



PATIENT

Gibby Pepe

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

10

WEIGHT

14.5

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway Animal
Hospital

REFERRING VET

Dr. Maniar

INVOICE

12775

DATE

11/6/25

PRESENTING CLINICAL SIGNS

History: re checking abd but added an echo because owner came to visit and noticed he was wobbly and was having trouble walking Abnormal Pro Bnp

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

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	--	NM	0.7	1.8	0.7	48	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	--	1.4	1.4		--	1.1	--
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** size and structure. Chamber volume and blood echogenicity were normal, no spontaneous contrast. The cranial and caudal **mitral** valve leaflets presented minor irregular age-related changes that are not clinically significant at this time with adequate extension in systole and union in diastole. No overt SAM or MR noted on doppler. The **left ventricle** presented mild to moderate increased free wall and septal thicknesses with mild a-linear contour. The **myocardium** presented some hyperechoic echogenicity with myocardial remodeling suggestive of age-related change or myocardial fibrosis. Concurrent mildly prominent remodeled hyperechoic papillary muscle. **Contractility** of the ventricular walls was adequate and in normal range for this breed and patient size. The **left ventricular outflow** tract demonstrated normal laminar flow with subjectively unremarkable structure. Subjective assessment of the **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted. **Tricuspid** valvular assessment demonstrated expected findings for this age patient. The **right ventricle** was of normal size (1/3 diameter of LV), echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx. 1:1 pa/ao ratio). Normal measured RVOT velocity was noted. No visible **pericardial** or free pleural fluid was noted. The **mediastinum** was free of masses in the visible window.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or



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sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild, indistinct loss of corticomedullary distinction and previously noted bilateral renomegaly were present. The renal medullary volume was subjectively reduced. The left kidney measured 5.2 cm in length. The right kidney measured 5.3 cm in length.

Adrenal Glands

No obvious pathology in the area of the left and right adrenal glands.

Spleen

The spleen was not definitively visualized owing to previous splenectomy.

Liver

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. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hypertrophic cardiomyopathy phenotype with LV myocardial remodeling and suspect fibrosis
- Normal LA/RA/RV
- Normal gastrointestinal tract/colon
- Static, chronic renal changes exhibiting mild renomegaly – consistent with patient variant without evidence of renal neoplastic criteria
- Static, mild gallbladder debris
- Non-visualized spleen – previous splenectomy



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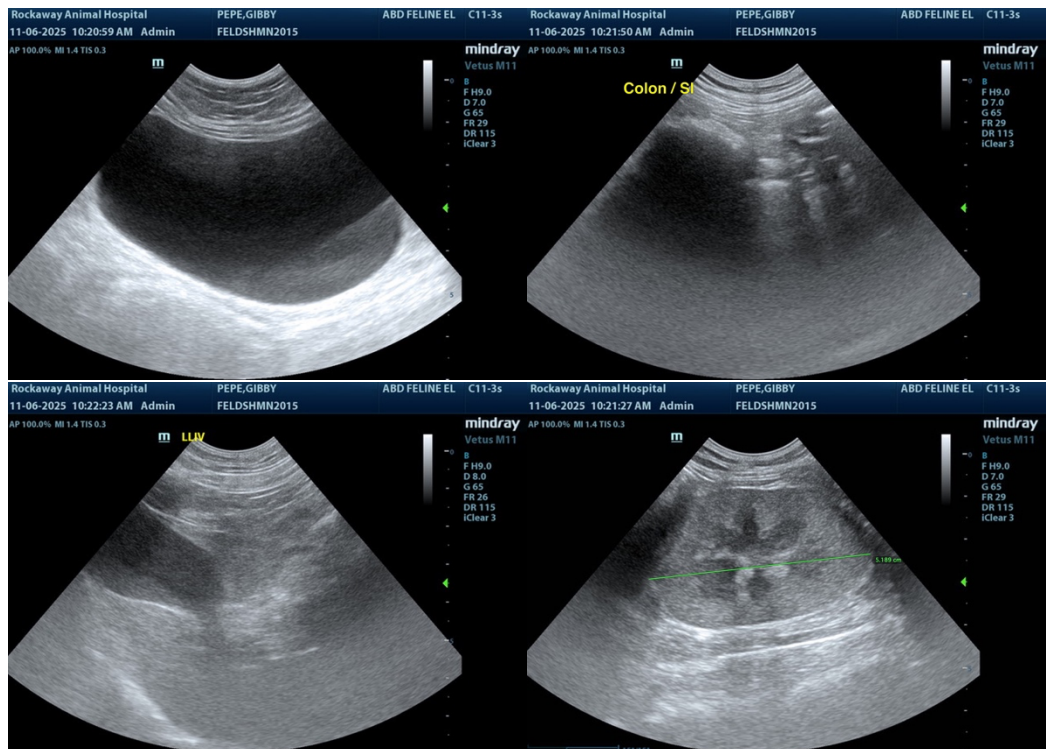
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Hypertrophic cardiomyopathy would be a rule out diagnosis once the patient is deemed euthyroid and normotensive. Correlation with T4 level and systemic BP if possible is recommended. The lack of LA enlargement indicates that the current and future risk of complication is likely low. No overt anticipated cardiac clinical signs at this stage. ECG assessment suggested to assess for potential paroxysmal or non-obvious arrhythmia given patient clinical signs. No overt indication for cardiac medications. Sonographic monitoring indicated for further assessment and prognosis. Recheck echo suggested in 6 months, sooner if clinically indicated. If required, anesthetic risk is considered mild. 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.

