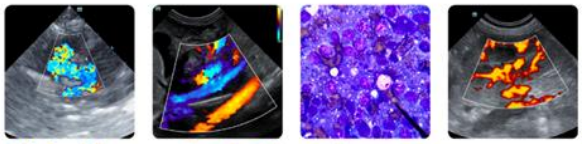

PATIENT

Tigger Schaub

SPECIES

Feline

BREED

Bengal

SEX

MN

AGE

6

WEIGHT

9.1

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

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REFERRING VET

Dr Maniar

INVOICE
23430

DATE
01/05/2026

PRESENTING CLINICAL SIGNS

re check prev 12/2 12/9 V/D E/D ok , hiding Not getting meds consistantly getting meds owners can't always give. Current meds Clopidrogel Pimobendan

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND 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	--	172	0.67	1.5	0.71	40	75
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	--	2.2	2.2		--	0.9	NM
Sisson D et al. JVIM 1991; 5: 232, Jacobs et al. Am J Vet Res 1985; 46:1705							

Cardiac Presentation

Left ventricular wall is mild hypertrophied exhibiting similar IVS and free wall dimension with mild irregular myocardial contour. Mild hyperechoic endocardium, which may suggest fibrosis and ventricular remodeling. Mildly prominent remodeled papillary muscle.

Adequate LV contractility. Static to significantly increased LA dimension and sphericity with possible indistinct LA spontaneous contrast. No evidence of formed LA thrombus.

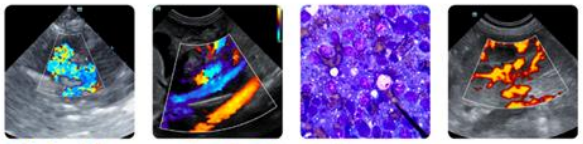
Non-thickened mitral valve with mild MR on Doppler. Concurrent mildly prominent right atrial dimension, static compared to the previous study. Normal current RV dimension. Normal measured RVOT velocity. No overt TR or other valvular regurgitation. No evidence of pericardial or pleural effusion.

No obvious cardiac tumors or arrhythmia.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. Mild loss of corticomedullary border demarcation with increased cortex echogenicity. Intermittent small to variably sized non-capsule deforming cysts were present. The left kidney measured 4.3 cm in length. The right kidney measured 4.1 cm in length.



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The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was normal to mildly subnormal in size, likely given presence of gastric ingesta with minor non-organized debris. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild non-shadowing ingesta sonographically suggestive of food echogenicity with no signs of ileus, obstruction or foreign material.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The duodenum wall measured 0.36 cm width. The jejunum wall measured 0.32 cm width. The ileocolic wall measured 0.39 cm width.

The visualized colon exhibited intact, mildly thickened wall layering with soft fecal matter. The proximal colon wall measured 0.30 cm in width.

Pancreas

The left pancreas was mildly prominent in size with mild capsule asymmetry and mild non-homogenous remodeled to hypoechoic parenchyma. Mildly prominent pancreatic duct present.

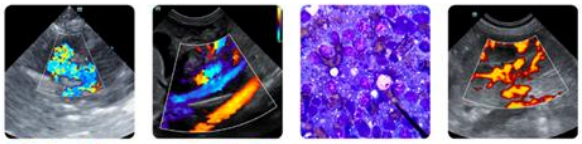
Free Abdomen

No evidence of peritoneal effusion was present.

Intermittent minor prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

ULTRASONOGRAPHIC FINDINGS

Primary



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- Thickened mildly remodeled LV.
- Static significant LA enlargement with possible indistinct spontaneous contrast
- Borderline RA enlargement.
- Mild eccentric MR
- Probable IBD enterocolic pattern
- Mild chronic pancreatitis
- Mild gallbladder debris.
- Static chronic renal changes exhibiting cysts

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Similar cardiac presentation compared to the previous study without overt significant progression, which suggests HCM or unclassified cardiomyopathy phenotype given primarily significant LA and possible RA enlargement. The degree of LA enlargement continues to indicate current and future risk of CHF, thrombotic event or malignant arrhythmia is elevated. Continued cardiac therapy with diuretic if evidence of left side of congestion is recommended. Elective anesthesia is not advised. Sonographic monitoring indicated for further prognosis. Recheck echo is recommended in 4-6 months, sooner if clinical signs arise.

