogenic debris. The bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. The left kidney measures 4.34 cm. The right kidney measures 4.78 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measures 0.38 cm. The right adrenal gland measures 0.53 cm.

Spleen

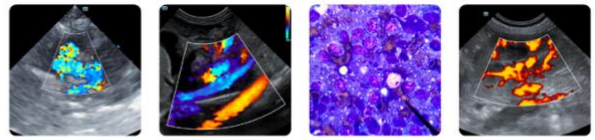
The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 1.0 cm at the hilus.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecolic junction are patent, and the colon contains normal shadowing feces. There is no



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evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

There is no significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- The cardiac findings are consistent with dynamic subaortic stenosis, as there is SAM present, but no convincing hypertrophy is identified. It is unlikely that any of the clinical/radiographic signs are related to underlying heart disease.
- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- There is no overt underlying etiology for the reported clinical signs noted prior to today's study. Consider occult pancreatitis, gastroenteritis, or early inflammatory bowel disease or other chronic enteropathy, as potential underlying etiologies.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations/Treatment:

Given the absence of any underlying heart disease, no cardiac therapy will be recommended. In addition, there are no cardiac objections to fluid therapy or steroid use. Owing to the presence of an outflow tract obstruction, a follow up echo is recommended in another 6-12 months to make sure no progression has occurred.

Anesthesia considerations:

If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a reduced rate (e.g., 5 ml/kg/hour) if possible (i.e., if not hypotensive). A shorter anesthetic duration will reduce the risk of complications. Pre-oxygenation is advised. Premedication with an opioid (i.e., butorphanol, hydromorphone, oxymorphone) with or without a benzodiazepine is generally the safest protocol. An induction agent such as Propofol, alfaxalone can be used to effect. Maintenance of anesthesia with isoflurane or sevoflurane is reasonable.

Diet:

No special considerations are necessary. Any high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina is reasonable.

Activity:

No special considerations are necessary.

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes



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A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

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Continued supportive care for presumptive pancreatitis or acute gastroenteritis is clinically indicated at this time pending additional diagnostic tests.

