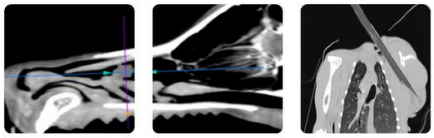


PATIENT

Sora Pham

SPECIES

Canine

BREED

Pitbull

SEX

Female Spayed

AGE

10Y

WEIGHT

23.1kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Laila Soliman, Kassidy Rubes

HOSPITAL NAME

Neel Veterinary Hospital

REFERRING VET

Dr. Alyson Fryer

INVOICE

73947

DATE

2-26-26

PRESENTING CLINICAL SIGNS

- Sora is a patient presenting with a 48-hour history of constipation, vomiting, and hematochezia. Previous veterinary examination on February 13th revealed a large abdominal mass without further diagnostic workup. Client has referral for ultrasound examination. Discussion regarding treatment options included symptomatic care and hospitalization, with ultrasound scheduling available for the following day.
- ABD ultrasound was done that showed a splenic masses and possible nodules of the liver.

Abnormal PE/Chem/CBC/UA Results: Decreased RBC, Hematocrit, hemoglobin, MCV, MCH, lymphocytes, platelets Increased RDW, Monocytes, MPV

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

Pre- and post-contrast computed tomographic examination of the thorax and abdomen. Two series were acquired: one pre-contrast (bone algorithm) and one delayed post-contrast (bone algorithm).

COMPUTED TOMOGRAPHIC FINDINGS

ABDOMEN

There is an extremely large, multilobulated soft tissue mass occupying the mid-abdomen, extending bilaterally within the abdominal cavity. The mass appears contiguous with the body and tail of the spleen. It measures approximately 15 × 12 × 8 cm in its largest component and 5.3 × 7.1 cm in a more caudal component. The lesion demonstrates heterogeneous contrast enhancement with multiple internal hypoattenuating cavitary/cystic regions.

The mass is slightly right sided in predominance and produces marked mass effect with displacement of adjacent organs. The stomach, cecum, ascending colon, transverse colon, and descending colon are displaced. Both kidneys are dorsally displaced, more pronounced on the right.

The interface between the mass and the liver is partially effaced in a focal region out of the collimation; however, in most areas, the splenic mass is distinguishable from the liver by intervening abdominal structures (stomach, pancreas, transverse colon), supporting primary splenic origin.

The liver is diffusely enlarged with predominantly regular margins. Mild bulging of the right medial liver lobe is present. Hepatic parenchymal enhancement is predominantly homogeneous on delayed-phase imaging. No discrete hypoattenuating hepatic nodules are definitively identified on this study.

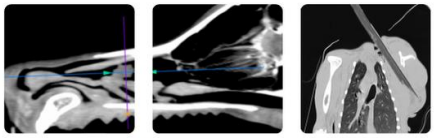
The gallbladder contains homogeneous hypoattenuating fluid with mild gravity-dependent mineral material (consistent with tiny cholelithiasis). The common bile duct is unremarkable.

The gastrointestinal tract is displaced secondary to mass effect but maintains normal wall thickness and luminal distension.

Moderate heterogeneous fecal material is present within the descending colon and rectum, no evidence of mural mass effect.

No significant abdominal lymphadenomegaly is identified.

The kidneys are normal in size, shape, and attenuation. The renal pelves and ureters are unremarkable.



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

The pancreas and adrenal glands are unremarkable.

THORAX

The trachea and mainstem bronchi are within normal limits.

The pulmonary parenchyma demonstrates normal attenuation. No pulmonary soft tissue nodules or masses are identified. Multiple small hyperattenuating mineral foci are present within the subpleural pulmonary parenchyma, consistent with incidental mineralization. Discrete atelectasis parenchymal bands.

The bronchial tree demonstrates normal branching and tapering. Bronchial walls are thin and smooth. The bronchus-to-artery ratio is within normal limits.

The cardiac silhouette and pulmonary vasculature are within normal limits, considering reduced contrast conspicuity.

The sternal, cranial mediastinal, and tracheobronchial lymph nodes are within normal limits.

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

Multifocal complete and incomplete bridging spondylosis deformans is noted affecting multiple thoracic, thoracolumbar, and lumbosacral vertebral endplates. At L7–S1, the vertebral endplates exhibit a few osteolytic lesions and mild irregularities.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- There is an extremely large multilobulated splenic-associated mass measuring, demonstrating heterogeneous enhancement with cavitary regions and resulting in marked abdominal mass effect and organ displacement. The primary differential diagnosis is a splenic neoplasm, particularly hemangiosarcoma. Hemangioma, other primary splenic sarcomas, lymphoma, or a large splenic hematoma (s) remain differential considerations.
- There is mild diffuse hepatomegaly without discrete hepatic nodules identified on delayed-phase imaging. Differential considerations include reactive or congestive hepatopathy, metabolic or vacuolar hepatopathy, inflammatory disease, or early infiltrative metastatic disease.
- There is no computed tomographic evidence of pulmonary metastatic disease.
- Incidental pulmonary subpleural osteomas are present.
- Multifocal spondylosis deformans is noted as an incidental degenerative finding. At L7–S1, the vertebral endplate irregularities raise concern for early discospondylitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT examination identifies a very large multilobulated mass most consistent with primary splenic origin. Primary differential diagnoses include a splenic neoplasm, such as hemangiosarcoma. Other differential diagnosis includes large hemangioma, or less likely differentials include other primary splenic neoplasms (e.g., sarcoma or lymphoma) or a large splenic hematoma.

