



PATIENT

Rikki Shevchuk

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

9 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Mariusz
Chmielinski

HOSPITAL NAME

Apex Veterinary
Services

REFERRING VET

Alpine 24/7 ER Doctor

INVOICE

77732

DATE

5/19/26

PRESENTING CLINICAL SIGNS

History: Persistent pyrexia, lethargy, intermittent cough, and bilateral pleural effusion of unclear etiology.

Presented for approximately 3 days of anorexia and lethargy. Owner reports intermittent coughing over previous 2 weeks. Occasional vomiting historically; known plastic-chewing behavior. No diarrhea. Indoor-only cat.

Febrile to 40.2°C Tachycardic/tachypneic QAR but stable respiratory effort Mild periodontal disease otherwise PE largely unremarkable. Thoracic Radiographs Mild cranial pleural effusion suspected. Thoracic FAST / POCUS Bilateral pleural effusion confirmed Initial concern for mild pericardial effusion; not confirmed on repeat scans No obvious B-lines appreciated. Repeat TFAST Findings Right: Rt Md pleural fluid approximately 2 cm Rt Cr pleural fluid approximately 1 cm. Left: Lt Md pleural fluid approximately 0.58 cm Lt Cr pleural fluid approximately 1.77 cm. Laboratory Findings Neutrophilic leukocytosis Monocytosis Hyperglobulinemia/hyperproteinemia Hyponatremia Hyperglycemia Low BUN UA: USG 1.045 with mild glucosuria/proteinuria; possible cocci noted.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 separate LA measurements. The cranial and caudal **mitral** valve leaflets presented normal linear structure and kinetics. The **left ventricle** measured at the upper limits of normal. there was no evidence of volume overload or pressure overload. **Contractility** of the ventricular walls was adequate and in normal range for this patient evidenced by the fractional shortening measurement and subjective evaluation of the different regions and angles of the myocardium. The **left ventricular outflow** tract demonstrated normal laminar flow and subjective structural integrity. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** insufficiency was noted at 3 m/sec. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx. 1:1 pa/ao ratio). **Pleural effusion** was noted with enhanced, surrounding pleural fat. The cranial **mediastinal** lymph node was mildly enlarged, yet reactive and measured 1.1 x 0.57 cm. Areas of lung consolidation was noted.

E Wave Velocity 0.66 m/sec

FELINE CARDIAC PARAMETERS	BODY WEIGHT	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	9 lbs	NM	0.59	1.32	0.7	58	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	1.35	1.48	1.5		1.1	0.56	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 FINDINGS

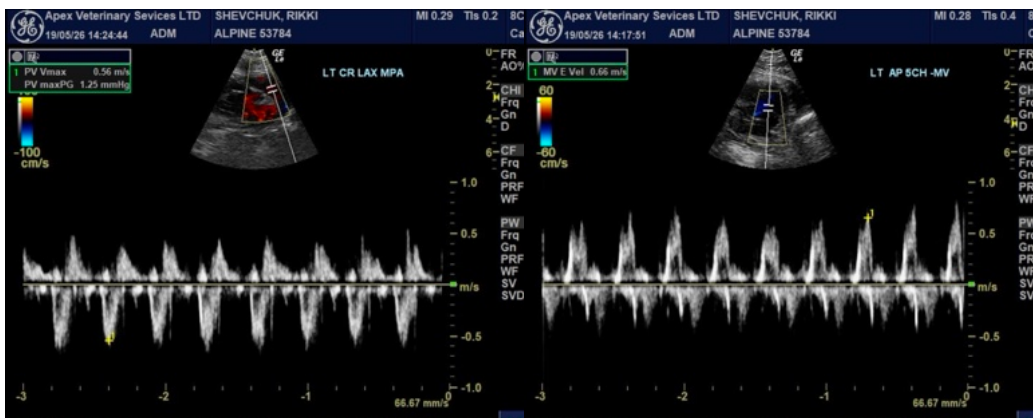
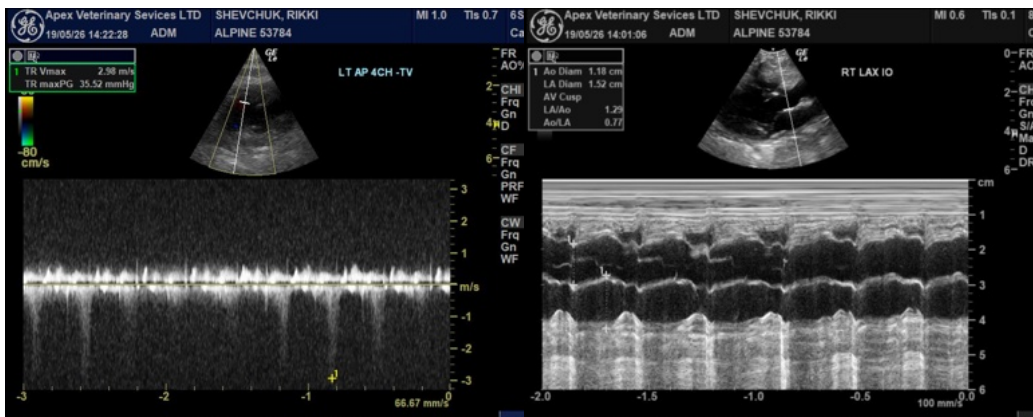
Normal echocardiogram with mild tricuspid insufficiency.

