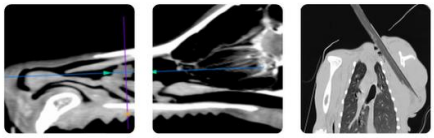


PATIENT

Dusk Cameron

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

9Y, 2M

WEIGHT

10.8lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Laura Baumert

HOSPITAL NAME

Wilson Veterinary Hospital

REFERRING VET

Dr. Vitale

INVOICE

74114

DATE

3-10-26

PRESENTING CLINICAL SIGNS

- Pet presented on 3/6/26 to primary care DVM for acute anorexia. BW revealed mild increase GGT, and x-rays revealed ascites. Pet was transferred here for further diagnostics and supportive care. Abdominal US revealed a liver mass. The ascites was drained, and clin path review was consistent with either an exudate or modified transudate. A CT was advised to gather more information about the liver mass, to assess for surgical feasibility, and to assess for other abdominal pathology.

Abnormal PE/Chem/CBC/UA Results: GGT = 5 Mild neotrophilia

COMPUTED TOMOGRAPHIC STUDY OF THE ABDOMEN

A pre- and post-contrast CT study of the abdomen are provided for review totaling 3 series. One pre-contrast series of the abdomen, soft tissue algorithm. Two post-contrast series of the abdomen, soft tissue algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

ABDOMEN

A large cystic–cavitary lesion is identified primarily involving the right medial hepatic lobe, with suspected extension into the quadrate lobe. The lesion demonstrates a thin irregular peripheral wall; however, the ventral portion of the wall is poorly defined, raising suspicion for partial rupture of the lesion. The lesion measures approximately 4.2 × 4.0 × 3.1 cm.

The lesion closely involves the gallbladder, which is poorly distended and contains hypoattenuating fluid material. A double-wall appearance of the gallbladder is noted. The cystic duct measures approximately 4.6 mm, which is at the upper limit of normal. The common bile duct is partially visualized and appears subjectively within normal limits. No evidence of cholelithiasis is identified.

The remaining hepatic lobes demonstrate homogeneous attenuation and contrast enhancement with preserved contours.

A large intraluminal filling defect is identified within the right branch of the portal vein, which appears tortuous and enlarged. The tributary portal and mesenteric veins are mildly enlarged as a consequence of portal pathway congestion.

There is a marked amount of peritoneal effusion with associated serosal fat stranding.

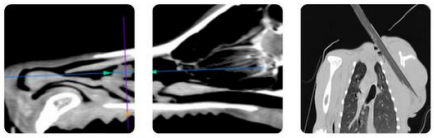
The gastrointestinal tract is normally distended but displaced by the peritoneal fluid. No evidence of a large mural mass effect or severe mural thickening is identified.

The colon and rectum contain gas admixed with heterogeneously soft tissue attenuating fecal material with normal wall thickness.

The mesenteric abdominal lymph nodes are more conspicuous due to the surrounding peritoneal effusion; however, there is no evidence of significant enlargement or mass effect.

The retroperitoneal and medial iliac lymph nodes are unremarkable.

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



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The urinary bladder is mildly distended with homogeneously hypoattenuating fluid material admixed with contrast medium. The urinary bladder wall is mildly and diffusely thickened.

The spleen is homogeneous in attenuation and contrast enhancement, with normal size and shape.

The pancreas and adrenal glands are within normal limits.

Multifocal degenerative changes are observed in the vertebral column, including complete bridging spondylosis deformans at T12–T13, L6–L7, and L7–S1. At L6–L7, an in-situ mineralized intervertebral disc is noted. The adjacent vertebral endplates appear mildly irregular with small osteolytic foci.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- A large cystic–cavitary lesion centered in the right medial hepatic lobe with probable involvement of the quadrate lobe and suspected partial rupture. Differential diagnoses include necrotic or cystic hepatic neoplasm, less likely complicated hepatic cyst, large hepatic hematoma or abscess.
- There is an intraluminal filling defect within the right branch of the portal vein consistent with portal vein thrombosis, associated with enlargement of the portal and mesenteric tributaries suggesting acquired portal hypertension.
- A marked amount of peritoneal effusion is present. Differential diagnoses include exudate, modified transudate. Possible causes, secondary to hepatic rupture or inflammation associated with the hepatic lesion and/or portal hypertension (Budd-Chiari like syndrome)
- The gallbladder demonstrates a double-wall appearance. Differential diagnoses include consequence of peritoneal effusion, cholangitis or edema.
- Mild diffuse urinary bladder wall thickening is present. Differential diagnoses include which may represent cystitis or under distension artifact.
- Multifocal vertebral degenerative changes including spondylosis deformans and disc mineralization are also noted.
- At L7-S1, due the presence of vertebral endplates appears mildly irregular with small osteolytic foci, consider incipient discospondylitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The tomographic findings identify a large cystic–cavitary lesion centered in the right medial hepatic lobe, with probable involvement of the quadrate lobe and suspected partial rupture. The morphology and location of the lesion raise primary concern for a necrotic or cystic hepatic neoplasm. However, non-neoplastic etiologies such as a complicated hepatic cyst, hepatic hematoma, or hepatic abscess cannot be completely excluded based on imaging alone.