Potential for emergent to low-grade intestinal round cell neoplasia, such as lymphoma, is thought less likely, yet cannot be definitively excluded. Triaditis is a potential in this patient. Correlation with full lab work is recommended. An internal medicine consult is recommended as steroid therapy is not recommended given cardiomyopathy.

For an additional charge, internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services

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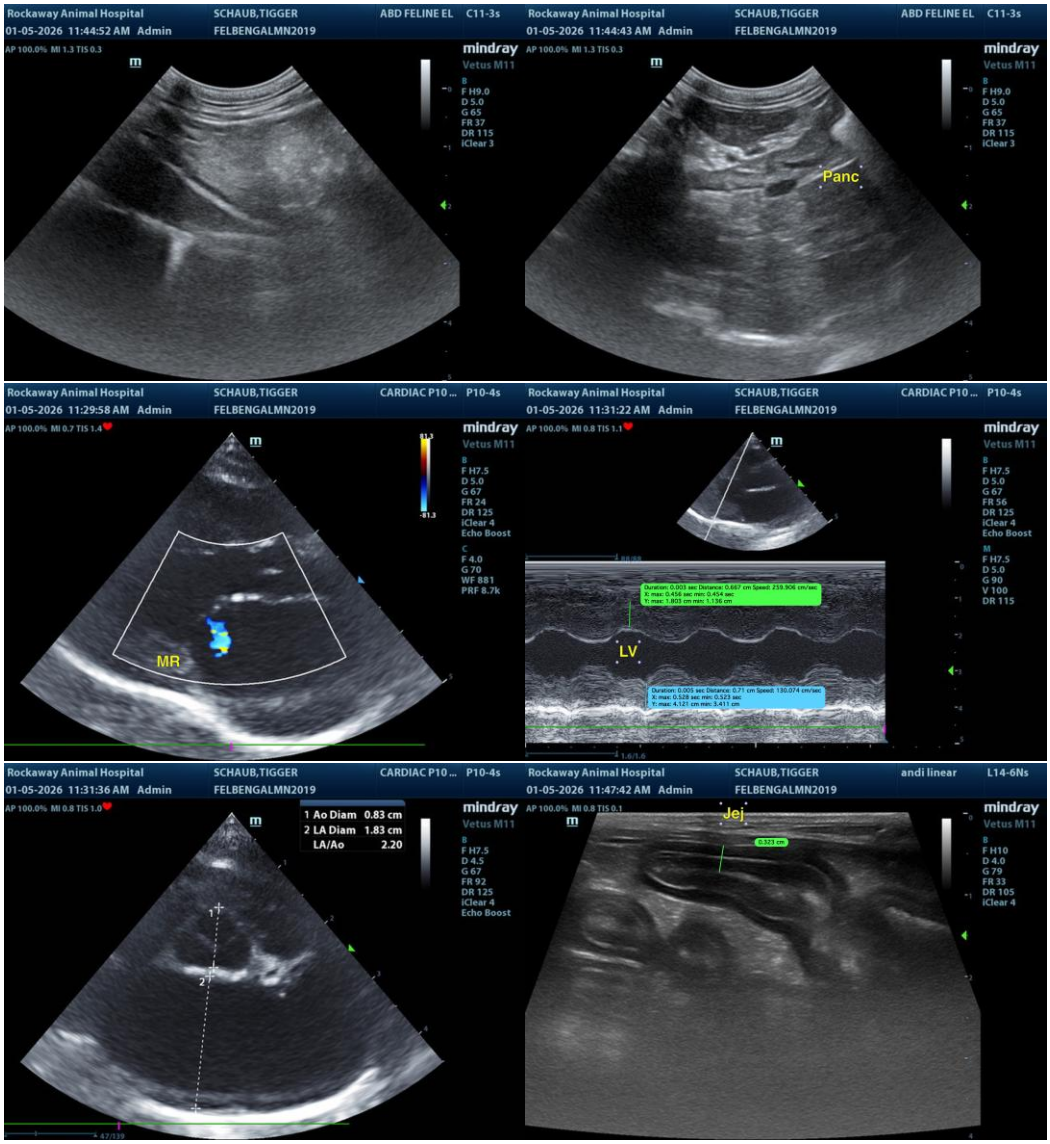

