



PATIENT

Revan Sych

SPECIES

Feline

BREED

DSH

SEX

Castrated Male

AGE

10

WEIGHT

7

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Christensen

HOSPITAL NAME

Tranquility Veterinary
Clinic

REFERRING VET

Dr. Antonelli

INVOICE

10894

DATE

12/8/2025

PRESENTING CLINICAL SIGNS

Weight loss and vomiting reported by owner.

Abnormal PE/Chem/CBC/UA Results: ALY= 22, BNP= 154, Grade 2/6 systolic heart murmur. TP= 5.8. Abdominal mass aspirated.

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	3.18 kg	110	0.45	1.38	0.48	54%	88%
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	1.06	1.15	1.18	1.1	0.4	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. The anterior and posterior mitral and tricuspid valve leaflets presented normal linear structure, extension in systole, and union in diastole without regurgitation. There is no evidence of systolic anterior mitral valve motion documented. The left ventricular outflow tract demonstrated normal laminar flow and subjective structural valvular integrity. The visible aorta is unremarkable. Pulmonary outflow tract assessment revealed normal valve structure, laminar flow, and appropriate diameter and distensibility. There is no evidence of 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 moderately distended with anechoic urine, and a moderate amount of suspended echogenic swirling debris. The 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.



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The kidneys are normal in size. The cortices are hyperechoic with a loss of corticomedullary definition. The cortex to medulla ratio is appropriate with no significant pyelectasis or pelvic dilation. The capsules are mildly irregular bilaterally. The left kidney measures 4.28 cm, and the right kidney is 3.88 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. Left adrenal measures 0.4 cm, and the right adrenal measures 0.36 cm.

Spleen

The spleen is subjectively, mildly enlarged with a hyperechoic parenchyma. The capsule is smooth without significant irregularity and there's no evidence of congestion, spontaneous echo contrast, or thrombosis. The spleen measures 0.76 cm at the hilus.

Liver

The liver is subjectively enlarged and mildly hyperechoic with a normal contour. The vasculature is normal with no evidence of congestion. The gallbladder contains a mild amount of echogenic debris with no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach is non-distended with normal wall thickness and maintenance of normal wall layering. The pylorus is patent with no evidence of pyloric outflow obstruction. The small intestinal wall is diffusely thickened with a prominent muscularis layer that distorts the normal 1:3 muscularis to mucosal ratio. There's minimal small intestinal dilation with no shadowing foreign material or evidence for gastrointestinal obstruction. The colon contains normal shadowing feces.

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

The mesentery is diffusely hyperechoic, and there is a mild volume of anechoic free fluid. There are multiple severely enlarged, hypoechoic mass structures that are suspected to be lymphatic in origin. These have distorted length to width ratios and hypoechoic parenchyma with no normal discernable architecture.

ULTRASONOGRAPHIC FINDINGS

- These findings are consistent with an essentially normal echocardiogram. The presence of an elevated BNP is often associated with underlying heart disease, but can be seen in animals without heart disease. In addition, changes on chest X-rays can occur without significant underlying disease. The absence of any abnormalities on the echo excludes any meaningful cardiac disease at this time. Any murmur will be considered functional in origin at this time.



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- 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.
- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. There is no evidence of pelvic dilation present.
- The hyperechoic liver and mildly enlarged spleen are concerning for potential infiltrative metastatic disease. Given the other changes in the abdomen, round cell neoplasia would be considered most likely.
- The thickened small intestinal wall with prominent muscularis layer likely represents infiltrative disease. Infiltrative round cell neoplasia is a primary concern given the other changes in the abdomen, however, chronic enteropathy such as inflammatory bowel disease can't be definitively excluded.
- The mesenteric and jejunal lymph nodes presented abnormal length to width ratio with distorted, swollen, irregular contour. Parenchymal detail was indiscernible. This is most consistent with lymphoproliferative disease such as lymphoma/round cell neoplasia, metastatic disease, or an aggressive inflammatory process. FNA, cytology and culture are warranted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given these findings, no cardiac therapy is recommended. There are no cardiac contraindications to corticosteroids or fluid therapy as indicated for further treatment. No specific recheck echocardiogram is recommended.

