



PATIENT

Cookie Reilly

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

11 years

WEIGHT

13 lbs

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Christensen

HOSPITAL NAME

Tranquility VC

REFERRING VET

Dr. House

INVOICE

75385

DATE

5/12/26

PRESENTING CLINICAL SIGNS

History: Reason for Scan: _ADR, supraventricular tachycardia on ECG, HR 331; and cardiomegaly on chest radiographs_

Current medications: _Diltiazem 15mg PO SID (not started yet but ordered)

Abnormal PE/Chem/CBC/UA Results: CBC/Chem/T4 wnl

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The left atrium is severely enlarged. There are no distinct left atrial thrombi/clots or spontaneous echo contrast appreciated. The left ventricle is upper limits of normal in dimension as well as wall thickness, and no evidence of restriction. Left ventricular systolic function is reduced, with decreased contractility. 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 with mild regurgitation bilaterally. There is no evidence of systolic anterior mitral 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 semilunar valve insufficiency or pulmonary hypertension documented. There is no visible pericardial, pleural, or free peritoneal fluid noted.

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	5.91 kg	NM	0.47	1.44	0.35	21	46
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	2.52	2.58	2.91	0.5	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							



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ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The kidneys are normal in size and structure. There is a prominent, hyperechoic, corticomedullary band noted and a mild degree of pyelectasia that is most prominent on the left kidney rather than the right. The cortices are mildly irregular bilaterally. The cortex to medulla ratio is appropriate and there is no significant mineralization noted. The left kidney measured 4.48 cm and the right kidney measured 4.61 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 measured 0.5 cm and the right adrenal gland measured 0.54 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 measured 0.57 cm at the hilus.

Liver

The liver is normal in size, contour, and structure. Appropriate echogenicity that is hypoechoic to the spleen and naturally coarse is noted. The hepatic vasculature and caudal vena cava appear prominent and mildly dilated. The gallbladder has thin walls with contains 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 are free of stasis and adequate peristaltic activity, with no significant dilation noted. There is overall normal wall thickness with multi-focal regions that have a slightly prominent muscularis layer that distorts the normal 1:3 muscularis to mucosa ratio. The pylorus, pyloric-duodenal junction and ileocecolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material identified.

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Pancreas

The pancreas is slightly prominent with a mildly hypoechoic parenchyma and slightly irregular margins. However, there was no evidence of regional hyperechoic mesentery or omental fat.

Free Abdomen

There is no evidence of abdominal lymphadenopathy. No free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- These findings identify severe left atrial dilation in the absence of any left ventricular hypertrophy or outflow tract obstruction. In the absence of any intrinsic disease (hyperthyroidism or severe anemia) or iatrogenic factors (steroid or fluid administration), these findings would be most consistent with the myocardial form of restrictive cardiomyopathy (RCM). Due to the reported supraventricular tachyarrhythmia, a tachycardia-induced cardiomyopathy must also be considered.
- 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 a hyperechoic renal corticomedullary band present, with a uniform corticomedullary ratio. This is most consistent with a medullary rim sign. There are mild degenerative renal changes noted, with a uniform capsular contour. This is an idiopathic finding, yet at times can be related to FIP or lymphoma in cats.
- The dilated caudal vena cava and hepatic vasculature likely representative of the severe underlying cardiac disease noted.
- The focal areas of prominent muscularis layer within the small intestine may represent infiltrative disease such as inflammatory bowel disease or other chronic enteropathy.
- Infiltrative neoplastic process such as round cell neoplasia cannot be definitively excluded.
- The changes to the pancreas are likely chronic and represent chronic remodeling possibly secondary to chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Therapy with Vetmedin (0.25-0.35mg/kg BID) is reasonable at this time. Enalapril/benazepril (0.5mg/kg q24) can also be considered, pending BP and kidney function. If an ACEi is started, a recheck chemistry panel and blood pressure should be performed 1-2 weeks after starting therapy. Additionally, Plavix/clopidogrel should be initiated as an anti-thrombotic (1/4 of a 75 mg tablet, or 18.75 mg PO q 24 h). Due to the bitter taste of this medication, it may be best to place it in an empty gelatin capsule or use products such as a Pill Pocket. Should fluid administration or corticosteroids be required, concurrent administration of furosemide (3.125mg q24) is reasonable. Barring any setbacks or complications, a repeat echocardiogram, thoracic radiographs, blood pressure, and chemistry panel are indicated in another 3-6 months.