Additionally, an intraluminal filling defect is identified within the right branch of the portal vein, consistent with portal vein thrombosis (or tumor invasion). The associated enlargement of the portal and mesenteric tributaries supports the presence of acquired portal hypertension. This vascular alteration likely contributes to the marked peritoneal effusion observed in the abdomen.

The presence of a large volume of peritoneal effusion, together with the suspected partial rupture of the hepatic lesion, suggests that the effusion may represent an exudate or modified transudate secondary to hepatic rupture, inflammation associated with the hepatic lesion, and/or portal hypertension, potentially resulting in a Budd–Chiari–like syndrome.

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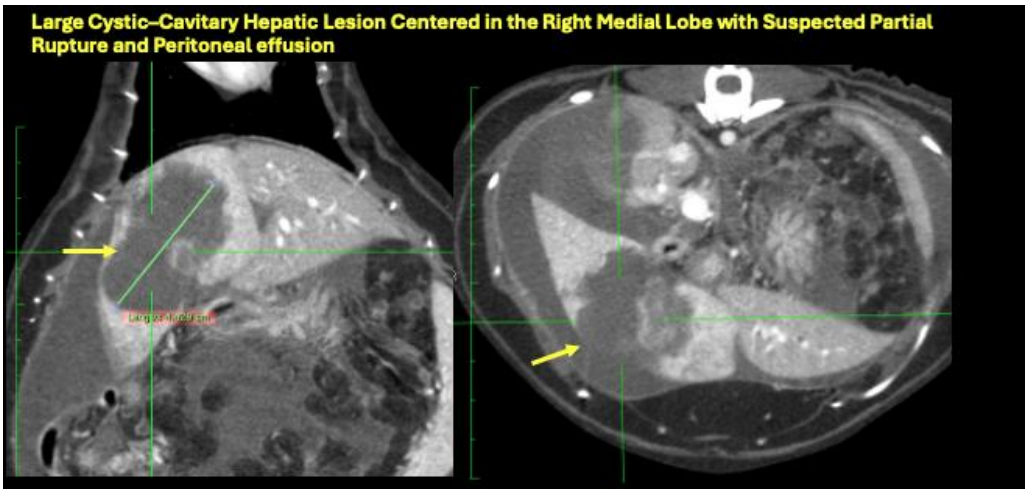
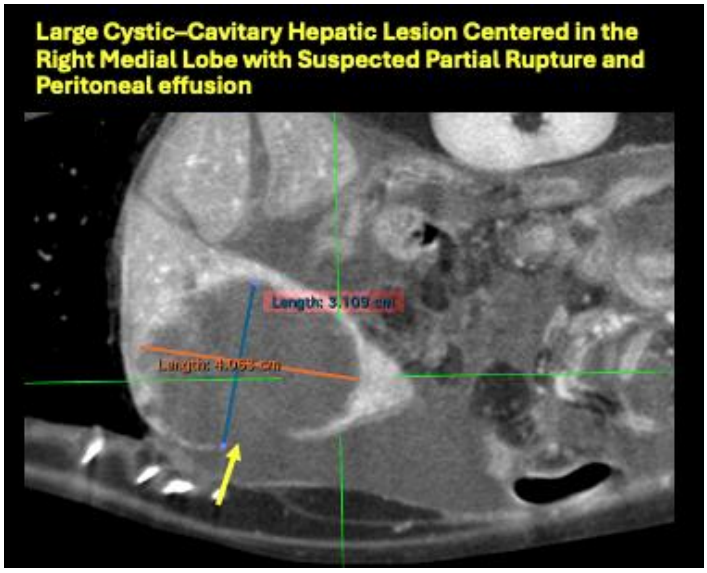
The gallbladder demonstrates a double-wall appearance, which may represent reactive changes secondary to peritoneal effusion, cholangitis, or gallbladder wall edema. Considering the adjacent hepatic lesion and the presence of marked peritoneal effusion, gallbladder rupture cannot be completely excluded.

Surgical consultation is recommended. Despite the severity of the condition and the presence of vascular involvement, the hepatic lesion appears to be predominantly centered within the right medial and/or quadrate lobes, which may allow for potential surgical management, including hepatic lobectomy. This consideration is particularly relevant given the suspicion of lesion rupture or underlying neoplasia. However, the case is complicated by the presence of portal vascular thrombosis and possible gallbladder involvement, which may increase surgical complexity.





