



PATIENT

Mack Blucher

SPECIES

Canine

BREED

Kelpie

SEX

MN

AGE

10

WEIGHT

25.6

INTERPRETED BY

Tilde Rodrigues Froes,
DMV, MSc., Dr. Med
Vet., Dipl. CBraRVet

IMAGING PERFORMED BY

Eamon

HOSPITAL NAME

Belconnen Veterinary
Centre

REFERRING VET

Eamon

INVOICE

73228

DATE

1-8-26

PRESENTING CLINICAL SIGNS

reduced appetite 1 month exploratory suspect hepatocellular carcinoma
Abnormal PE/Chem/CBC/UA Results: met screening alkp/alt/ggt elevated markedly

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of thorax and abdomen are provided for review totaling 7 series. One pre-contrast series of the thorax and abdomen, soft tissue algorithm. One pre-contrast series of the thorax, lung algorithm. One pre-contrast series of the thorax and abdomen, bone algorithm. Two post-contrast series of the thorax and abdomen, soft tissue algorithm. Two pre-contrast series of the head, soft tissue & bone algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

THORAX

The trachea and main bronchi are within normal limits.

The sternal, cranial mediastinal, and tracheobronchial lymph nodes are unremarkable.

Sparse subpleural pulmonary hyperattenuating mineral foci are present. The remaining pulmonary parenchyma shows normal attenuation. No pulmonary soft tissue micronodules, nodules, or mass lesions are identified.

The bronchial tree demonstrates normal branching and tapering. Bronchial walls are thin and smooth, with a normal bronchus-to-artery ratio.

The cardiac silhouette and pulmonary vessels are within normal limits. Post-contrast vascular opacification is adequate.

The pleural space, diaphragm, ribs, and thoracic wall are unremarkable.

The thoracic esophagus is unremarkable.

Discrete enthesophyte formation is present at the insertion of the biceps brachii muscle tendons bilaterally.

ABDOMEN

A large, elongated intraluminal filling defect is present within the portal vein, involving the region of the porta hepatis and extending into the intrahepatic portal vein, predominantly progressing toward the left portal vein branch.

The hepatic lymph nodes are enlarged.

The liver is normal in overall size and shape. Scattered small hypoattenuating microcystic areas are diffusely distributed throughout the hepatic parenchyma, likely incidental. No hypoattenuating hepatic nodules or mass lesions are identified.

The remaining abdominal lymph nodes are within normal limits.



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There is moderate dilation of the gallbladder neck and cystic duct, no evidence of radiopaque calculi. The gallbladder contents are predominantly homogeneous and hypoattenuating, with a small amount of more hyperattenuating material in the gravity-dependent portion.

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The spleen is mildly enlarged and demonstrates mildly heterogeneous (“mottled”) contrast enhancement, with a few small hyperattenuating nodules dispersed throughout the parenchyma.

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The kidneys are normal in size, shape, contour, and attenuation on pre- and post-contrast images. The renal pelvises and ureters are within normal limits.

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The urinary bladder is moderately distended with hypoattenuating fluid admixed with contrast medium. Wall thickness is within normal limits.

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The gastrointestinal tract shows normal luminal distension and anatomical distribution.

The colon and rectum contain gas mixed with heterogeneously soft tissue-attenuating fecal material. Wall thickness is normal.

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The pancreas and adrenal glands are within normal limits.

Mild fat stranding is noted in the cranial abdominal serosal fat adjacent to the pancreas. The remaining serosal fat shows normal attenuation.

The prostate and testicles are normal in size, shape, and attenuation.

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Multifocal incomplete and complete bridging vertebral endplate spondylosis deformans is present.

