



PATIENT

Coco Fairclough

SPECIES

Feline

BREED

Tattoo Cross

SEX

Spayed female

AGE

22 years

WEIGHT

2.09 kg

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

East Plains AH

REFERRING VET

Dr. Cumming

INVOICE

68786

DATE

11/18/25

PRESENTING CLINICAL SIGNS

History: Findings: - known chronic kidney disease, new systemic hypertension and suspected IBD chronically - Progressive weight loss and current anorexia, vomiting and diarrhea - chronic heart murmur - Grade 3/6 Current Medications amlodipine 0.625mg SID, mirtazapine 3.75mg q 72 hours, cerenia SID, Telmisarten 2mg SID

Abnormal PE/Chem/CBC/UA Results: See attached BW Primary Question to Be Answered in This Exam Reason for new ALT elevation and hypercalcemia + progressive weight loss? Also what is the cause of the heart murmur? Is heart disease cause of the poor appetite and weight loss?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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. 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.

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	2.09	NM	0.48	1.09	0.51	46	81
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	1.28	1.25	1.2		0.8	1.1	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, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure. The cortices are hyperechoic with a loss of corticomedullary definition. The cortex to medulla ratio is appropriate with no significant pyelectasia or pelvic dilation. There is no mineralization or urolithiasis. The ureters taper normally with no sign of obstruction. The capsules are minimally irregular bilaterally. The left kidney measured 2.72 cm and the right kidney measured 2.89 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 0.22 cm and the right adrenal gland measured 0.26 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 0.81 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 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 is non-distended with a patent pyloroduodenal junction and normal wall thickness and layering. The proximal portion of the duodenum has a thickened wall with a prominent and hypoechoic muscularis layer. The gastrointestinal tract is minimally distended with no shadowing foreign material or evidence for a mechanical obstruction. The remainder of the small intestinal wall is within normal



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limits for thickness. There are several focal regions with a very subtly prominent muscularis layer that slightly distorts the normal 1:3 muscularis to mucosa ratio. The colon contains normal shadowing feces.

Pancreas

The pancreas is hypochoic with regional, hyperechoic mesentery or omental fat. The pancreatic duct is minimally prominent with an irregular capsular contour. There is no significant lymphadenopathy or free fluid noted.

ULTRASONOGRAPHIC FINDINGS

These findings are consistent with an essentially normal echocardiogram. Any murmur auscultated will be considered functional in origin (dynamic right ventricular outflow tract).

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 thickened duodenal wall with prominent muscularis is suggestive for an infiltrative disease such as inflammatory bowel disease or other chronic enteropathy. Additionally infiltrative neoplastic disease such as round cell neoplasia cannot be definitively excluded.

The prominent, hypochoic pancreas with an irregular contour and mixed ill-defined hyper and hypochoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

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:

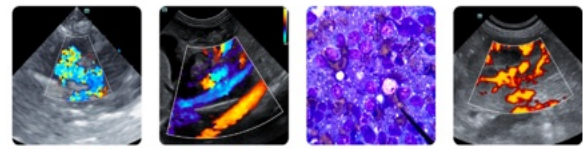
No special considerations are necessary. Any high-quality food from Hills, Royal Canin, Science Diet, Eukanuba, Iams, or Purina is reasonable.

Activity:

No special considerations are necessary.

Abdominal Recommendations:

The normal appearance of the liver does not exclude an early cholangiohepatitis. Fine needle aspirates of the 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



