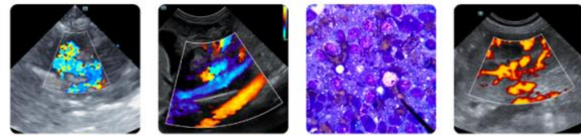


PATIENT

Mr. Big Percelay

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10

WEIGHT

15.7

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway Animal Hospital

REFERRING VET

Dr. Maniar

INVOICE

15073

DATE

04/14/26

PRESENTING CLINICAL SIGNS

Anorexia, decreased BM's and urine Hx of Grade 3/6 HM Had a prev echo 5/27/25

Abnormal PE/Chem/CBC/UA Results: Lipase 19.7

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

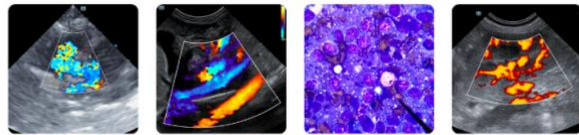
FELINE CARDIAC PARAMETERS	BODY WEIGHT	HR (BPM)	IVSd (cm)	LVIDd (cm)	LVWd (cm)	FS (%)	EF (%)
NORMAL PARAMETER	------	150-240	0.3-0.6	1.0-2.1	0.25-0.6	35-67	80-100
PATIENT	15.7	NM	0.53	1.3	0.56	50	82
FELINE CARDIAC PARAMETERS	LA/AO (M-mode)	LA/AO HEART BASE (Sisson)	LAD LA MAX 4 Chamber		LVOT VEL. (m/s)	RVOT VEL. (m/s)	IVRT (m/)
NORMAL PARAMETER	<1.5	1.6	0.7-1.7		<1.6	<1.3	40-60
PATIENT	--	1.3	1.4		--	0.9	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** dimension 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. 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

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Echogenic to particulate nondependent minor to hyperechoic 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.



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Mild renal enlargement 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. Loss of corticomedullary distinction was also present. Mild pyelectasia was present bilaterally. The left kidney measured 5.0 cm in length. The right kidney measured 4.9 cm in length.

Adrenal Glands

No obvious visualized pathology in the areas of the left or right adrenal glands yet 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 & Gallbladder

The liver presented normal in size. Homogenous mildly hyperechoic parenchyma compared to the spleen. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild nonorganized 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. The small intestine wall measured 0.24 cm wall width.

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

Pancreas

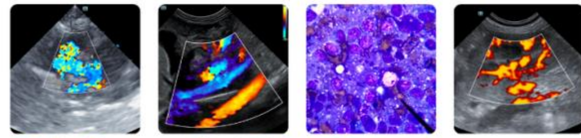
The pancreas presented normal in size with capsule asymmetry exhibiting mild homogenous hypoechoic parenchyma with mildly prominent pancreatic duct.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Normal cardiac structure/function.
- Sonographically unremarkable gastrointestinal tract and colon.
- Suspect mild pancreatitis.



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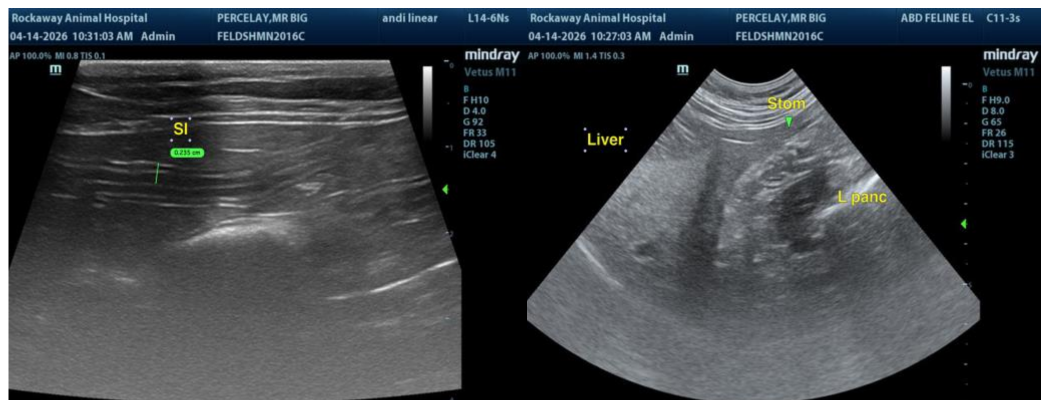
- Mild hyperechoic liver with mild gallbladder debris.
- Nonspecific bilateral chronic nephrosis pattern exhibiting mild pyelectasia.
- Minor urine sediment.

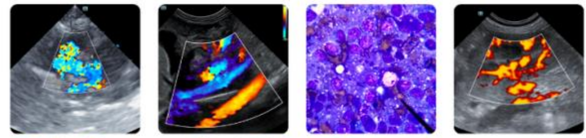
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A definitive cause of the murmur was not identified. Assuming no volume changes such as dehydration or anemia, a benign flow murmur is probable. A small nonvisualized flow abnormality is not excluded. Regardless of classification, the hemodynamic effects of the murmur are low. Monitoring of the heart murmur is recommended without indication for cardiac medications. Recheck echocardiogram is recommended in 6-12 months, sooner if murmur intensity increases or clinical signs arise. 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.

The appearance of the liver was nonspecific but may indicate hepatitis/cholangiohepatitis, lipidosis, vacuolar or cholestatic hepatopathy or fibrosis while round cell hepatic neoplasia cannot be excluded. Assuming normal coagulation parameters, ultrasound guided FNA of the liver using a 25-gauge needle would be warranted for cytology, primarily to assess for evidence of inflammatory cells and to rule out round cell neoplasia. Vitamin K administration would be suggested prior to FNA if elected. A GI panel to include PLI, TLI, cobalamin and folate, if lipidosis is confirmed. Correlation with pancreas and assessment for a non-structural intestinal disease is recommended.

Monitoring of renal parameters and urinalysis +/- screening culture/sensitivity and UPC ratio for renal staging and pending urinalysis is recommended. Gastrointestinal support is indicated.





SonoPath.com info@sonopath.com 1.800.838.4268

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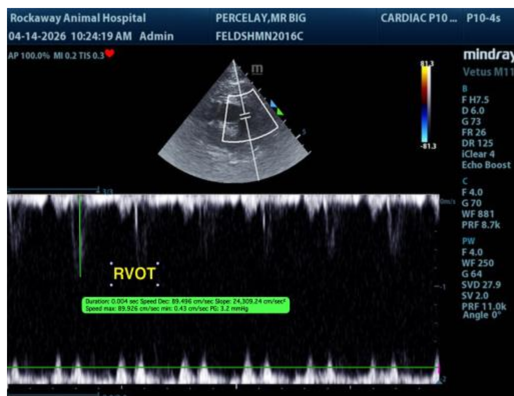

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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