

PATIENT

Keenan Dr. Baker

SPECIES

Feline

BREED

Siamese

SEX

MN

AGE

5 years

WEIGHT

7.5 lbs

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Dr. Baker

REFERRING VET

Dr. Staci Baker

INVOICE

12040

DATE

5/29/2026

PRESENTING CLINICAL SIGNS

AUS revealed bilateral hyperechoic kidneys with infarcts. Ken is a five-year-old male castrated indoor cat. He lives with three other cats. He has had PUPD for the last three or four weeks when I was finally able to get the first blood work, I was shocked to see the renal damage and insufficiency this is the first time he has ever had any up. He also has severe stomatitis and halitosis, and that's been going on for about a year. Blood pressure 170-220.

Abnormal PE/Chem/CBC/UA Results: LABs attached ECG ATTACHED

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	3.41 kg	190	0.55	1.3	0.55	59	91
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	NM	1.55	1.36		1.2	1.0	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, with equivocal wall thickness, and no evidence of restriction. A hyperechoic false tendon is noted in the left ventricular lumen. Left ventricular systolic function is normal, with adequate contractility. The right atrium and ventricle are subjectively normal in dimension and systolic function. There is no evidence of systolic anterior motion of the mitral valve or other valve abnormalities with no mitral regurgitation. The tricuspid valve leaflets presented normal linear structure, extension in systole, and union in diastole with trace regurgitation. 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.

Cardiac

There is a six-lead ECG with a paper speed of 50mm/s, 10mm/mV available for review. The underlying rhythm is regular at an average rate of 190bpm. The rhythm appears to be sinus in origin with narrow QRS complexes. A leftward deviation in the mean electrical axis is documented. There is no atrial or



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ventricular ectopy and no conduction delay or block identified. This is most consistent with a normal sinus rhythm with a left axis deviation.

ULTRASONOGRAPHIC FINDINGS

- These findings are consistent with an essentially normal echocardiogram. The borderline/equivocal left ventricular wall measurements may represent an early manifestation of hypertrophic cardiomyopathy; however, may also represent a variation of normal for this patient. Additionally, a left axis deviation is noted. This could represent normal patient variation or indicate left heart enlargement. It is unlikely that any of the clinical signs are related to underlying heart disease at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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, as the need likely outweighs the risk. Owing to the presence of a equivocal wall thickness, a follow up echo is recommended in another 6-12 months to make sure no progression has occurred.

Anesthesia considerations:

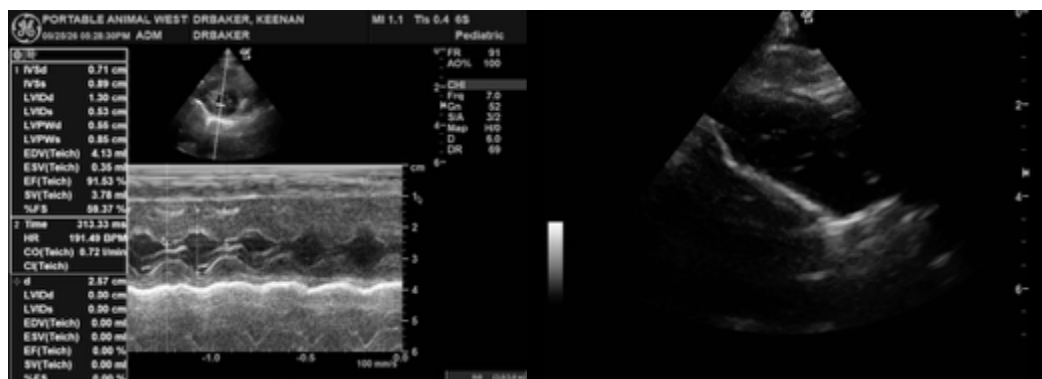
If anesthesia is necessary, then alpha-2 agonists, ketamine, high dose acepromazine, and Telazol should be avoided. Fluid therapy during anesthesia should be considered at a reduced rate (e.g., 5 ml/kg/hour) if possible (i.e., if not hypotensive). A shorter anesthetic duration will reduce the risk of 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.



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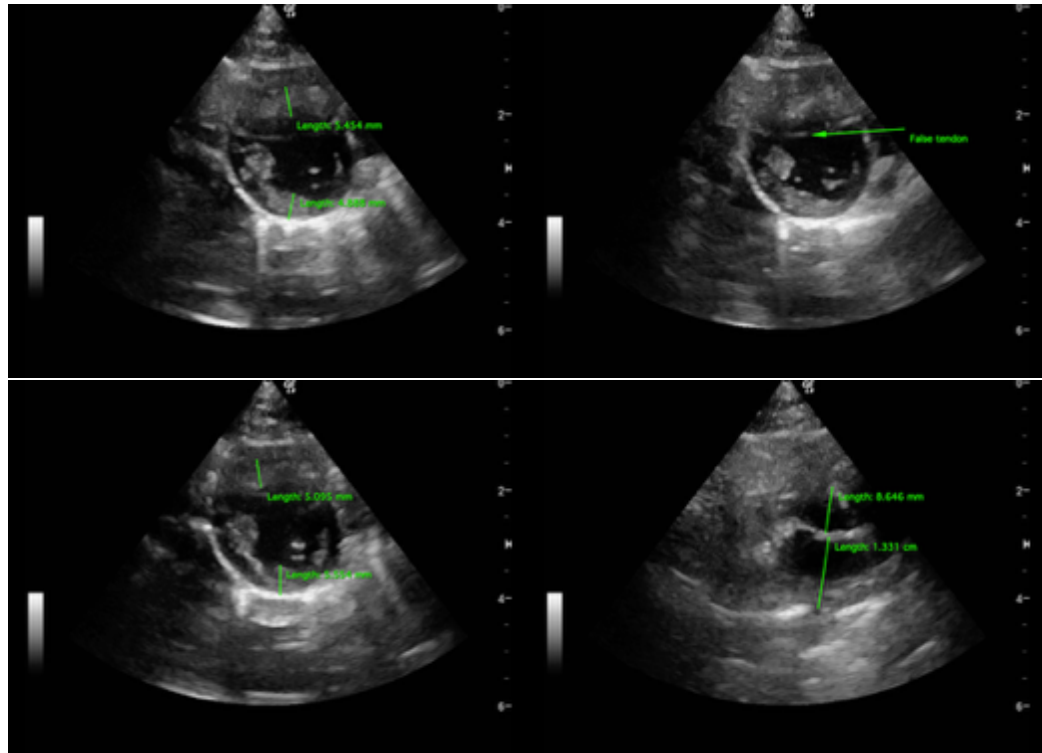
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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