



PATIENT

Mickey Denigris

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years 8 Months

WEIGHT

20 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Farview Animal Clinic

REFERRING VET

Dr. Mosaad

INVOICE

12791

DATE

12/22/25

PRESENTING CLINICAL SIGNS

Labored breathing, wheezes in chest, radiographs show worsening lungs.

Meds: Convenia and depomedrol given last week

Abnormal PE/Chem/CBC/UA Results: Labs pending

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	--	165	1.46	1.6	0.48	45	80
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	--	1.25	1.3		1.0	0.8	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** size based on 2 separate LA measurements. The cranial and caudal **mitral** valve leaflets presented normal linear structure and kinetics. 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 normal laminar flow and subjective structural integrity. Normal measured LVOT velocity. 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. Adequate to normal measured RVOT velocity. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx. 1:1 pa/ao ratio). 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. No evidence of hepatic congestion.

Transdiaphragmatic and focal peripheral pulmonary comet tail artifact was visualized. Subjective mild space occupying peripheral nodule in the left lung measuring approximately 3.0 cm in diameter.



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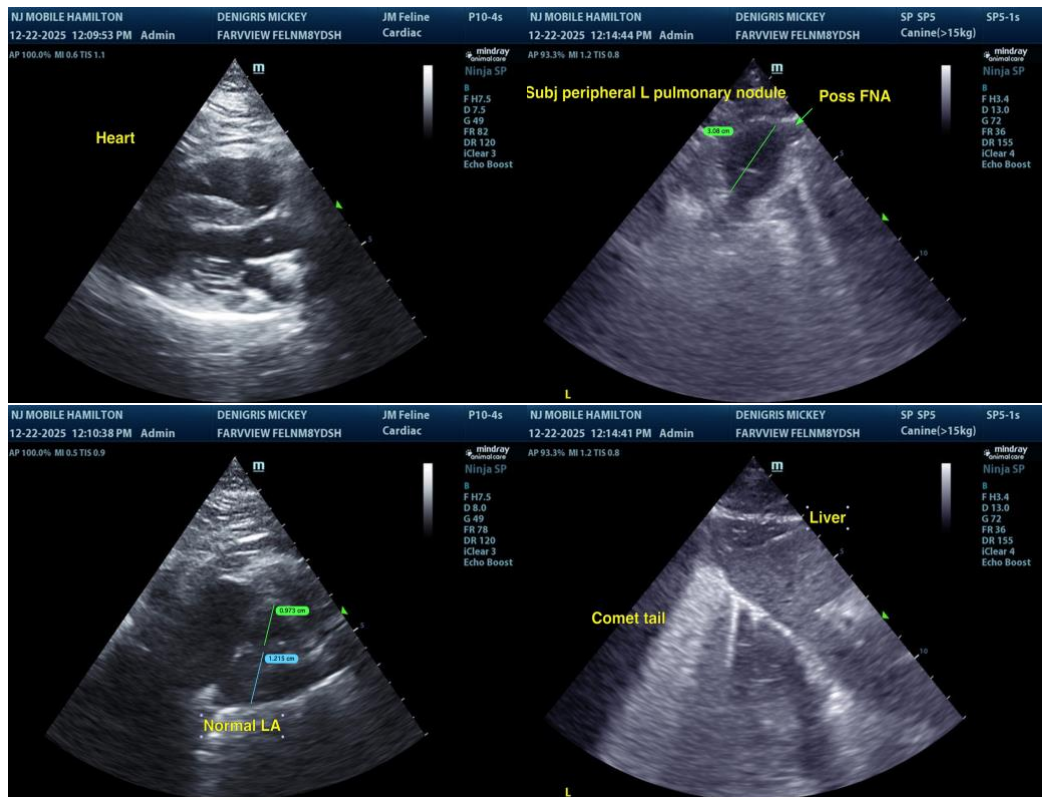
Subjective subcutaneous thoracic fat was visualized in several views of the left thorax with no overt significant pleural effusion.

