



**PATIENT**

Ebony Sanabria

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

11

**WEIGHT**

8.4

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Jenn

**HOSPITAL NAME**

Rockaway Animal  
Hospital

**REFERRING VET**

Dr. Brooks

**INVOICE**

16218

**DATE**

05/15/26

**PRESENTING CLINICAL SIGNS**

Weight loss of 3 lbs since Aug, hyporexia lethargy less vocal than normal, concern for mass in abd and pleural effusion.

Abnormal PE/Chem/CBC/UA Results: HCT 24.9% WBC 28.97 Neu 25.1 bands suspected Lipase 6.8

**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	8.4	NM	0.46	1.2	0.46	48	81
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	NM	1.25	1.3		NM	0.7	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 obvious visible **pericardial** effusion with subjective mild volume of free pleura fluid was noted. 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 to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with minor urine sediment which may indicate minor cellular/crystalline debris, lipid or mucus. The ureteral papillae



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

Mildly enlarged 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. Moderate loss of corticomedullary border demarcation was also present. The left kidney measured 4.7 cm in length. The right kidney measured 4.5 cm in length. Subtle peripheral hypoechoic halo bilaterally.

### **Adrenal Glands**

No obvious pathology in the areas of the left or right adrenal glands.

### **Spleen**

The spleen presented borderline enlarged with asymmetrical contour primarily secondary to expansive nonhomogenous hypoechoic splenic nodule that measured 1.6 cm in diameter with associated medial capsule distortion.

### **Liver & Gallbladder**

The liver presented mildly enlarged in size with rounded contour and nonhomogenous discretely nodular parenchyma.

The gallbladder was non distended in size with mild biliary sludge. Possible bi-lobed gallbladder. The common bile duct was not visualized.

### **Gastrointestinal**

Regional moderate to significant gastric wall thickening and loss of gastric wall layer detail was present. The thickened gastric walls exhibited decreased mural echogenicity and an asymmetrical luminal surface. Mild retained anechoic fluid and lumen gas was present in the gastric lumen without evidence of foreign material. Gastric wall measured 1.2 cm. Surrounding perigastric nonhomogenous nodular omentum and suspect probable hypoechoic to swollen perigastric lymph node measuring 2.5 cm x 1.6 cm.

The small intestine was indistinctly visualized. The visualized segments of small intestine exhibited overtly intact wall layering, maintained wall layer ratio and empty lumen.

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 significant peritoneal effusion was present.

## ULTRASONOGRAPHIC FINDINGS

- Normal cardiac structure/function.



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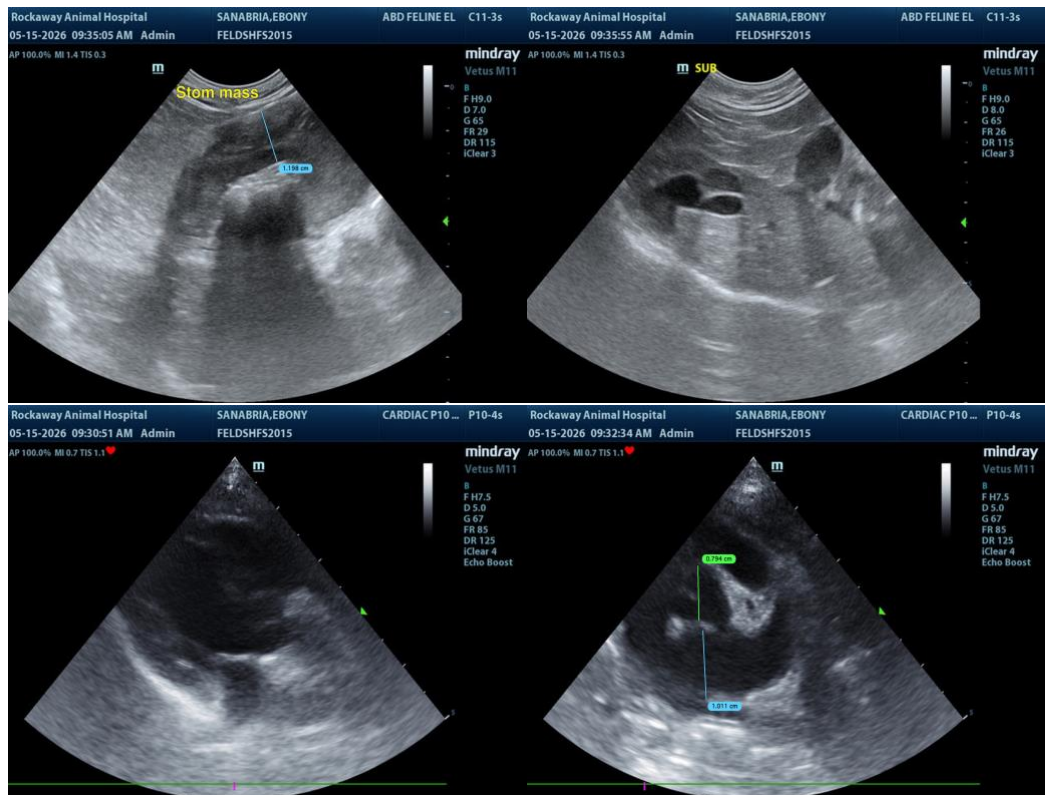
05/15/26

