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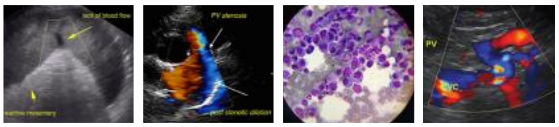


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

**PATIENT**

Bugaboo Archer

**SPECIES**

Feline

**BREED**

DSH

**SEX**

FS

**AGE**

10 years

**WEIGHT**

9 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Sara Hansen

**HOSPITAL NAME**

Ark Animal Hospital

**REFERRING VET**

Dr. Jackson

**INVOICE**

16269

**DATE**

2/22/23

## PRESENTING CLINICAL SIGNS

History of skin concerns and itching, only mild excoriations found at time of exam (2/20/23). O reports abdominal mass surgically removed in July and was supposed to be on antibiotics long term but did not complete month long course recommended, only 10 days provided. Mass was suspected to be involved with the colon during surgery, histopathology was done as well as culture. O wanted recheck of the abdomen today to see if it has returned. PE - few excoriations around the face, firm lobulated abdominal mass palpable in cranial abdomen. Recommended abdominal ultrasound to find location/source of mass.

Abnormal PE/Chem/CBC/UA Results: Eosinophilic sclerosing fibroplasia is an idiopathic condition in cats, but it is speculated to be an atypical fibroblastic response of the feline gastrointestinal tract to eosinophilic inflammation that, in some cases, is associated with bacteria. These lesions may occur anywhere within the gastrointestinal tract, but they often occur at the pyloric sphincter or ileocecocolic junction, and regional lymph nodes are frequently involved. The origin of the abdominal mass in this case cannot be determined (ie colonic wall vs lymph node). In the report describing this condition, most cats were treated by surgical excision, and cats that were treated with prednisone, had longer survival times than those receiving other treatments (Craig et al, Vet Pathol 2009; 46:63-70). The gram stain reveals tangled bundles of long, plump filamentous to slightly beaded gram positive rods within the areas of necrosis. They are acid fast negative. This morphology and staining pattern suggests Actinomyces, but culture would be necessary for definitive diagnosis (and we cannot perform a culture on the formalin-fixed tissue, unfortunately). The GMS stain highlights the bacteria but is negative for fungi. Anaerobic culture found small amount of growth of clostridium perfringes Current Medications none Radiographic Findings not done

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

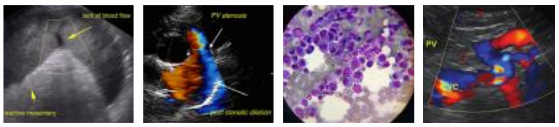
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.7 cm in length. The right kidney measured 3.8 cm in length.

### *Adrenal Glands*

The bilateral adrenal glands were overly normal in size, position, and shape. The left adrenal gland measured 0.29 cm width. The right adrenal gland measured 0.35 cm width.





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### *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. The spleen measured 0.88 cm width at the level of the hilus.

### *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 was empty with no signs of ileus, obstruction, or foreign material.

The small intestine exhibited primarily intact wall layering and subjective maintained 1:3 muscularis/mucosa ratio to the level of the ileum. A moderately sized, irregular, mixed echogenic, nonuniform to nodular mass was present in the area of the ileum and ileocolic junction measuring approximately 4.0-5.0 cm in diameter.

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

### *Pancreas*

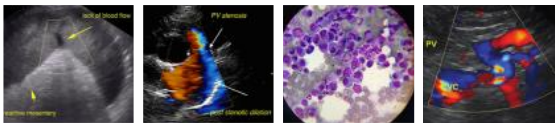
The left pancreatic limb was normal to borderline prominent in size with minor capsule asymmetry exhibiting mild nonhomogeneous to hypoechoic parenchyma compared to adjacent nonreactive omentum.

### *Free Abdomen*

Mild peripheral hyperechoic omentum and associated primarily uniform regional mesenteric lymphadenopathy were present. An example of a mesenteric lymph node measured 2.2 cm length x 0.65 cm. Subtle evidence of concurrent perilymphatic hyperechoic omentum was noted. No evidence of peritoneal free fluid was present.