No pulmonary or mediastinal metastases are identified.

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The liver appears diffusely enlarged but without discrete nodules on delayed-phase imaging. Small hepatic metastases cannot be completely ruled out due to the suboptimal contrast protocol.

In correlation with the ultrasonographic findings, surgical consultation may be considered for further evaluation and discussion of potential management options, including exploratory laparotomy and splenectomy.

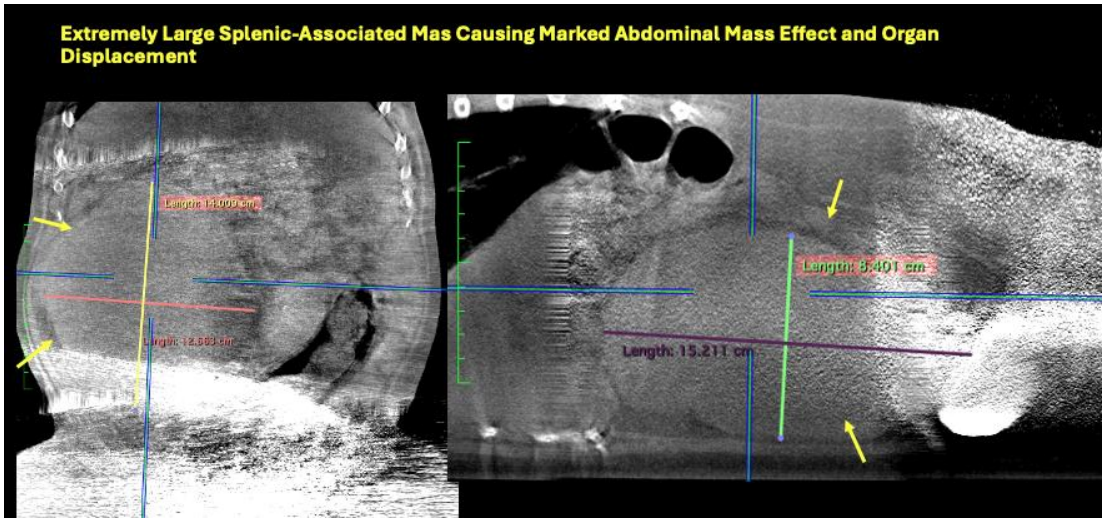
Histopathologic evaluation of the splenic mass is required for a definitive diagnosis.

At L7–S1, the vertebral endplate irregularities raise concern for discospondylitis. Empirical antimicrobial therapy may be considered pending further diagnostic evaluation (e.g., blood and urine cultures), if clinically indicated.

TECHNICAL COMMENTS

The quality of contrast enhancement in the delayed phase is suboptimal, particularly for adequate evaluation of the hepatic parenchyma. Optimal hepatic assessment typically requires a multiphasic (triphasic) contrast-enhanced protocol.

If further characterization is clinically indicated, repetition of the examination using a dedicated multiphasic protocol is recommended. Our Sonopath technical team is available to provide assistance with protocol optimization and technical support, if needed.



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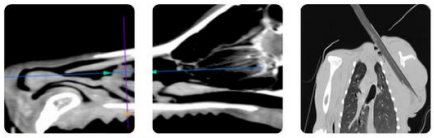