Non-cardiogenic pleural effusion with reactive mesenteric lymph node.

Areas of lung consolidation was noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chest CT is valid in this patient. There was no evidence of primary cardiac disease responsible for the clinical signs. The tricuspid insufficiency may be owing to pulmonary hypertension owing to thoracic disease. Pneumonia/pneumonitis or underlying neoplasia is possible. If accessible ultrasound-guided FNA of the consolidated lung as well as pleurocentesis is recommended. Abdominal sonogram is recommended to assess for primary disease that may be influencing the chest. Tricuspid insufficiency is likely secondary to increased pulmonary pressures. Primary respiratory protocol is warranted based on radiographic and sonographic findings. Treatment for pleuritis/pneumonia is warranted. However, underlying neoplastic process is entirely possible.





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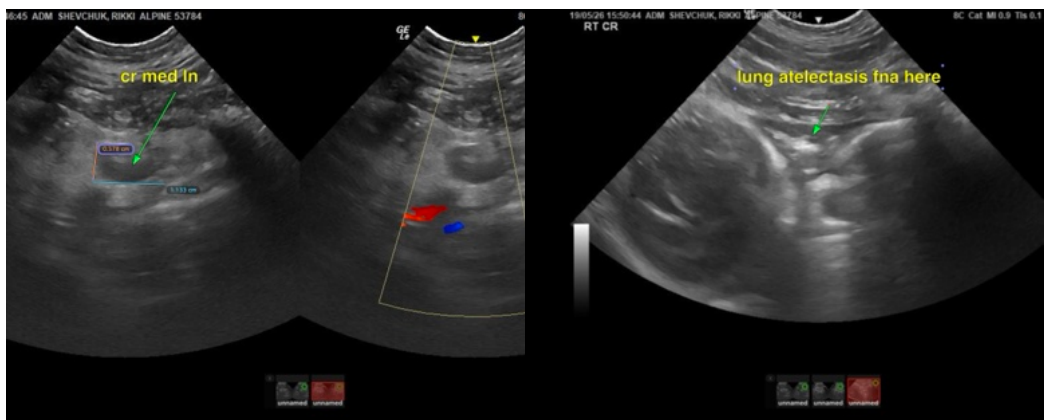
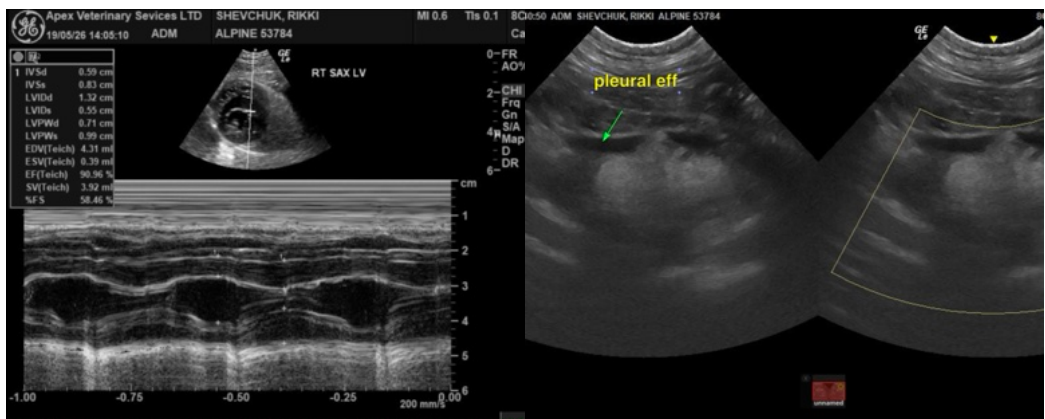
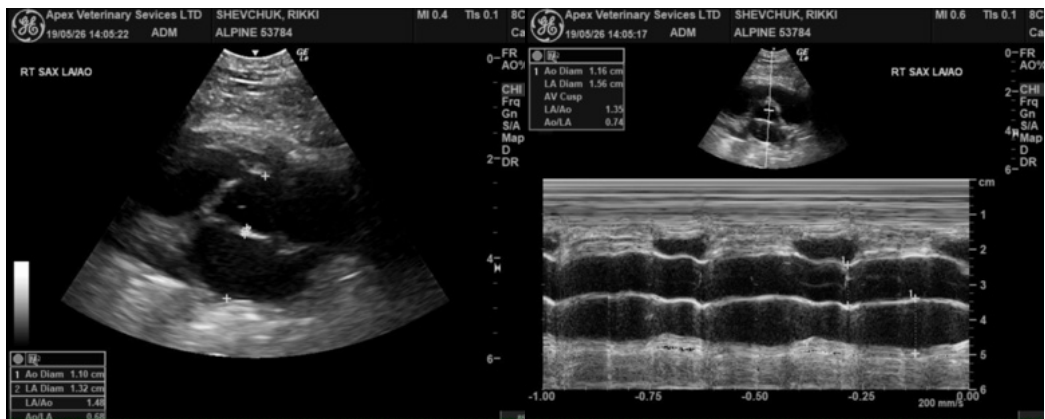
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

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