### ULTRASONOGRAPHIC FINDINGS

- Recurrent nonhomogeneous mixed echogenic / nodular mass area of the ileocolic junction
- Associated regional mesenteric lymphadenopathy and hyperechoic omentum
- Mildly hypoechoic left pancreas - nonspecific





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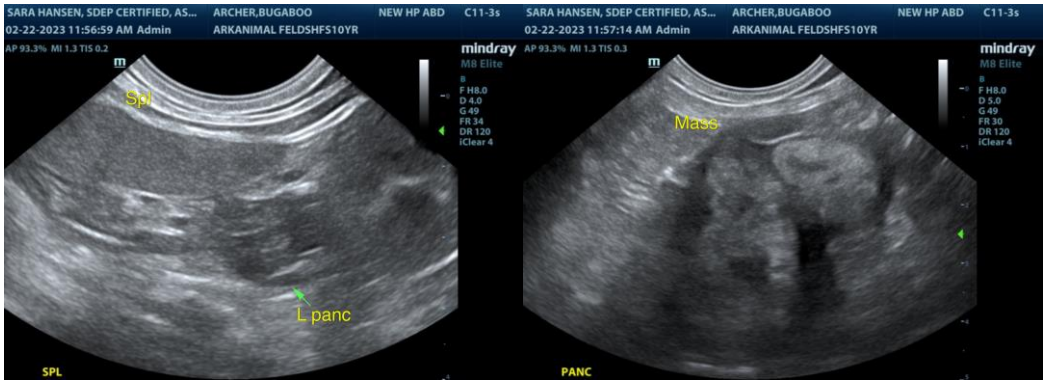
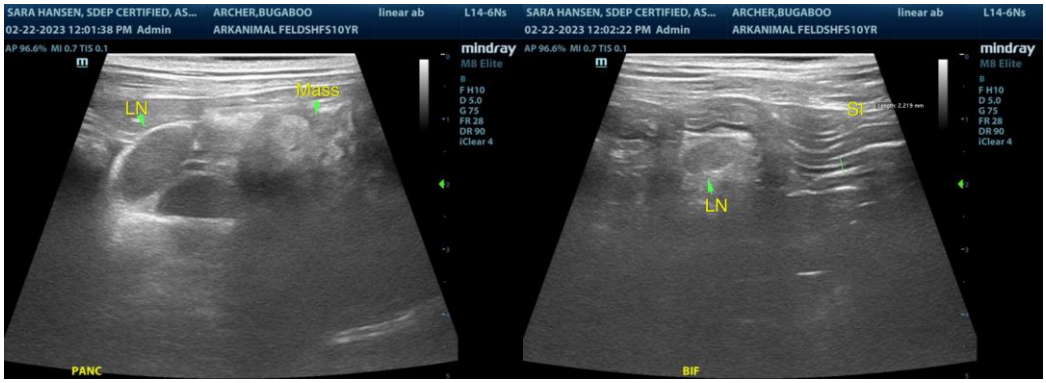
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The confirmed recurrent mass in the area of the ileocolic junction was most likely consistent with previous diagnosis of eosinophilic sclerosing fibroplasia, given the patient history, although other benign vs. neoplastic etiologies could be possible. Screening FNA cytology of the recurrent mass could be considered assuming normal clotting status for further assessment.

The potential for concurrent low-grade left pancreatitis could be considered if clinical signs consistent with low-grade pancreatitis are present or elevated fPL. However, no evidence of significant pancreatic pathology was noted.

Referral for surgical and/or oncology consult, given the patient's history, and sonographic findings may be considered. Recheck three view chest radiographs are recommended if not recently done.



