PATIENT

Tarzan Blair

SPECIES

Feline

BREED

Savannah

SEX

Neutered Male

AGE

8 Years

WEIGHT

23 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Newton Veterinary Hospital

REFERRING VET

Dr. Chan

INVOICE

14368

DATE

03/17/26

PRESENTING CLINICAL SIGNS

- respiratory disease
- increase kidney values
- r sided crackles
- meds: Lasix, Torb

Abnormal PE/Chem/CBC/UA Results: CR 2.3, BUN 40.8, ProBNP normal urine: pending

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

FELINE CARDIAC PARAMETERS	**BODY WEIGHT** (lbs)	**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	23.0	NM	0.51	1.32	0.55	45	78
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	--	1.5	1.5		1.0	0.5	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 3 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. 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 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.

Urinary System

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

The area of the aortic trifurcation was free of pathology.

Mildly prominent renal size with symmetrical margination was present in both kidneys, likely patient variant given the patient's body size. Mildly thickened cortex exhibiting normal corticomedullary echogenicity. Mild indistinct corticomedullary border demarcation. A small left kidney cyst was present. The left kidney measured 4.8 cm in length. The right kidney measured 4.9 cm in length.

Adrenal Glands

The area of the left and right adrenal glands was free of pathology.

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. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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 contained echogenic, mild to moderate nonshadowing ingesta without evidence of obstruction to pyloric outflow.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental mild similar appearing nonshadowing intestinal ingesta to the level of the colon.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Normal cardiac structure/function.
- Nonspecific mild nephropathy with small left kidney cyst.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of structural or functional cardiomyopathy or pulmonary hypertension as a cardiogenic contributing factor to the patient's respiratory signs. Lower airway disease is probable. Correlation with thoracic radiographs and concurrent respiratory support with clinical monitoring is recommended.

No evidence of abdominal pathology as a contributing factor to potential thoracic or pulmonary pathology. Full urinary workup including pending urinalysis +/- culture and sensitivity and UPC level if clinically indicated for renal staging is recommended. Assessment for potential renal toxic exposure is suggested if persistent or progressive azotemia.

No indication for cardiac medications with discontinuation of LASIX therapy is indicated in conjunction with mild azotemia.

New Jersey Mobile
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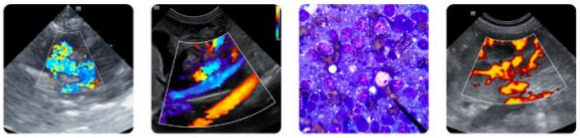

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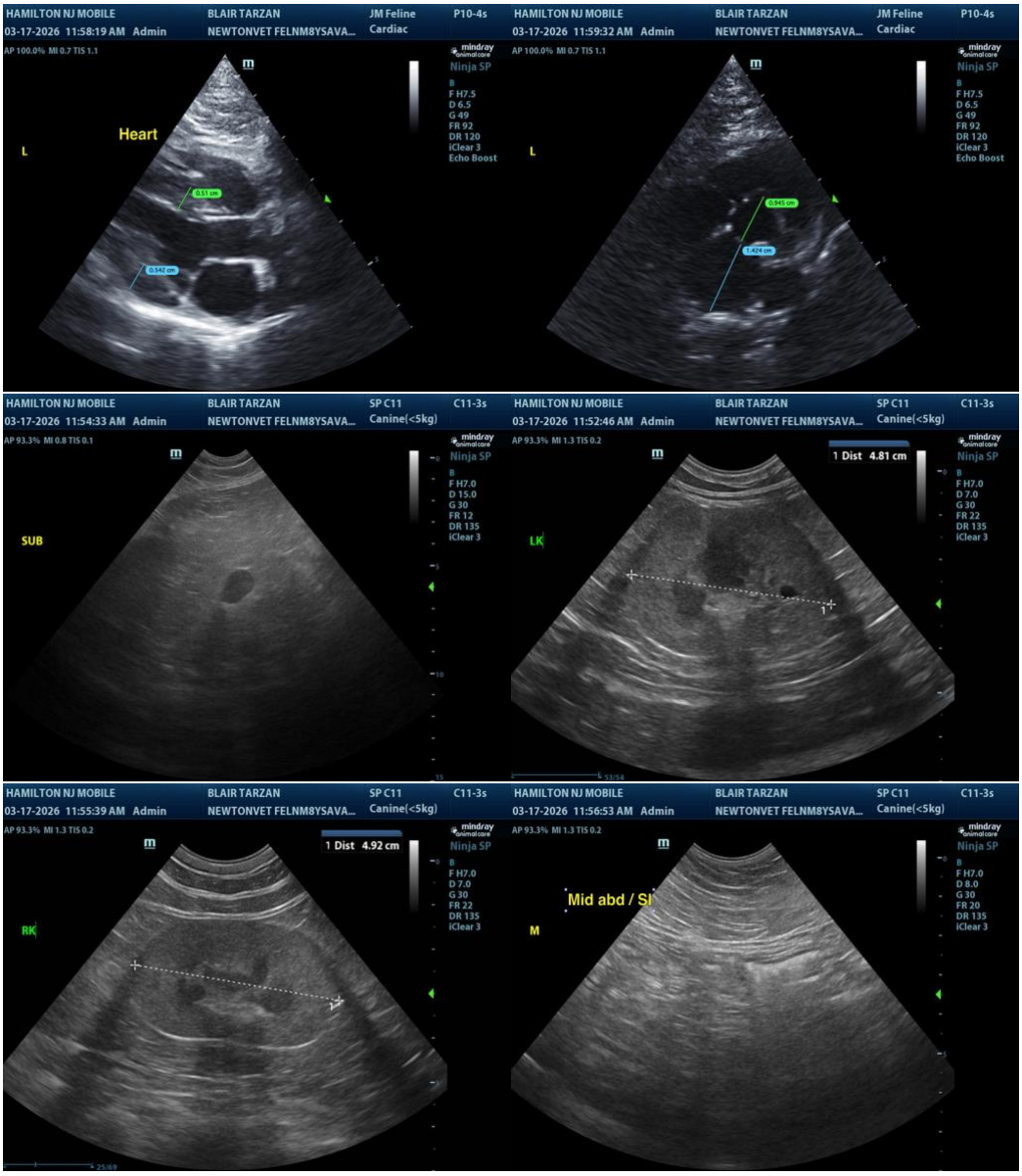

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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