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

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



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required for a definitive diagnosis. Consider an FPLI to evaluate the pancreas for active pancreatitis or inflammation.

Anesthesia considerations:

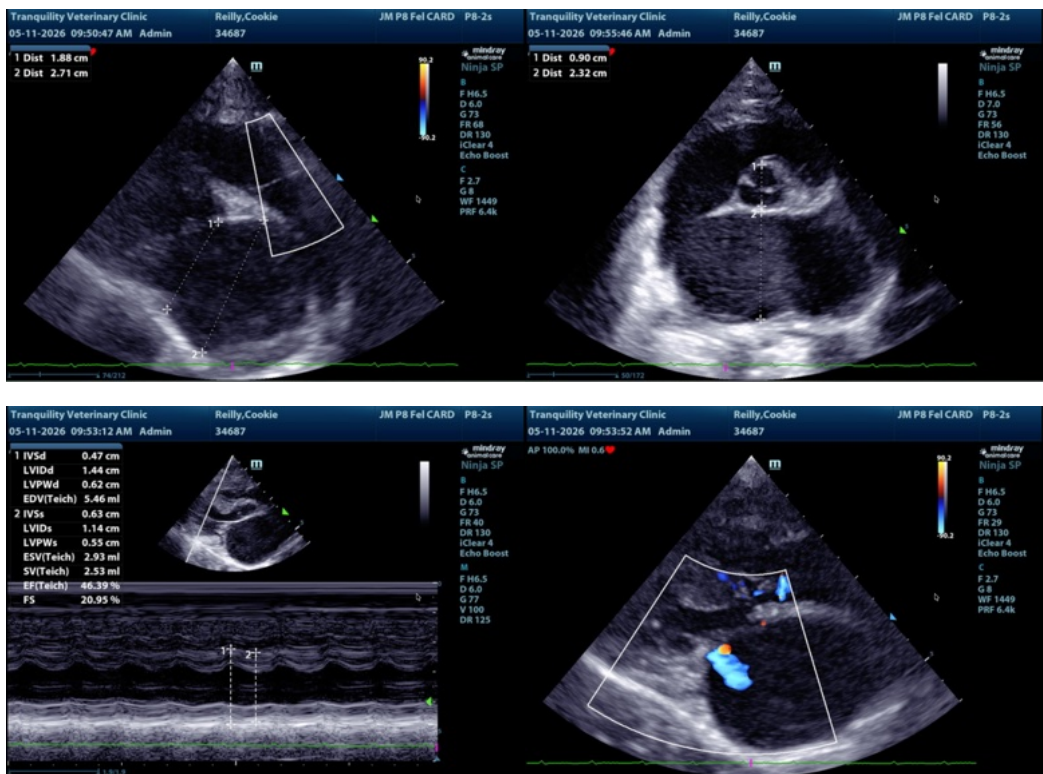
While there is no CHF present, there is likely an increased anesthetic risk which must be considered prior to any anesthetic procedure. If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. If an ACE inhibitor (enalapril, benazepril) or spironolactone is being given, it should not be administered on the morning of general anesthesia. Other cardiac medications should be administered per the normal dosing schedule. Fluid therapy during anesthesia should be considered at a reduced rate (e.g., 2-5 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, or diazepam/etomidate 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:

Avoid strenuous activity.





