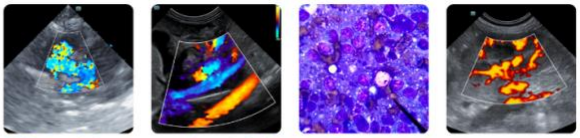

PATIENT

Fig Ailara

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years 8 Months

WEIGHT

5.85 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Bond Vet Montclair

REFERRING VET

Dr. Sposato

INVOICE

15015

DATE

04/10/26

PRESENTING CLINICAL SIGNS

Intermittent HM, PT acting off. HM intermittent 2/6

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	5.85	NM	0.65	1.44	0.71	40	72
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	--	1.9	1.8		NM	1,2	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 is mild / moderately hypertrophied with regions of irregularity. There is a diffusely hyperechoic endocardium consistent with fibrosis and ventricular remodeling. Papillary muscle hypertrophy with regions of remodeling. Mild increased left atrial dimension, no spontaneous contrast. Mildly thickened mitral valve leaflets without definitive systolic anterior motion (SAM) pf the mitral valve although not excluded. Previously noted eccentric MR was not definitively evident on the study, but likewise not excluded. Normal right atrial size. Normal right ventricle size. Normal RVOT velocity. No TR. No other obvious valvular regurgitation is present. There is no pericardial effusion noted. No pleural effusion appreciated. No obvious cardiac tumors.

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

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.4 cm in length. The right kidney measured 3.8 cm in length.

Adrenal Glands

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The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.32 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 cm width.

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 nonshadowing ingesta consistent with food echogenicity without signs of 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. The small intestine wall measure 0.24 cm to 0.25 cm wall width.

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.

ULTRASONOGRAPHIC FINDINGS

- Similar appearing to possible mild progressive thickened LV with myocardial remodeling/fibrosis.
- Static mild LA enlargement.
- Overall sonographically unremarkable abdomen with mild gastric ingesta- consistent with food echogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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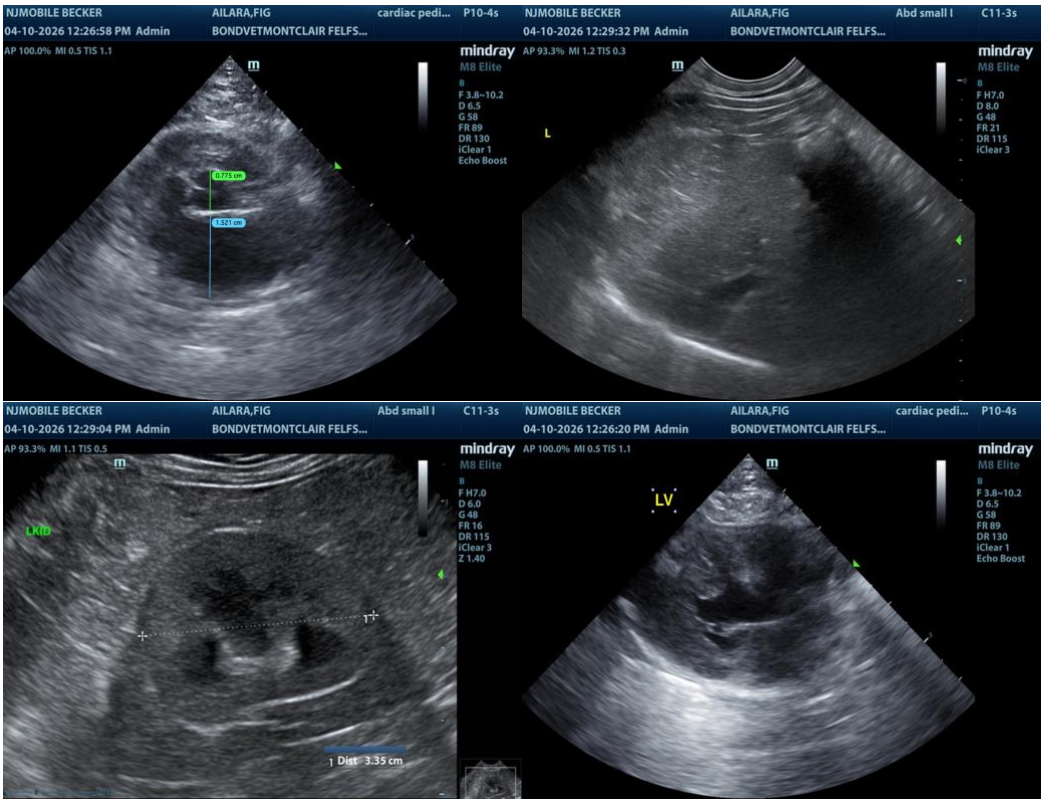
The echocardiogram is most consistent with previously noted HCM/HOCM phenotype, although definitive evidence of SAM or previously noted MR was not present in the study. The persistent mild increased LA dimension without evidence of significant progression suggests a potential risk of current and future complication, i.e. CHF or thrombotic event remains relatively low. No evidence of cardiac congestive criteria. No obvious indication for cardiac medication at this stage given no evidence of significant progression yet potential emerging intermittent clinical signs associated with cardiac disease are not definitively excluded.

