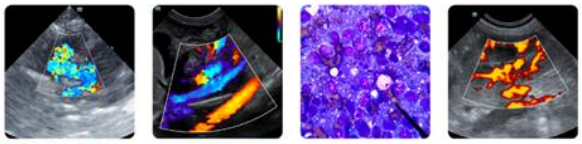


PATIENT

Smash Harvey

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

8

WEIGHT

17.5

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockawau Animal Hospital

REFERRING VET

Dr Harrs

INVOICE
24929

DATE
05/23/2026

PRESENTING CLINICAL SIGNS

New HM 3/6 and intermittent arhythmia , inappropriate elimination behaviors

Abnormal PE/Chem/CBC/UA Results: Abnormal ProBnp

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND HEART

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	17.5	NM	0.63	1.54	0.57	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	--	1.3	1.3		--	0.93	NM
Sisson D et al. JVIM 1991; 5: 232, Jacobs et al. Am J Vet Res 1985; 46:1705							

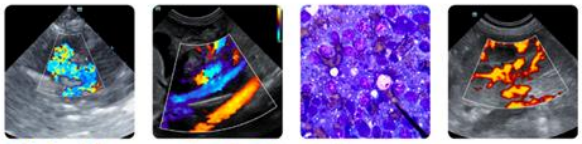
Cardiac Presentation

The echocardiogram in this patient demonstrated normal left atrial size and structure with no evidence of “smoke” or thrombi. The cranial and caudal mitral valve leaflets appeared mildly thickened with mild insufficiency noted on Doppler. The left ventricle presented borderline excessive free wall and septal thicknesses. The myocardium presented essentially normal echogenicity without immediate signs of fibrotic or ischemic disease. Contractility of the ventricular walls was considered excessive for this patient evidenced by the elevated fractional shortening measurement. The left ventricular outflow tract demonstrated turbulent laminar flow. Subjective assessment of the right atrium and auricle revealed normal size, structure and content. No evidence of masses was noted. Tricuspid valvular assessment demonstrated linear morphology. The right ventricle was of normal size with normal chordae structure, myocardial echogenicity and thickness. Pulmonic tract assessment revealed normal valve structure, laminar flow, and diameter. Normal measure RVOT velocity. No visible pericardial or free pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The mediastinum was free of masses in the visible window. No overt significant arrythmia noted.

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were 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



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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 4.4 cm in length. The right kidney measured 4.5 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

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. Normal vascular volume. 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 mild retained gastric fluid with no 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 mechanical/metabolic ileus, obstruction or foreign material. The small intestinal wall measured 0.24 cm in 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 omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Sonographically normal urinary bladder and visible proximal urethra with mild urine sediment
- Normal bilateral kidneys
- Mild hypomotile stomach

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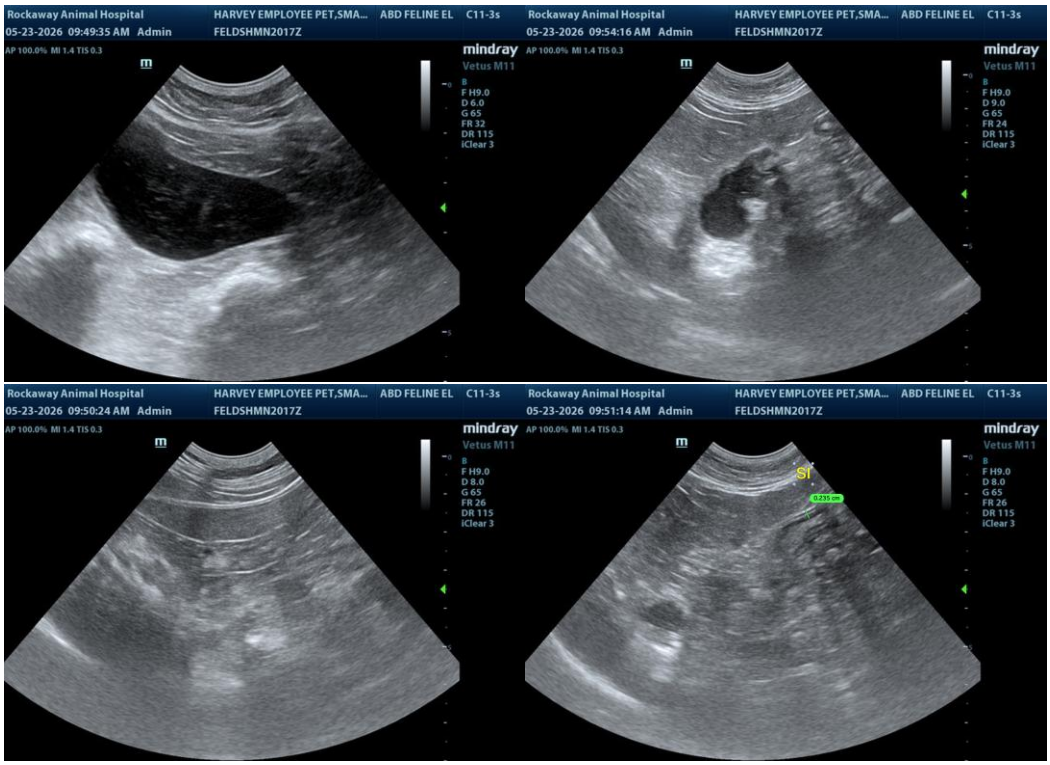
- Normal echocardiogram with borderline increased LV dimension
- Mild mitral insufficiency.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The borderline increased LV dimension may indicate emerging HCM phenotype, which would be a rule-out diagnosis once the patient is deemed euthyroid and normotensive. Assessment of T4 level and systemic BP suggested. The lack of cardiac chamber enlargement indicates that the risk of current and future complication is low. No indication for cardiac medications. Correlation with ECG for further assessment of the arrhythmia is recommended. Recheck echo suggested in 6 months and or if clinically indicated.

