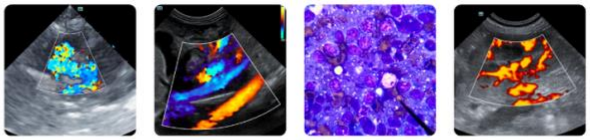

PATIENT

Hopkins Kalachman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15

WEIGHT

8.6

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Jenn

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PRESENTING CLINICAL SIGNS

Presented for losing weight, vomiting 4-5 times a week, pupils dilated Anemia -non regenerative, pancreatitis, azotemia, cardiomegaly on x-rays

Abnormal PE/Chem/CBC/UA Results: BUN 61 Lipase 4.9

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	0.36	2.1	0.43	38	68
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	--	2.0	2.2		--	0.92	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							

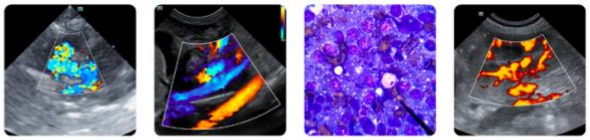
Cardiac Presentation

The left ventricular wall demonstrated remodeling with regions of asymmetry. Diffuse hyperechoic endocardium consistent with fibrosis. Mildly prominent remodeled papillary muscles. LV systolic dysfunction is adequate to mildly decreased. LV and RV are both dilated yet more prominent in the LV. Left atrium is significantly dilated and bulbous in appearance. Evidence of disorganized thrombus/smoke in the LA lumen was present. The right atrium appeared moderately dilated. No evidence of spontaneous contrast. Mitral valve presented mildly thickened and irregular in appearance. No evidence of significant MR with no obvious TR. Blood flow through both the LVOT and RVOT was subjectively normal. No evidence of pericardial effusion. Suspect mild caudal thoracic pleural effusion was present without obvious cardiac tumors.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Nondependent particulate moderate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural 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 loss of corticomedullary distinction



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was also present. The renal medullary volume was subjectively reduced. The left kidney measured 4.2 cm in length. The right kidney measured 4.3 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

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

The liver presented mildly enlarged in size with symmetrical yet swollen contour. The parenchyma exhibited conserved uniform parenchyma with normal echogenicity isoechoic to the spleen and falciform fat. Evidence of mild hepatic vasculature congestion with mildly prominent cranial abdomen caudal vena cava.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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 intestinal walls demonstrated intact mildly thickened wall and mild altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. Small intestine wall measured 0.31 cm wall width.

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

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

Intermittent mildly prominent 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). Scant peritoneal effusion was evident.

ULTRASONOGRAPHIC FINDINGS

- Bi-atrial enlargement with LA spontaneous contrast.
- LV myocardial remodeling/fibrosis.
- Increased LV internal dimension and adequate to mild decreased LV systolic dysfunction.
- Mild RV dilation.
- Suspect scant caudal pleural effusion.
- Moderate urine sediment.
- Bilateral chronic renal changes.