No obvious evidence of abdominal pathology, including no evidence of previously noted enteropathy pattern as an obvious contributing factor to the patient's clinical signs. Correlation with full lab work and urinalysis, including T4 level and assessment of systemic BP to assess for or rule out complicating factors is recommended. Serial echocardiographic monitoring is required for further assessment and prognosis. Recheck echo is suggested in four to six months, sooner if progressive, nonspecific or vague clinical signs.



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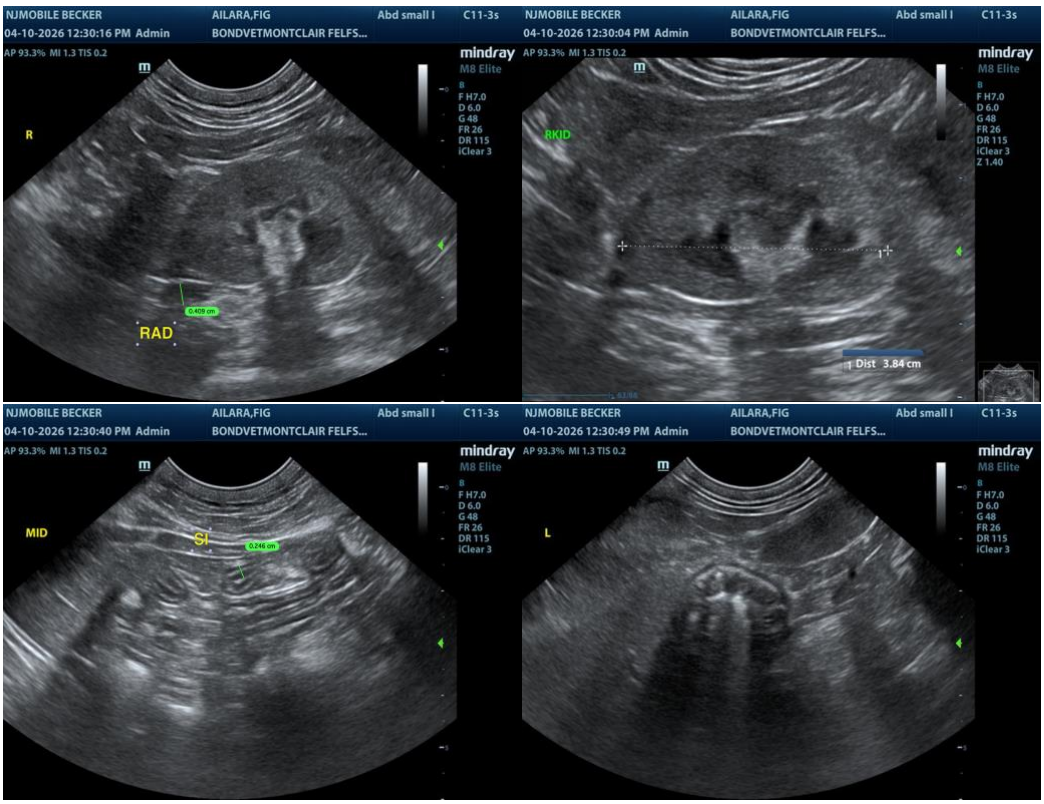

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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