ULTRASONOGRAPHIC FINDINGS

- Normal cardiac structure/function- noncardiogenic respiratory signs.
- Transdiaphragmatic and focal peripheral pulmonary comet tail artifact.
- Mild space occupying peripheral pulmonary nodule.
- Subjective subcutaneous fat- consistent with patient's body condition.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of structural or functional cardiomyopathy or overt pulmonary hypertension as a cardiogenic cause of the patient's respiratory signs. Additional intra-pulmonary pathology may be nonvisual owing to surrounded aerated lung. Infectious, inflammatory, granulomatous or neoplastic etiologies are all potentials in conjunction with radiographs, infectious or potential neoplastic etiologies are of primary concern. No cardiac anesthetic contraindications. Under anesthesia, ultrasound guided FNA of the peripheral pulmonary nodule or adjacent lung for cytology +/- culture/sensitivity could be considered. Additional lower airway sampling is likely required for further clarification. No indication for cardiac medications with continued respiratory support pending additional diagnostics is recommended. 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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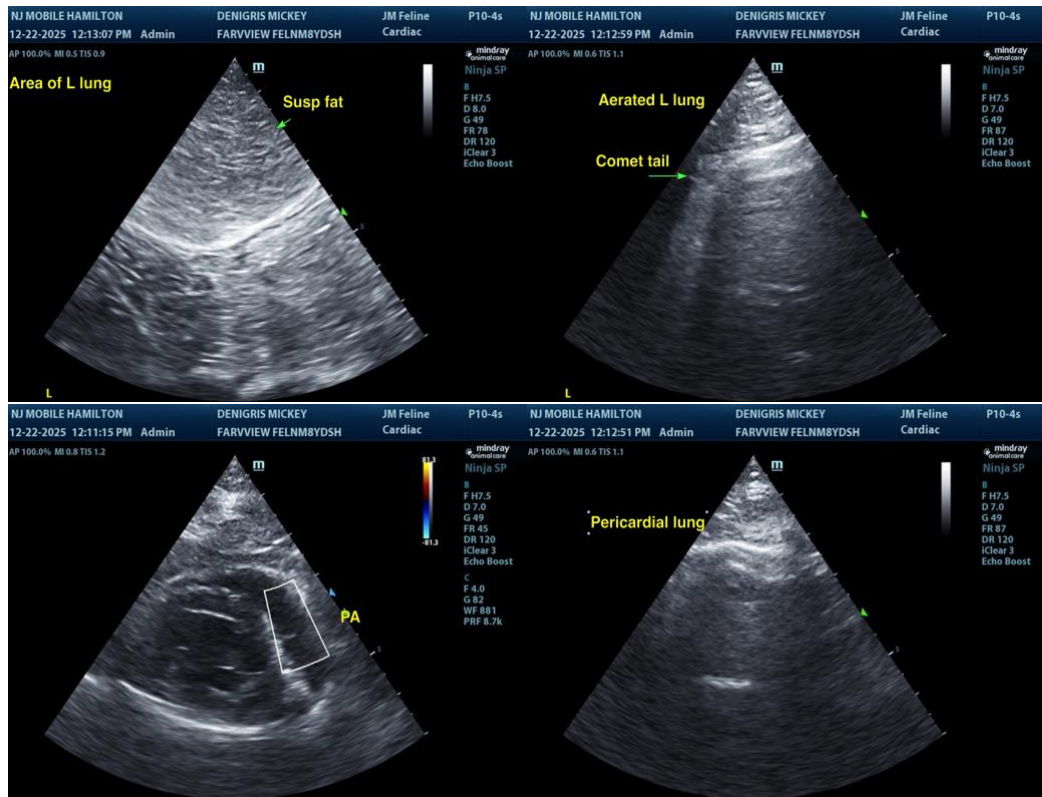
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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