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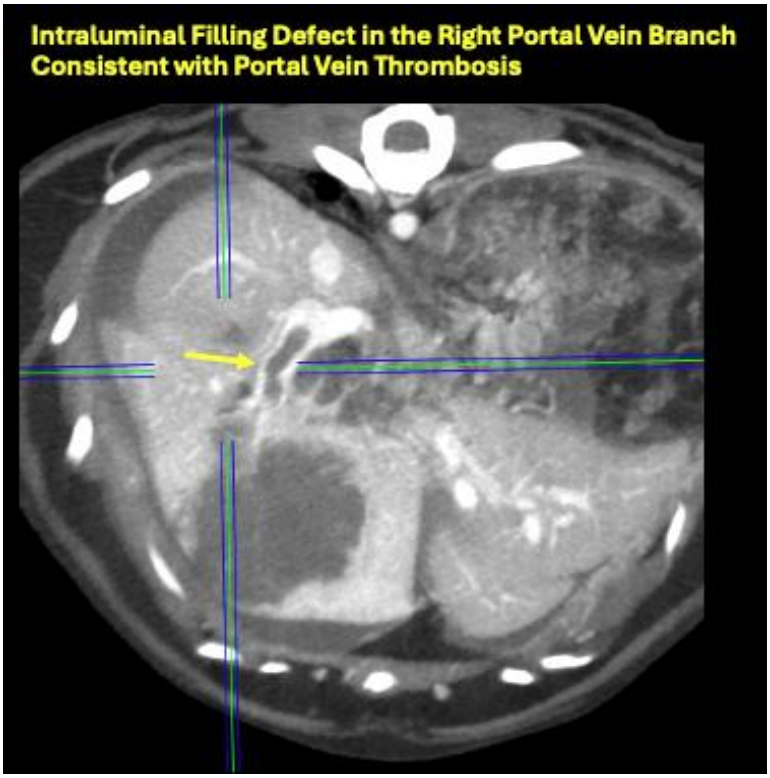

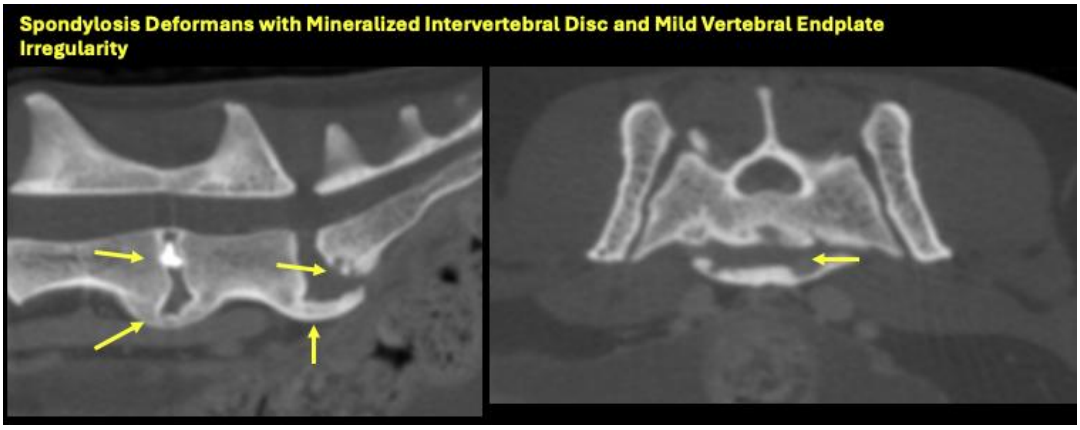

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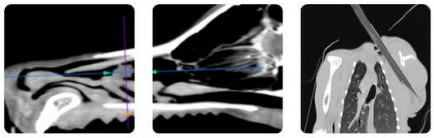

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Educational Teleconsultation Services™

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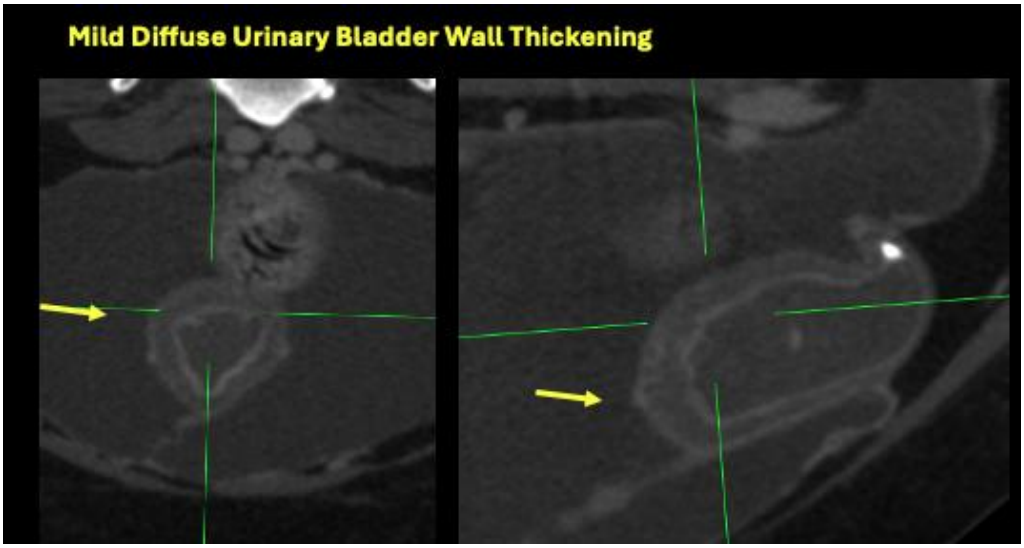

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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