Static abdominal presentation without evidence of significant or progressive pathology.





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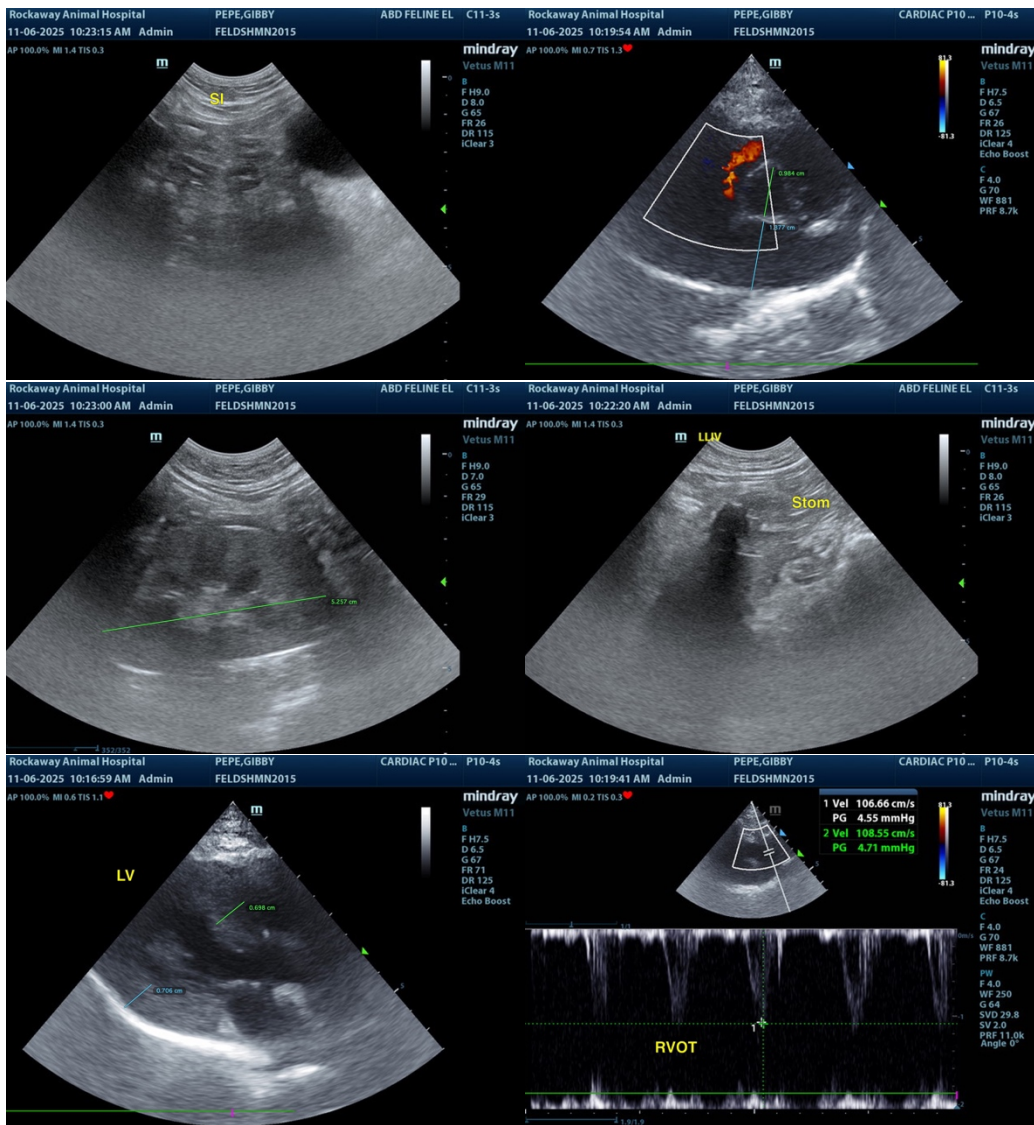
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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