Correlation with UA +/- C/S if evidence of inflammatory sediment is recommended. The hypomotile stomach may be incidental given no report of gastrointestinal signs. Empirical therapy for gastritis if gastrointestinal signs are present is recommended.

Cardiac anesthetic risk considered mild, if required to following protocol is suggested. 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.



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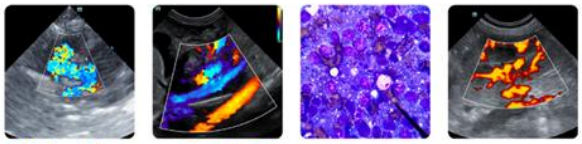

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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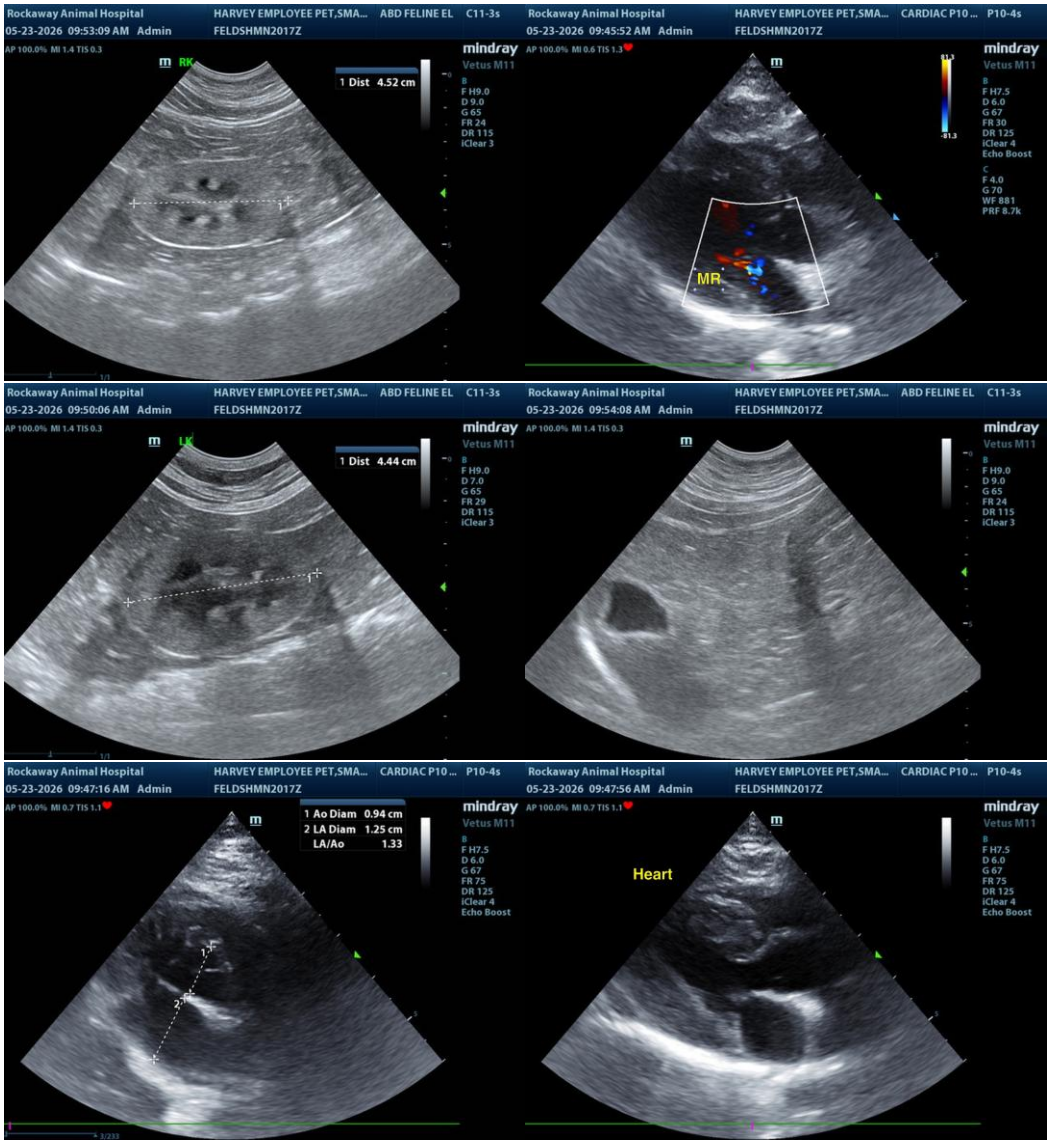

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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