Anesthesia considerations:

No special cardiac considerations are necessary

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 for potential urinary tract infection.

In addition to the pending cytology of the mid-abdominal mass, which is suspected to be lymphatic in origin, also consider fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.



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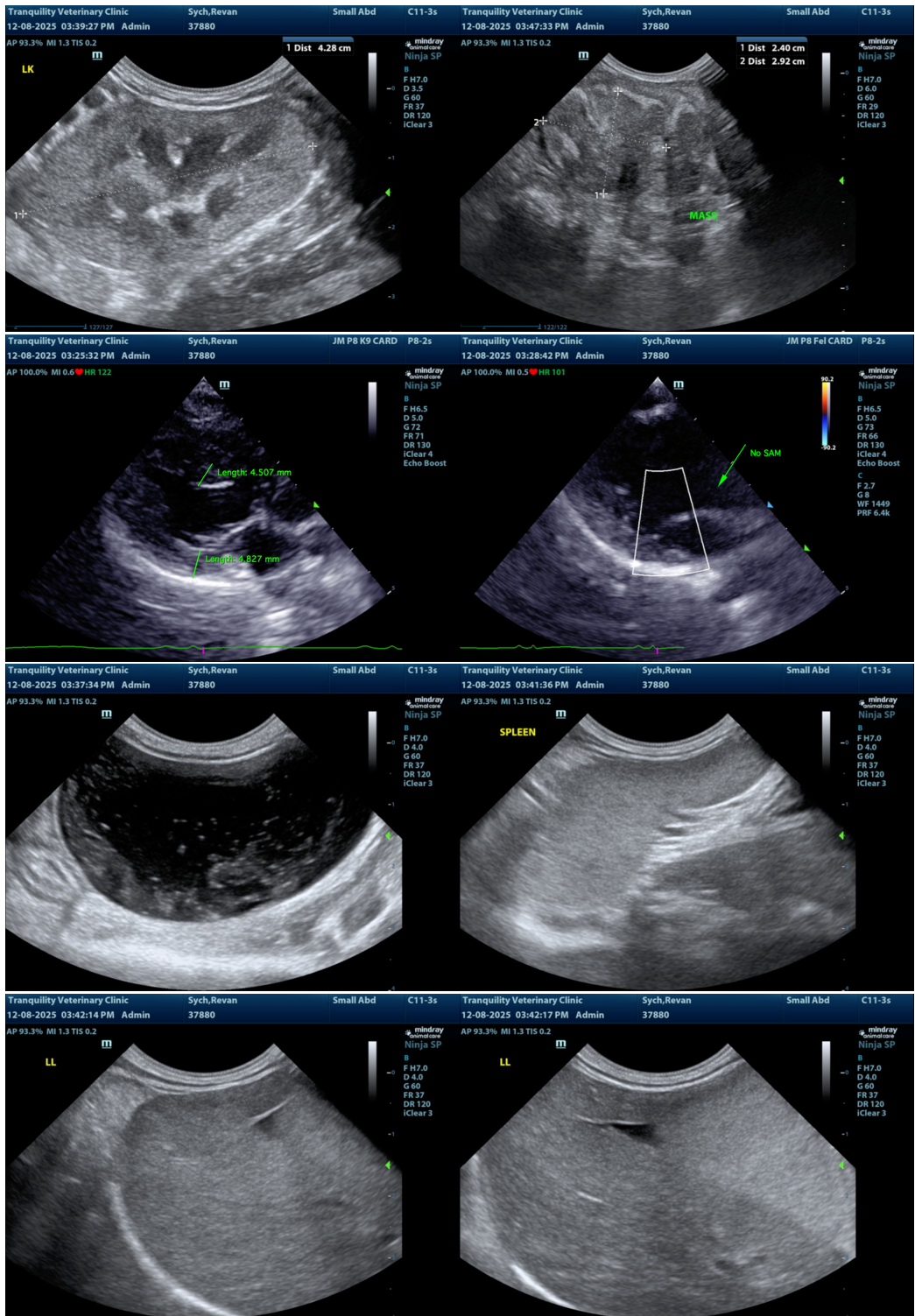
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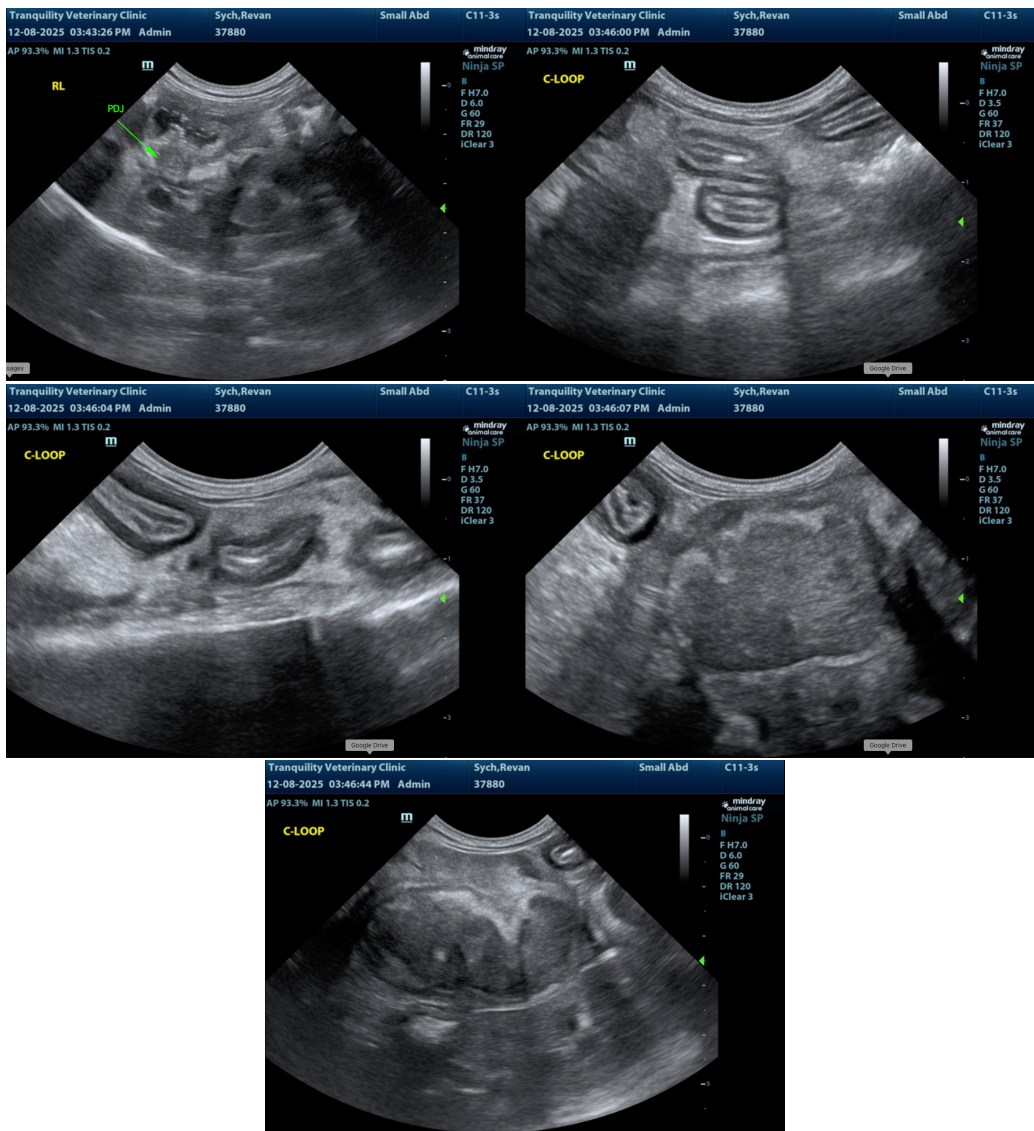
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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