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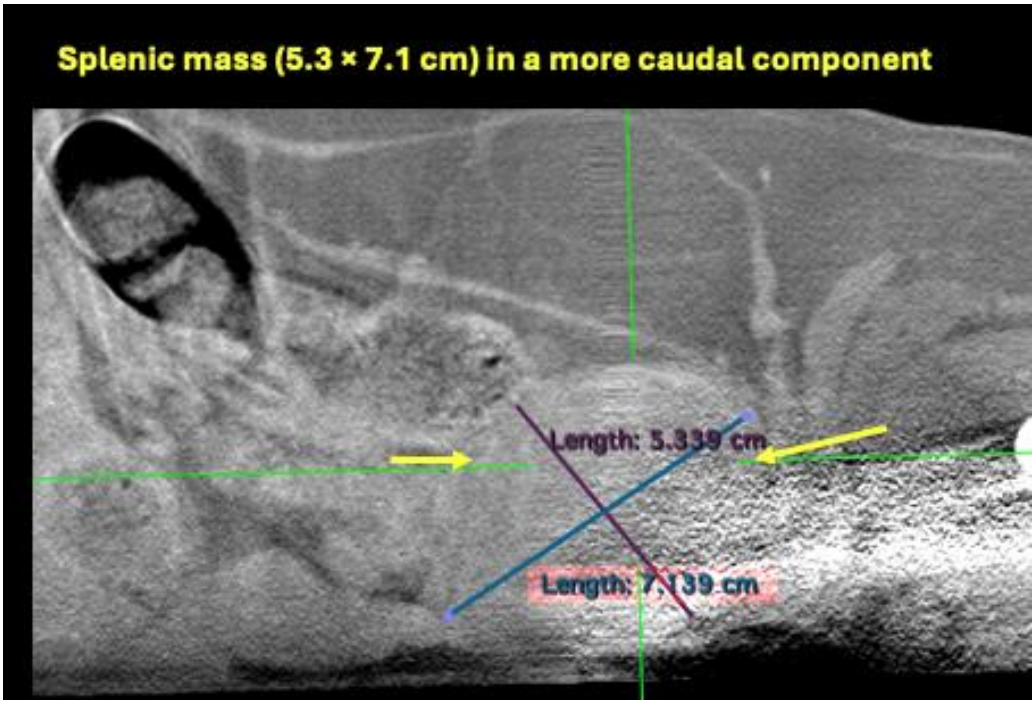

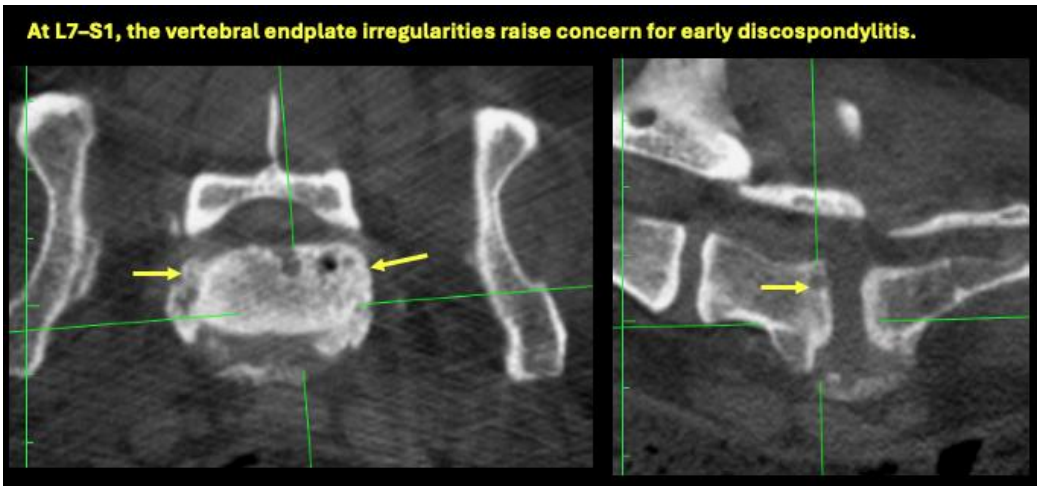

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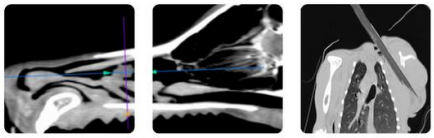

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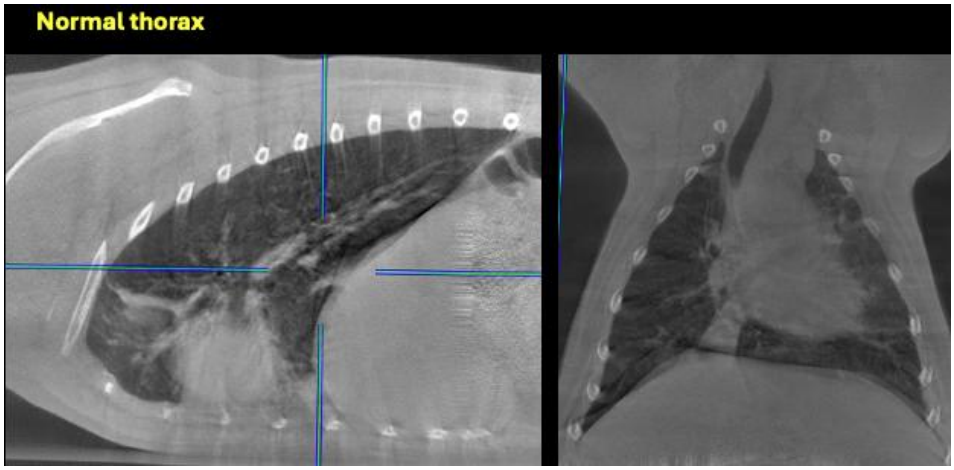

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tilde Rodrigues Froes, DMV, MSc., Dr. Med.Vet., Dipl.CBraRVet
info@sonopath.com