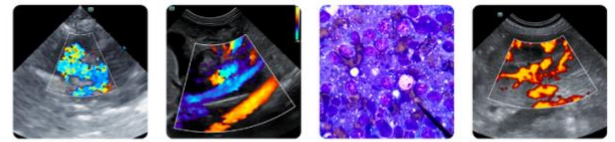
- Stomach mass.
- Enlarged discretely nodular liver.
- Expansive splenic nodule.
- Perigastric nonhomogenous nodular omentum and intermittent hypoechoic to swollen perigastric lymphadenopathy.
- Borderline renomegaly exhibiting chronic changes and subtle peripheral hypoechoic halo.
- Mild volume pleural effusion- noncardiogenic.
- Mild gallbladder debris with possible bi-lobed gallbladder.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Unfortunately, multicentric neoplastic criteria is met with multicentric round cell neoplasia, i.e. lymphoma or other probable.

Further assessment may include (assuming normal clotting status) stomach mass, hepatosplenic, and accessible lymph node FNA cytology with oncology consult. Curative surgical options are precluded. Unfavorable prognosis.





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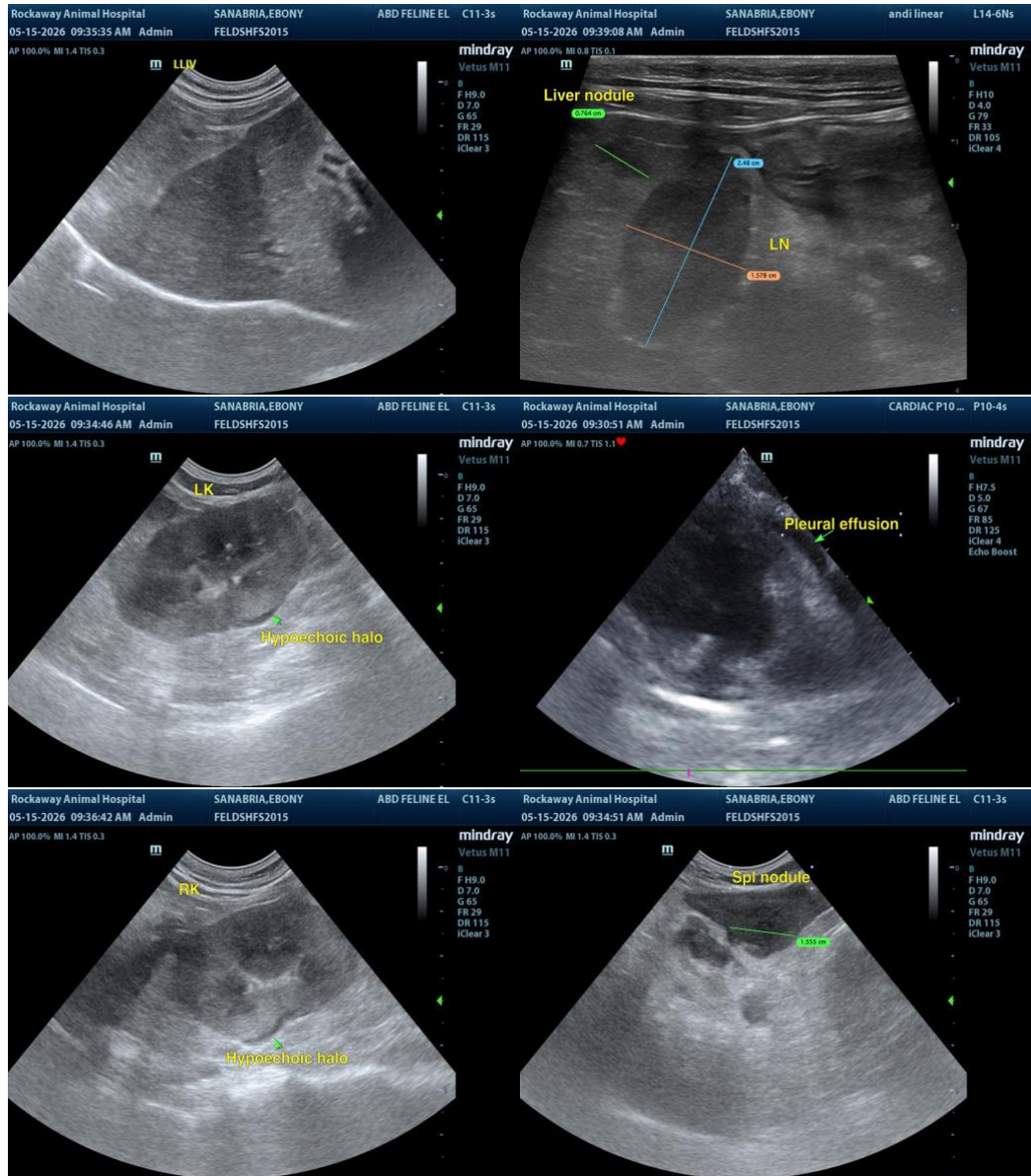
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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