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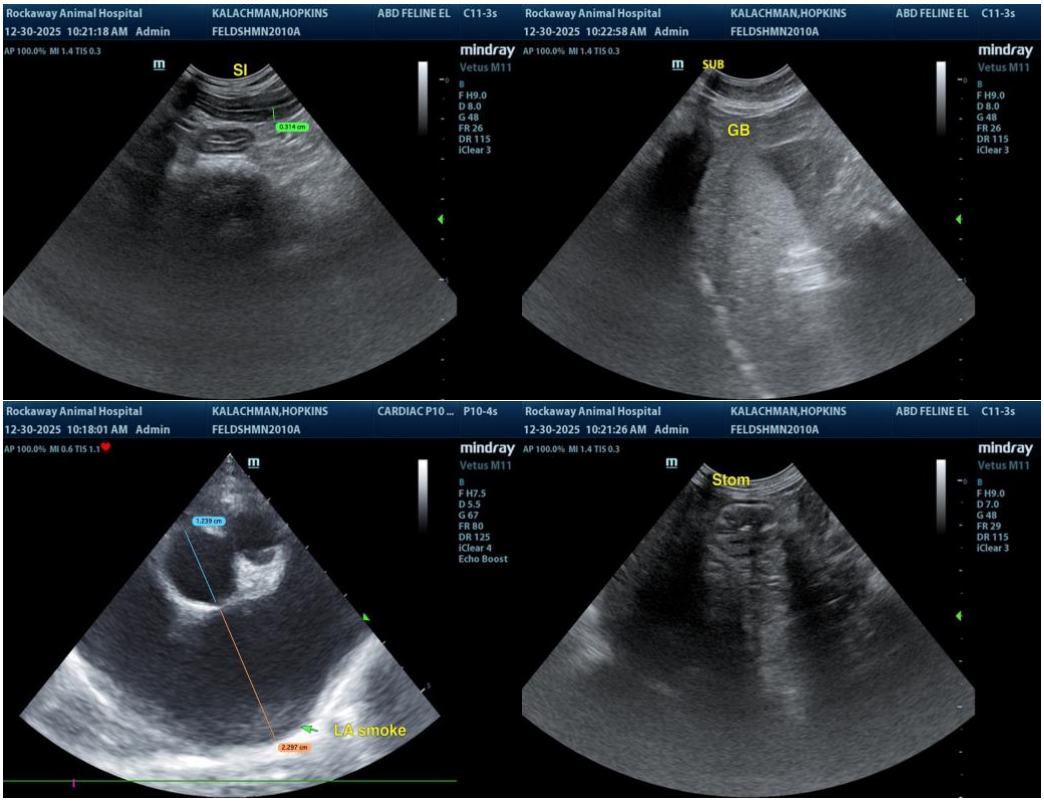
- Early to mildly congested liver.
- Enteropathy.
- Intermittent mild mesenteric lymphadenopathy and scant peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The finding of bi-atrial enlargement given the nonthickened LV wall is suggestive of unclassified cardiomyopathy criteria, although burnout or end stage HCM or RCM may have this appearance. Regardless of classification, the degree of atrial dilation is suggestive of CHF criteria. The presence of LA spontaneous contrast indicates the current and future risk of thrombotic events is elevated. Hospitalization with stabilization including IV diuretic therapy, if patient is unstable, is recommended. Lasix 1.0 to 2.0 mg/kg BID, Clopidogrel 75 mg TAB, ¼ TAB PO SID and Pimobendan 1.25 mg BID is recommended. Given concurrent azotemia, serial monitoring of renal parameters and systemic BP is indicated. Serial sonographic monitoring is advised for further prognosis, although long term extremely guarded to unfavorable prognosis is likely.

The enteropathy may indicate chronic IBD or other inflammatory enteropathy although potential for emerging or low-grade intestinal round cell neoplasia such as lymphoma is not excluded. Concurrent chronic pancreatitis may present sonographically normal. Correlation with a GI panel to include PLI, TLI, cobalamin and folate and urinalysis is recommended.



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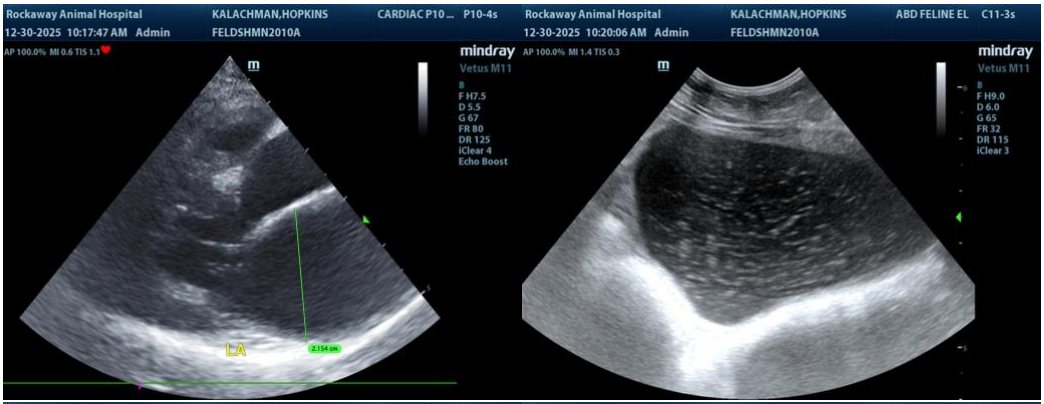

