

PATIENT

Fiona Fowler

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years

WEIGHT

4.28 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

IMAGING PERFORMED BY

Dr. Cassie Jackson

HOSPITAL NAME

Huntsville Animal
Hospital

REFERRING VET

Dr. Cassie Jackson

INVOICE

13387

DATE

01/23/26

PRESENTING CLINICAL SIGNS

- Sedated with gabapentin, Alfaxalone and butorphanol
- Grade 3/6 systolic murmur loudest at sternum, murmur has been present since 4 years of age
- No concerns at home

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	4.28	120	0.49	1.3	0.44	50	85
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	1.4		--	2.0	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 echocardiogram in this patient demonstrated normal **left atrial** dimension based on 2 separate LA measurements. The cranial and caudal **mitral** valve leaflets presented normal linear structure and kinetics. No overt MR on doppler. The **left ventricle** presented normal thicknesses with linear contour and was not dilated nor restricted. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. **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 subjective normal structural integrity. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated adequate linear morphology and kinetics. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** tract assessment revealed overtly normal valve structure, laminar out flow, and diameter (approx.1:1 pa/ao ratio). Borderline to mild increased measured RV outflow velocity with minor pulmonic valve insufficiency on doppler. No visible **pericardial** or free pleura fluid was noted or extra cardiac pathology in the visible planes. The cranial **mediastinum** and **pericardial** regions were free of masses in the visible window.

ULTRASONOGRAPHIC FINDINGS

- Normal cardiac structure/function.



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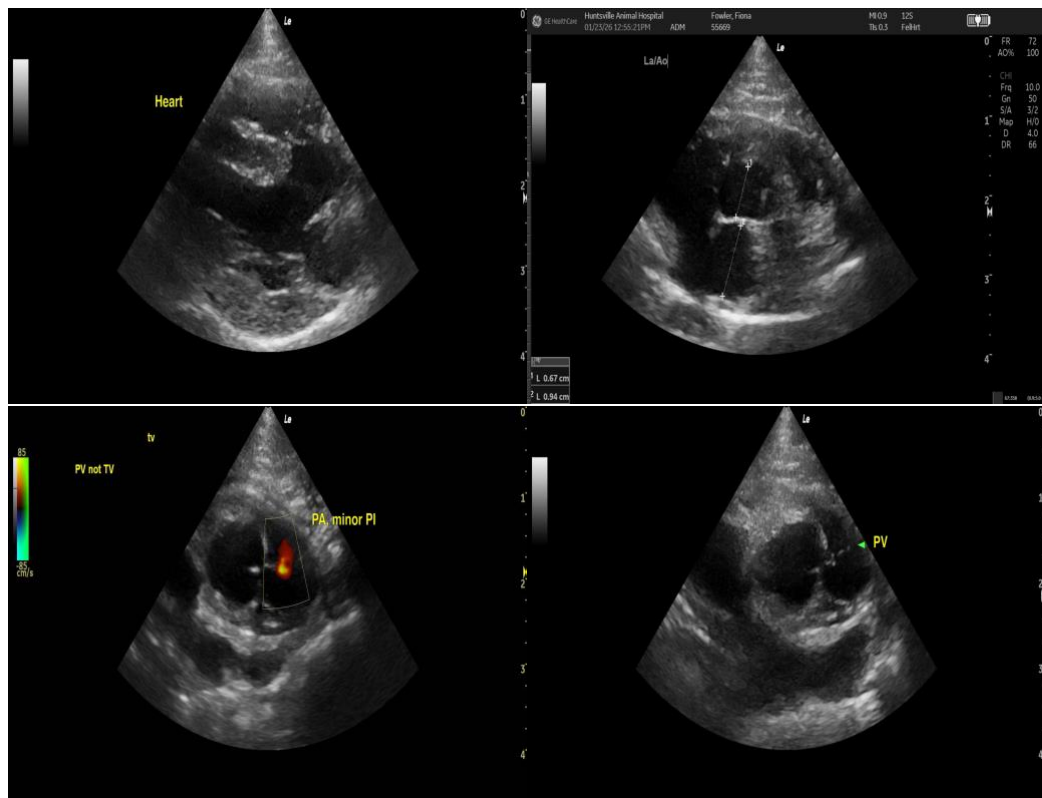
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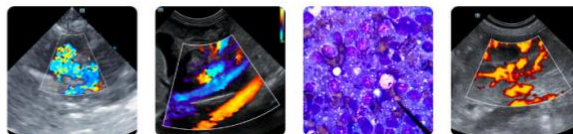
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- Borderline to mild increased measured RV outflow velocity with minor pulmonic insufficiency, overtly normal pulmonic valve.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The only cause of the murmur noted in the study is the borderline to mild increased measured RV outflow velocity, which without overt evidence of pulmonic stenosis, suggests potential dynamic right ventricle outflow tract obstruction, which is essentially classified as a flow murmur. An additional small non-visualized flow abnormality is not definitively excluded. Regardless of classification, the hemodynamic effects of the murmur appear low without evidence of left or right heart chamber enlargement. No indication for cardiac medication. Conservative monitoring of the murmur going forward is recommended with recheck echoe suggested in 6 to 12 months, sooner if increase in murmur intensity or if clinical signs arise. Anesthetic risk is low. Suggested anesthetic protocol may include opioid or Benzodiazepine pre-med, induction with Propofol or Alfaxalone, and appropriate gas anesthesia with avoidance of alpha 2 agonists.





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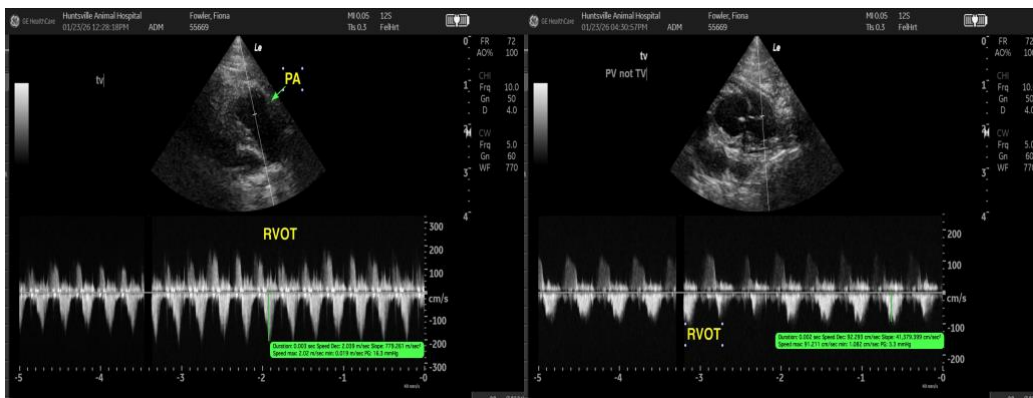
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com