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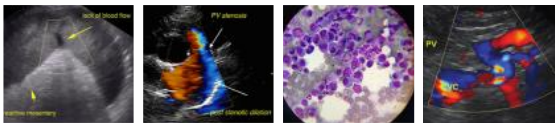

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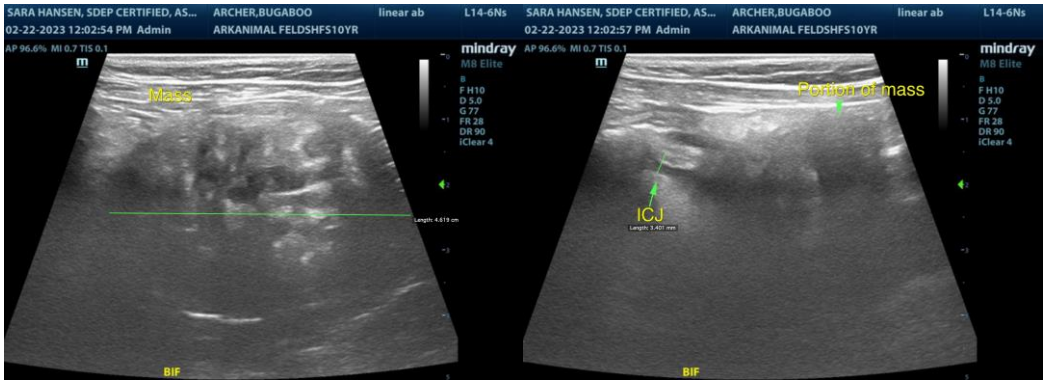


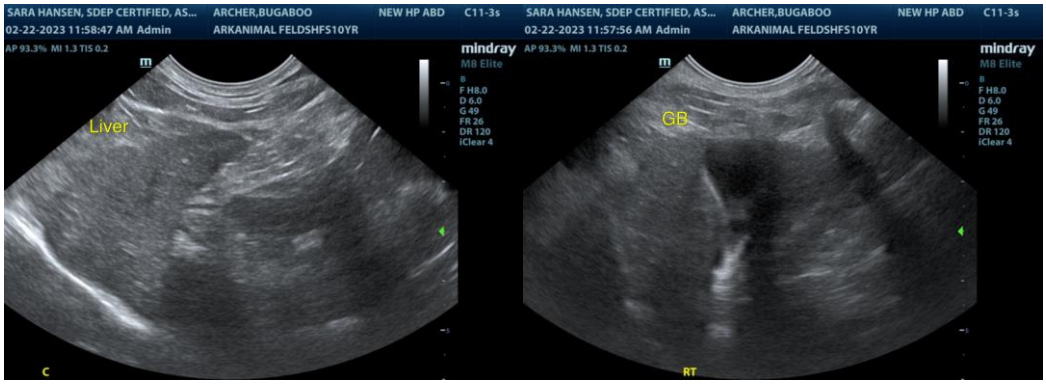


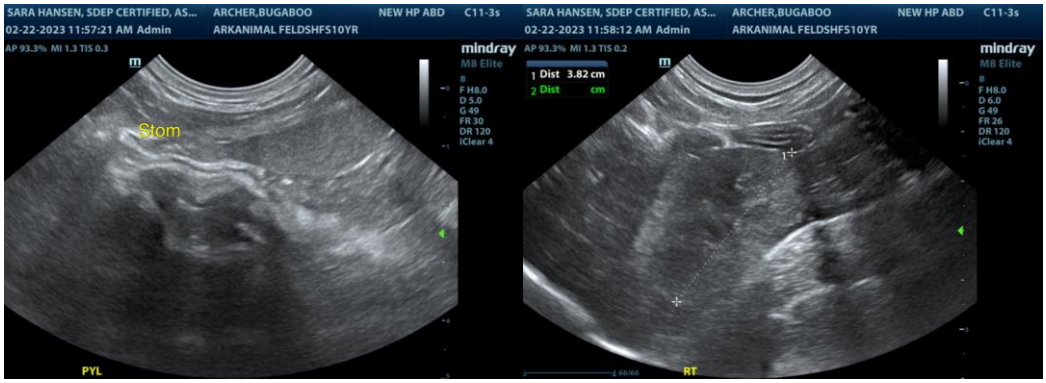


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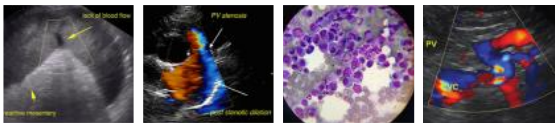

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)**
**info@SonoPath.com**