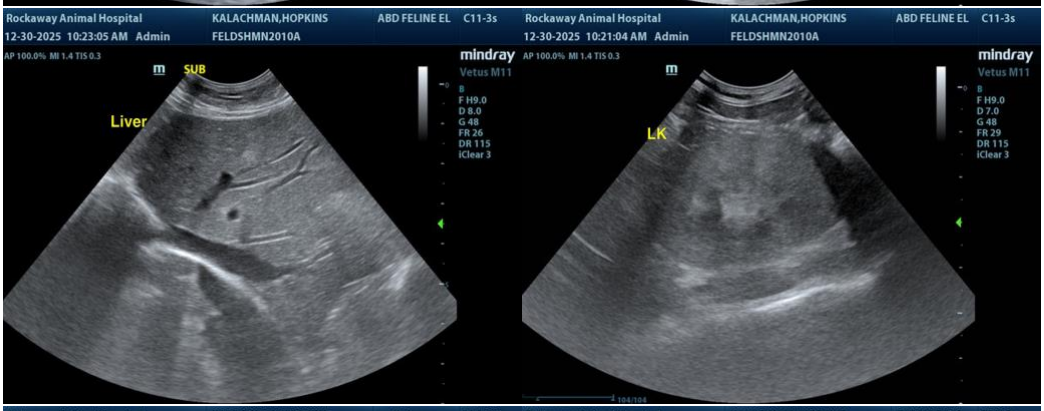

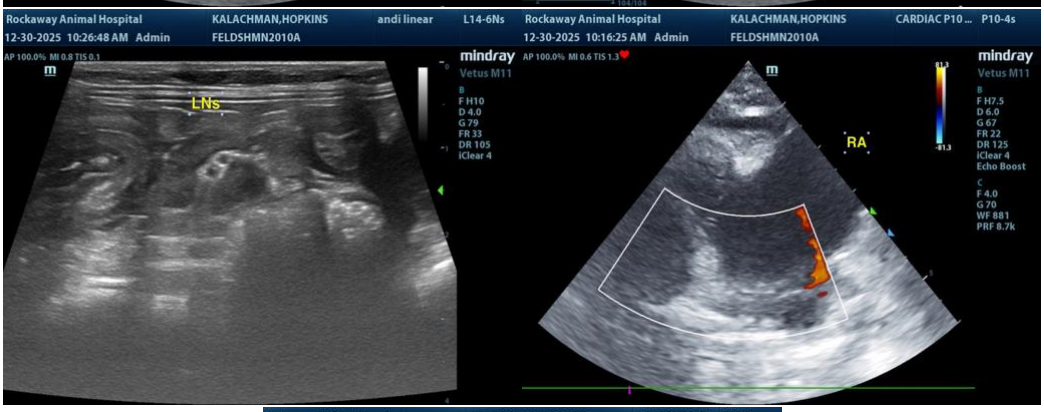

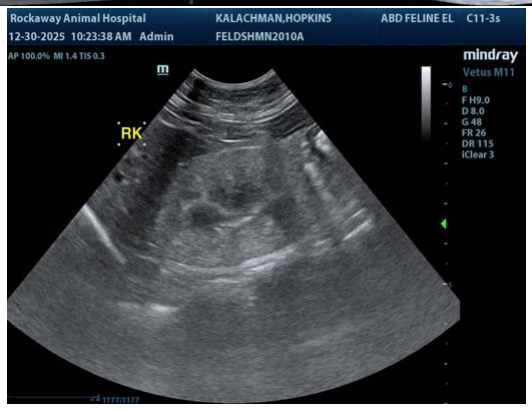

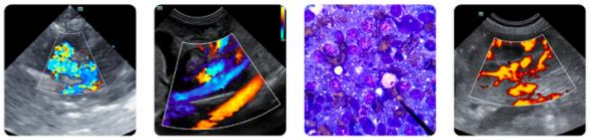

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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