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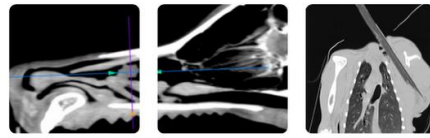
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COMPUTED TOMOGRAPHIC DIAGNOSIS

- Extensive intraluminal filling defect within the portal vein, involving the porta hepatis and extending into the intrahepatic portal system, predominantly affecting the left portal vein branch. Differential diagnoses include portal vein thrombosis, neoplastic thrombus considering the patient's history.
- Enlargement of the hepatic lymph nodes, likely reactive or less likely metastatic.
- Gallbladder neck and cystic duct dilation with gravity-dependent inspissated bile, consider cholangiohepatitis, cholangiectasis.
- Mild splenomegaly with heterogeneous enhancement and small hyperattenuating nodules. Differential diagnoses include incidental finding correlate to anesthesia, extramedullary hematopoiesis, lymphoid hyperplasia, immune-mediated disease, or infiltrative neoplasia.
- Mild focal cranial abdominal fat stranding adjacent to the pancreas, which may represent transudate, early peritonitis or early pancreatitis.
- Sparse pulmonary osteomas are noted. No evidence of pulmonary or mediastinal metastatic disease.
- Incidental findings: bilateral biceps brachii enthesopathy and multifocal vertebral spondylosis deformans.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most relevant tomographic abnormality is a large, elongated intraluminal filling defect within the portal vein, extending from the porta hepatis into the intrahepatic portal system, predominantly involving the left portal vein branch. These findings are most consistent with portal vein thrombosis, possibly associated with neoplastic thrombosis given the patient's clinical history. Considering the



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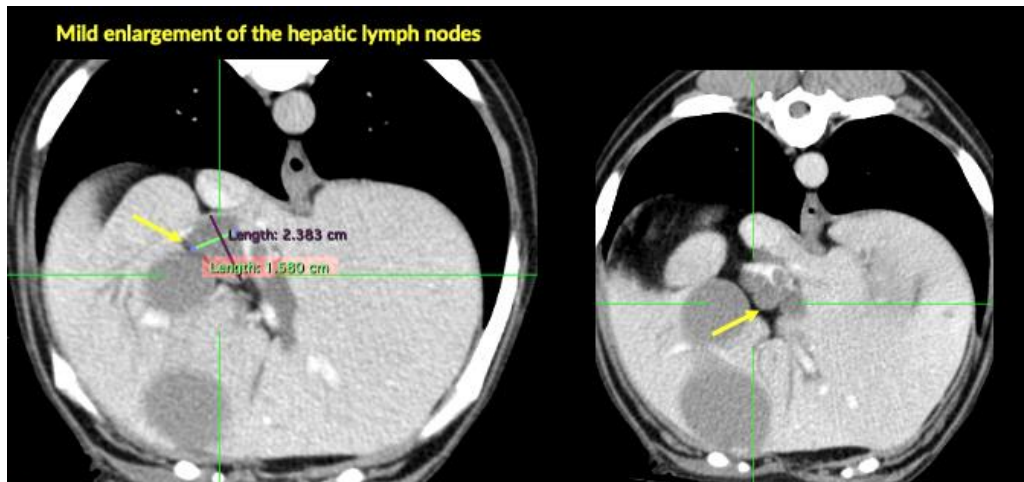
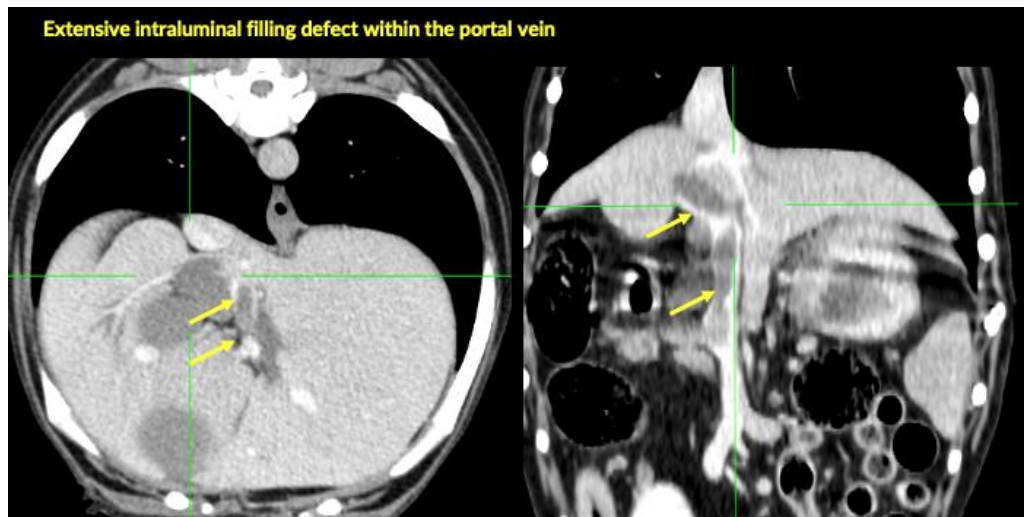
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marked elevation of hepatobiliary enzymes, an underlying hepatopathy and/or a prothrombotic condition should be considered.