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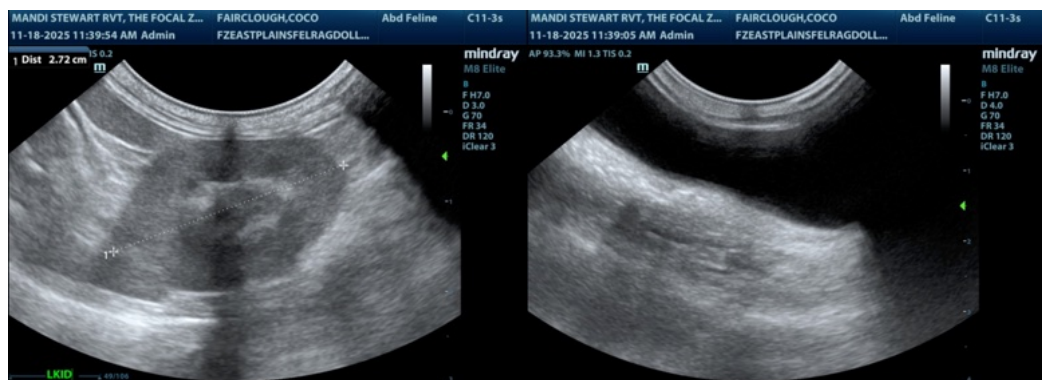
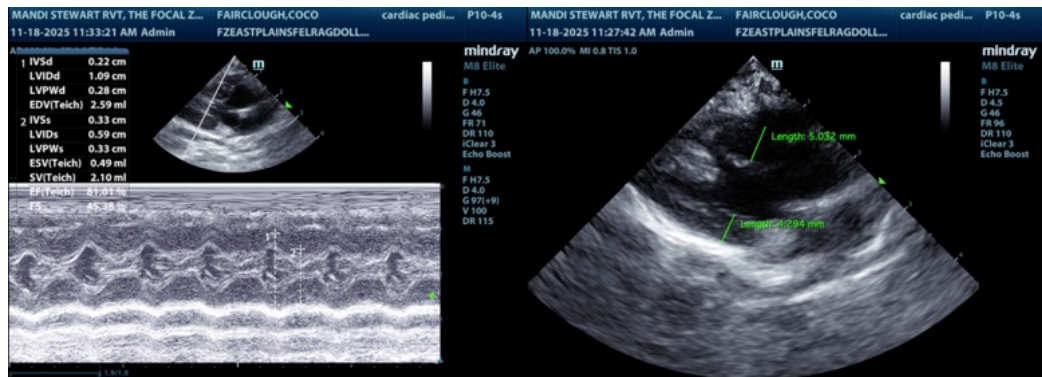
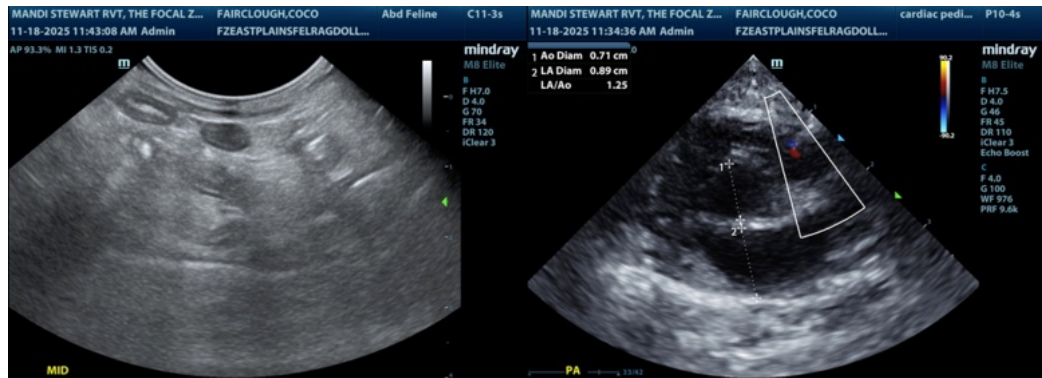
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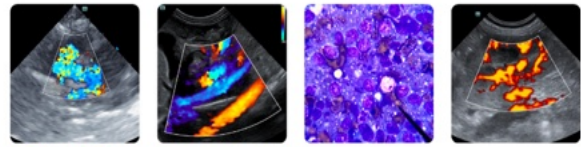
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exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

FPLI is indicated to further evaluate the pancreas for potential pancreatic inflammation or pancreatitis. 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.

Given the elevation in calcium consider an ionized calcium.