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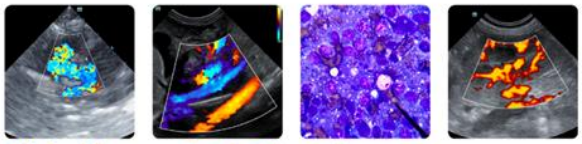

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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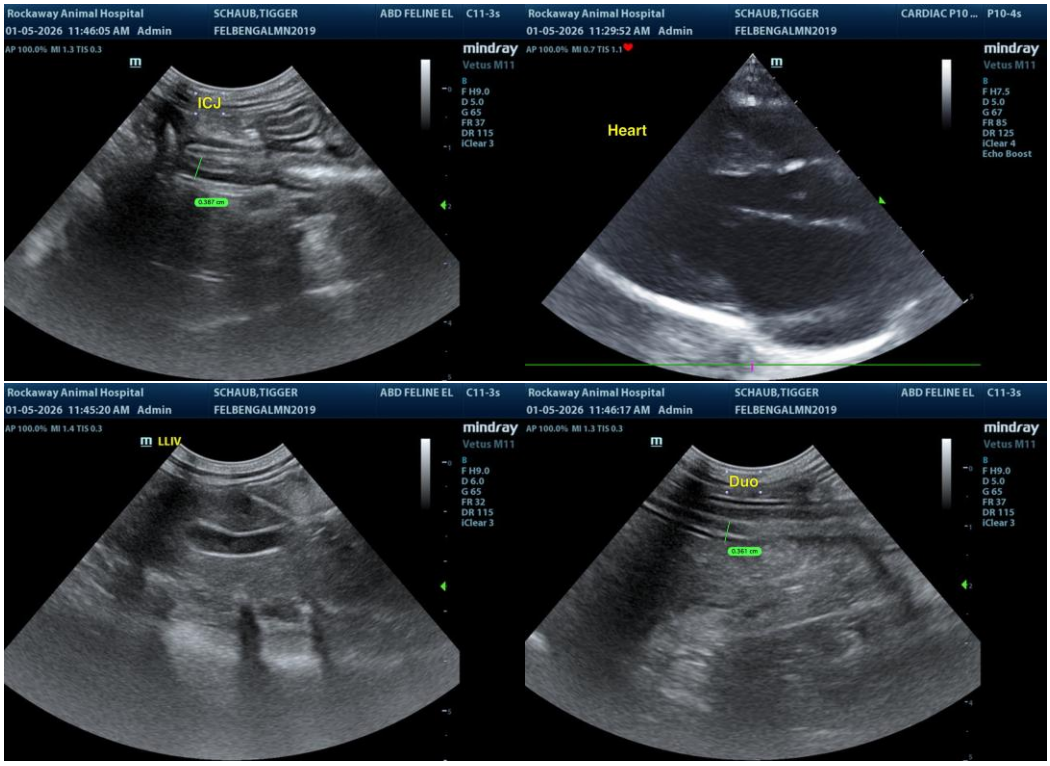

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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