

**PATIENT**

Molly Derderian

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

10 Years

**WEIGHT**

18 Pounds

**INTERPRETED BY**Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)**IMAGING PERFORMED BY**

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging MI

**REFERRING VET**

Airport Vet Hospital

**INVOICE**

39057

**DATE**

6/23/22

**PRESENTING CLINICAL SIGNS**

Not eating, not drinking much water, vomiting, losing weight Exam findings and abnormal lab values:  
 Blood work came back normal, no obvious physical findings  
 Abnormal PE/Chem/CBC/UA Results: See attached labs. Cytology pending.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.31 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.43 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.36 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.31 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size (0.79 cm in width at the level of the hilus), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

**Liver**

The liver is large in size and hyperechoic. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

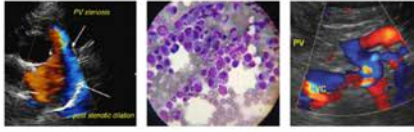
The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The bile duct appears mildly dilated and tortuous, measuring at 0.38 cm.

**Gastrointestinal**

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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svsimagingmi@gmail.com



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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.31 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

***Pancreas***

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

***Free Abdomen***

There is a scant amount of free abdominal fluid. No significant mesenteric lymphadenopathy is noted. The omentum is of increased echogenicity around the large abdominal mass.

There is a large mid abdominal mixed echogenic, hypoechoic, irregular mass effect measuring approximately 5.06 cm x 7.56 cm. This lesion could represent an effaced lymph node, a bowel mass (possibly off ICCJ?), or may represent a mesenteric lesion.

**ULTRASONOGRAPHIC FINDINGS**

- Large, mixed echogenic mid abdominal mass – The origin of this mass lesion is uncertain. Consider a fine needle aspirate.
- Large, hyperechoic/heterogeneous liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Mildly tortuous/dilated bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is a large mid abdominal mass that does not readily appear associated with any other structures, although it could have a connection to bowel, etc., which is not readily apparent. Recommend a fine needle aspirate of this lesion as well as 3-view thoracic radiographs. Depending on cytology results, consider either exploratory surgery in hopes of removal of this lesion, or a contrast CT scan to better evaluate its origin.

The liver is bright and large. In the absence of liver enzyme elevations, hopefully this is not a significant change. I suspect it may represent early lipidosis secondary to the decreased calorie intake recently, and biopsy could be considered at the time of surgery, or a fine needle aspirate.