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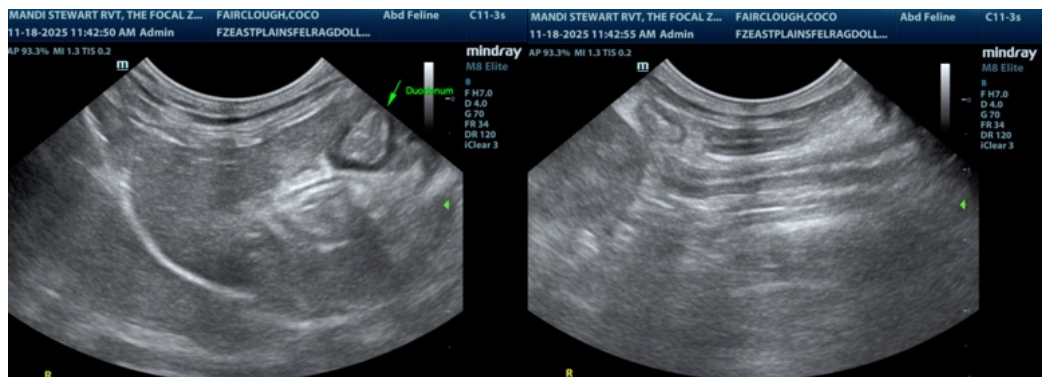
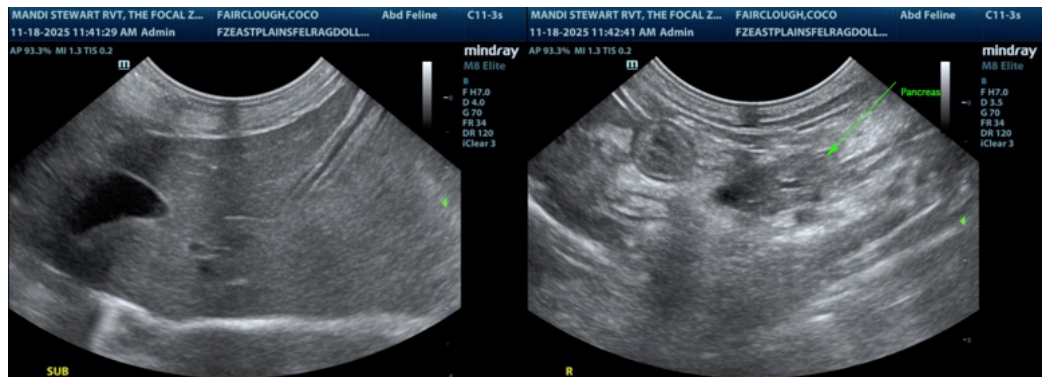
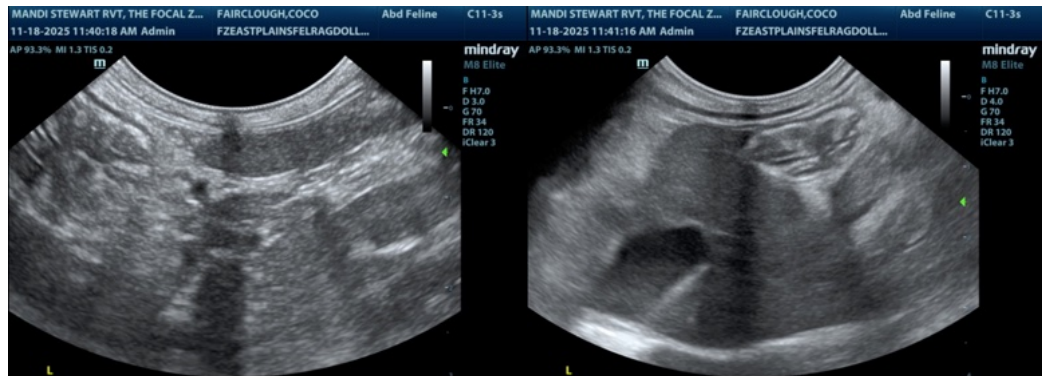
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com