No discrete hepatic mass lesion is identified on CT; however, the presence of portal vein thrombosis and mild enlargement of the hepatic lymph nodes may be secondary to inflammatory, infiltrative, or neoplastic hepatic disease not forming a focal mass.

In the thorax, sparse pulmonary osteomas are noted, no evidence of pulmonary or mediastinal metastatic disease.





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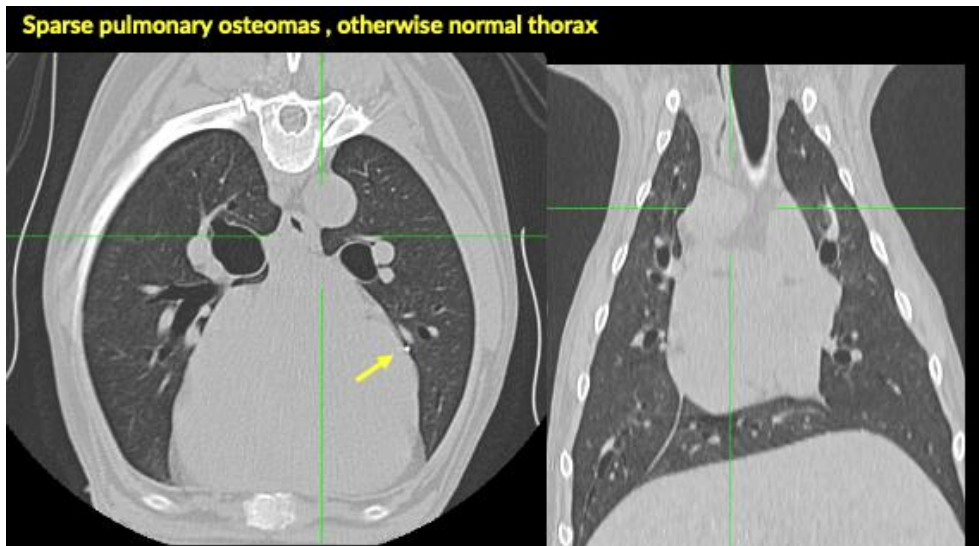
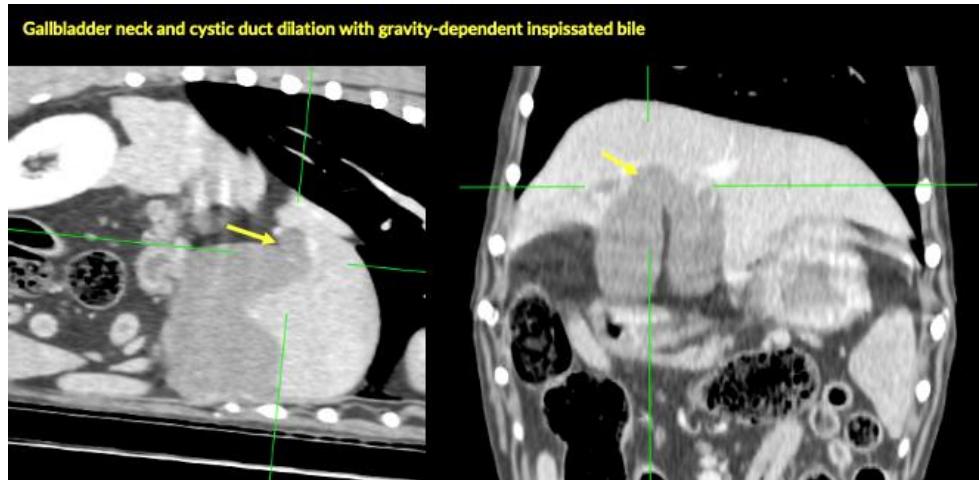
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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