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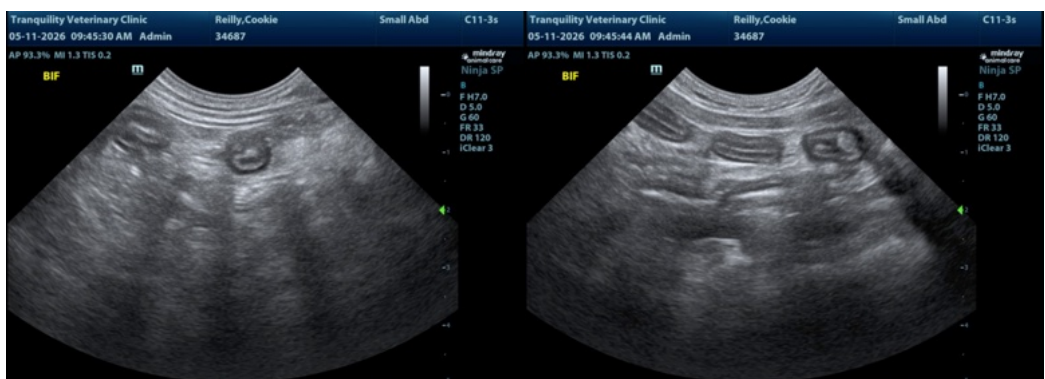
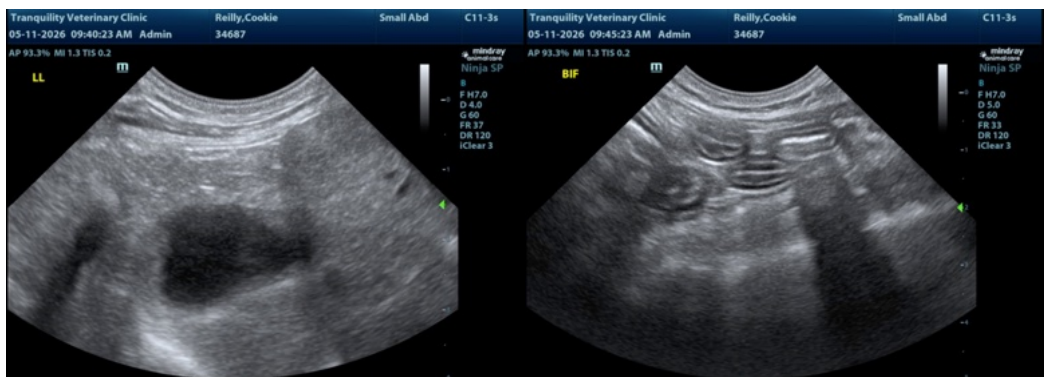
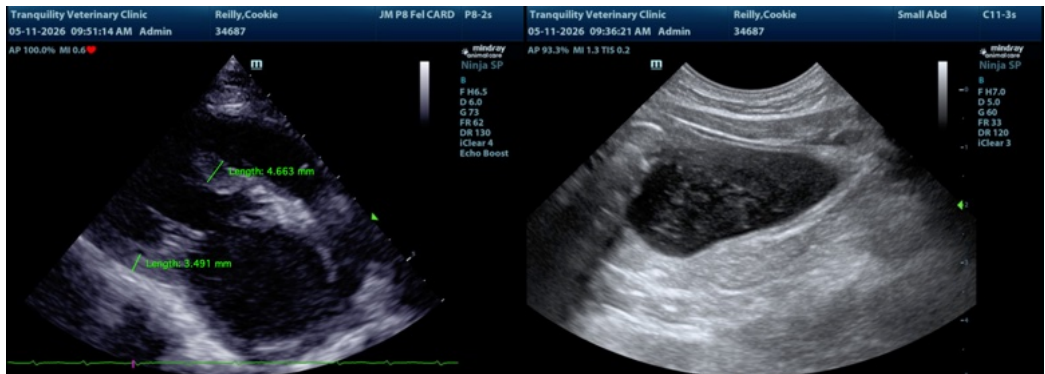
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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