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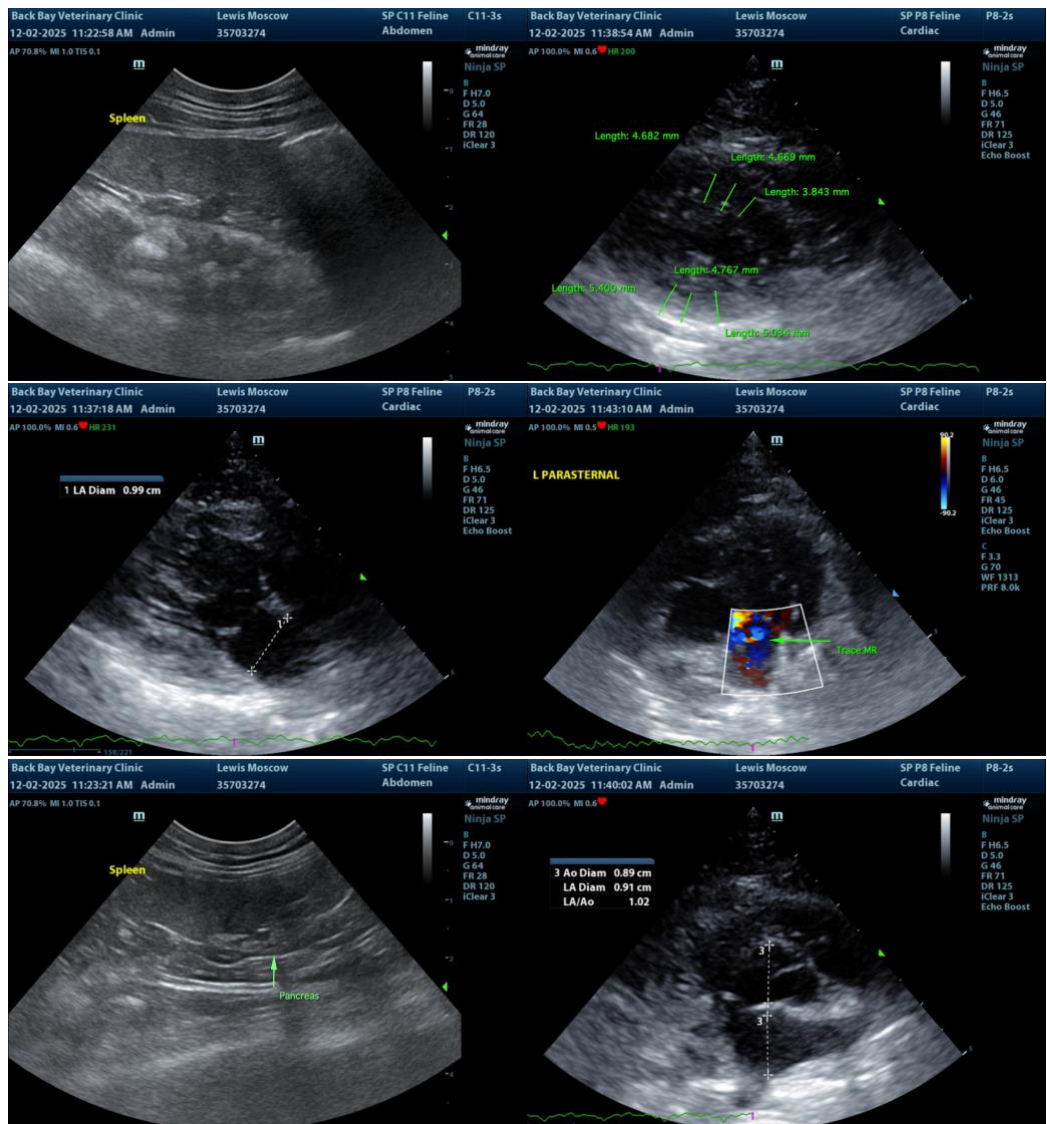
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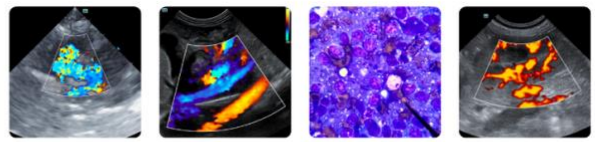
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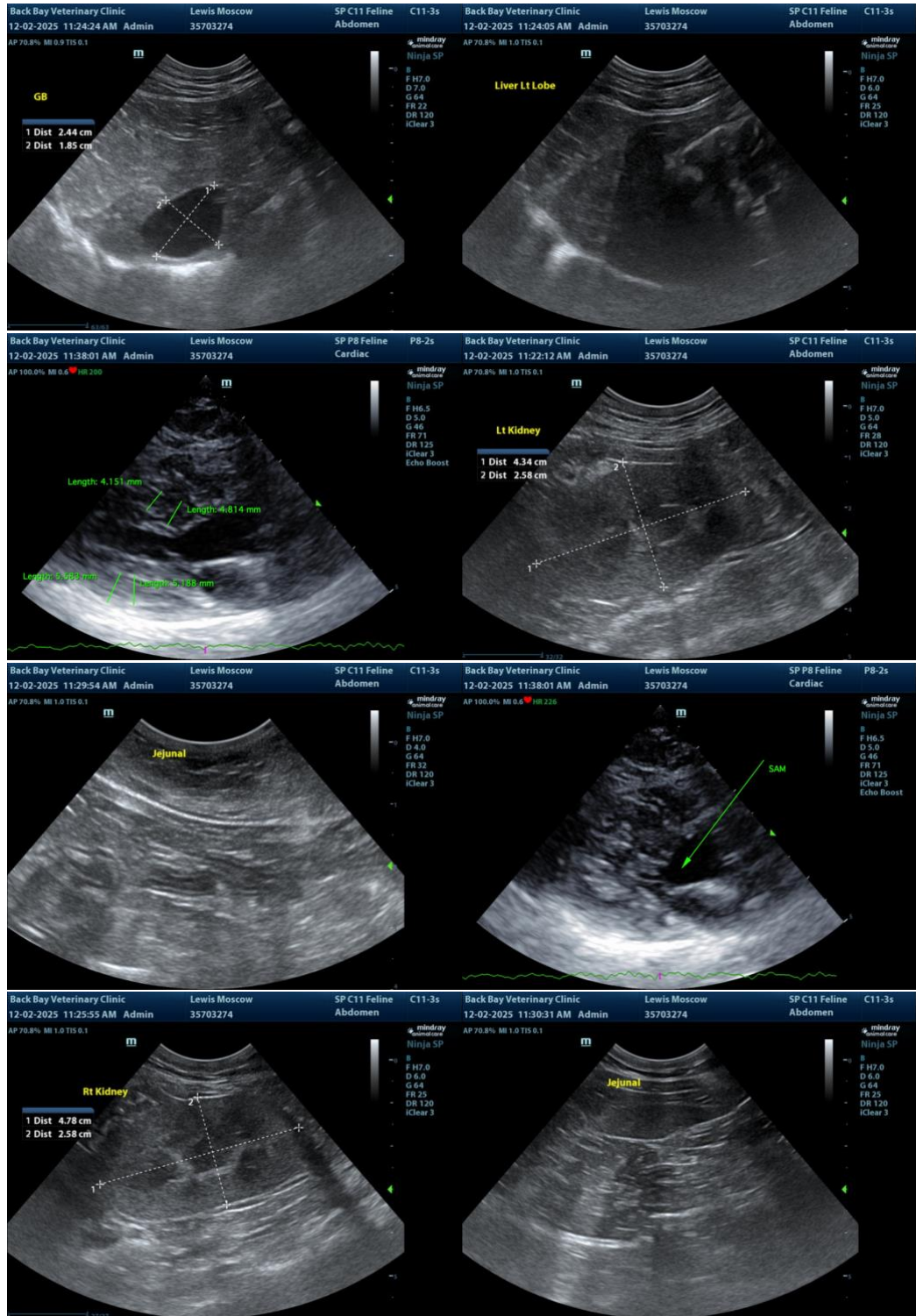
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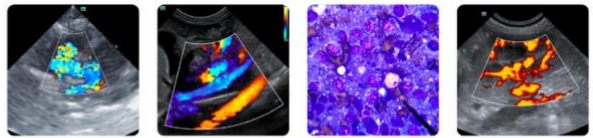
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

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