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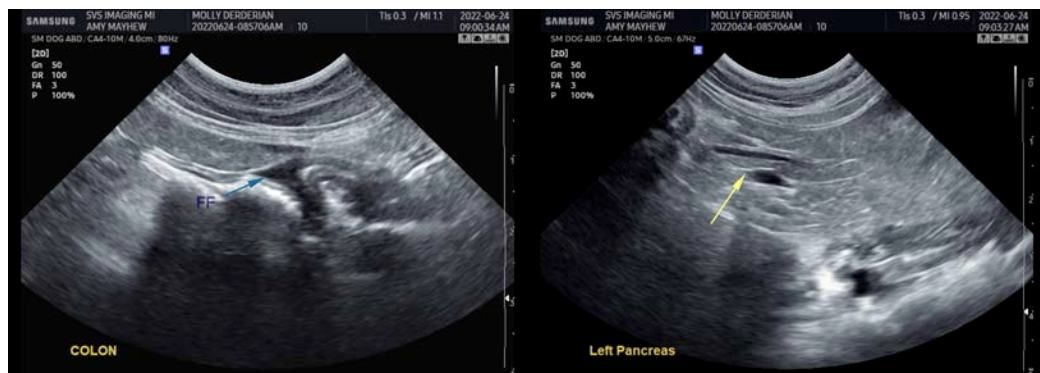
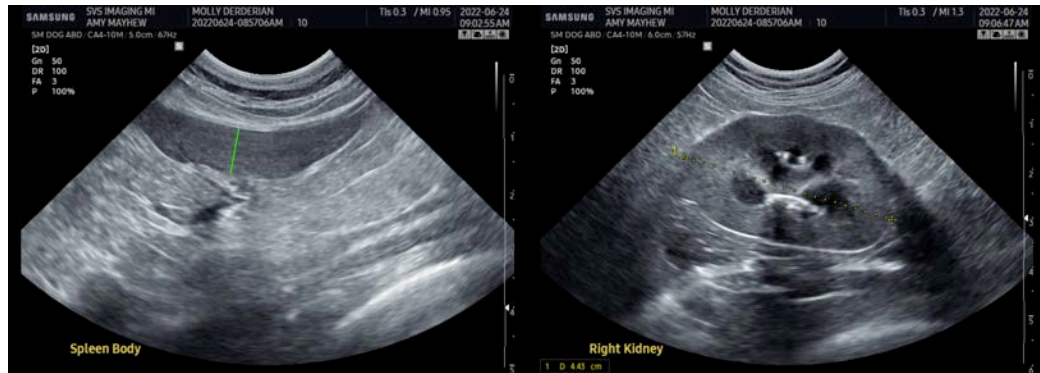
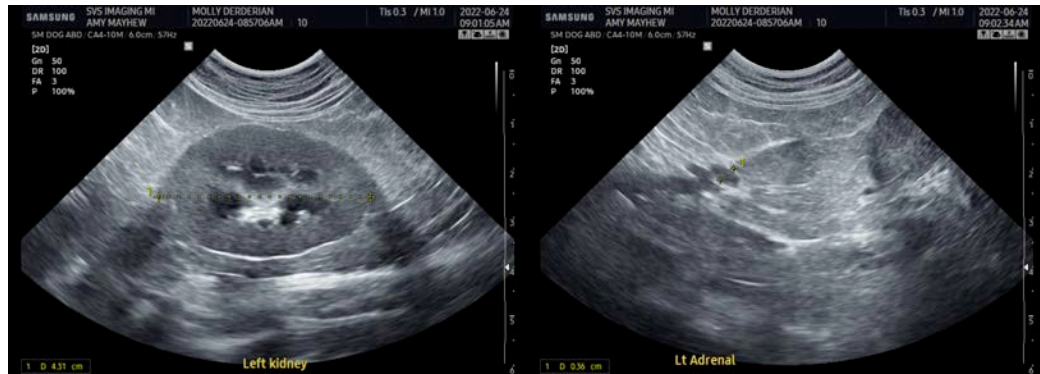
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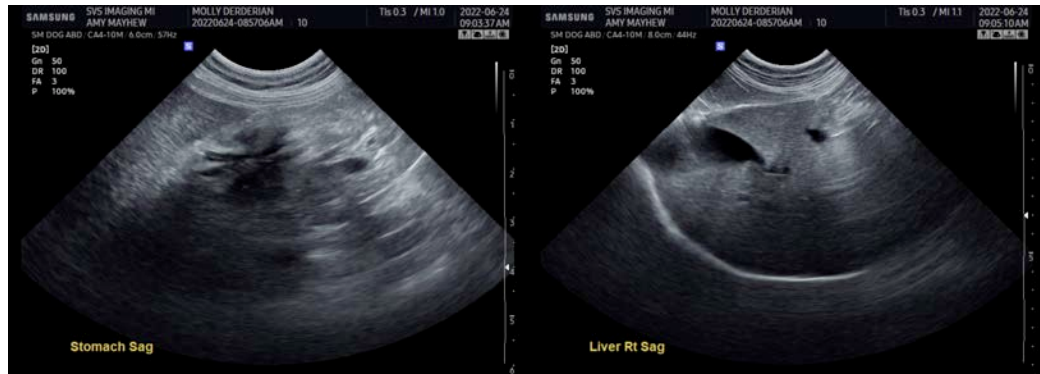
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

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