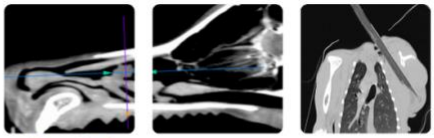


PATIENT

Buster Southwell

SPECIES

Canine

BREED

Cane Corso Mix

SEX

Neutered Male

AGE

12

WEIGHT

57

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Eamon

HOSPITAL NAME

Belconnon Veterinary Centre

REFERRING VET

Dr. Eamon

INVOICE

14045

DATE

03/03/26

PRESENTING CLINICAL SIGNS

- splenic mass

Abnormal PE/Chem/CBC/UA Results: anemia chem WNL

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of thorax and abdomen are provided for review totaling 6 series. One pre-contrast series of the whole-body, soft tissue algorithm. One pre-contrast series of the whole-body, bone algorithm. One pre-contrast series of the thorax, lung algorithm. One post-contrast series of the whole-body, soft tissue algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

ABDOMEN

An extremely large mixed hypoattenuating mass is identified arising from the splenic body and tail, occupying a large portion of the left abdomen and extending into the retroperitoneal region. The lesion markedly distorts the splenic capsule and measures at least 18.8 × 15.8 × 15.7 cm.

Between the mass and the splenic head there is a linear hypoattenuating interface with focal subcapsular fluid accumulation. This splenic parenchyma portion demonstrates diffusely reduced contrast enhancement.

Mild gravity-dependent peritoneal effusion is present within the abdomen. Serosal fat stranding is observed adjacent to the splenic mass.

A small hypoattenuating cystic lesion is present along the margin of the left medial hepatic lobe, measuring approximately 1.2 cm in diameter. The remaining hepatic parenchyma is homogeneous and demonstrates uniform contrast enhancement with overall normal hepatic size and shape.

The gallbladder is distended and contains predominantly hypoattenuating content with a small amount of gravity-dependent hyperattenuating material. The cystic duct and common bile duct are within normal limits.

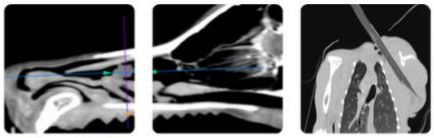
The stomach is mildly distended with heterogeneous hypoattenuating ingesta and gas. No mural thickening or mass effect is identified.

The small intestines demonstrate normal luminal distension and normal wall thickness; however, they are displaced caudally and peripherally secondary to mass effect from the splenic lesion.

The transverse and ascending colon are displaced caudally and dorsally secondary to mass effect from the splenic lesion. The colon contains a moderate volume of heterogeneous fecal material without mural abnormalities.

A 0.4 cm cortical hypoattenuating microcyst is identified in the left kidney, considered incidental. The kidneys are otherwise normal in size, shape, and attenuation before and after contrast administration. The renal pelvis and ureters are within normal limits.

One hepatic lymph node is mildly enlarged, measuring approximately 1.4 cm. The remaining abdominal lymph nodes are within normal limits.



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The pancreas and adrenal glands are unremarkable.

The urinary bladder is moderately distended with homogeneously hypoattenuating fluid and demonstrates normal wall thickness.

The prostate is within normal limits.

At least three small subcutaneous nodules/micronodules are identified within the right flank region, the largest measuring approximately 1.4 cm.

THORAX

The trachea and main bronchi are within normal limits.

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

Multiple subpleural hyperattenuating foci, some with mineral attenuation, are present within the pulmonary parenchyma.

A small incidental pulmonary bulla measuring approximately 0.5 cm is identified in the ventral aspect of the right cranial lung lobe.

The remaining pulmonary parenchyma demonstrates normal attenuation with no evidence of pulmonary nodules, micronodules, or masses.

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 vasculature are within normal limits, with adequate contrast opacification.

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

The caudal thoracic esophagus is mildly dilated with gas. A small rounded heterogeneous intraluminal structure measuring approximately 1.4 cm is present. The structure partially silhouettes with the esophageal wall, and the interface with the wall is indistinct.

Bilateral elbow osteoarthrosis, likely associated with chronic medial coronoid compartment disease.

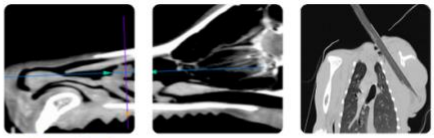
Within the imaged portion of the head, there is a small hypoattenuating lesion in the region of the left tympanic membrane, measuring approximately 0.5 × 0.4 cm.

COMPUTED TOMOGRAPHIC DIAGNOSIS

Extremely large splenic mass arising from the splenic body and tail with marked abdominal mass effect and mild associated peritoneal effusion. Differential diagnoses include neoplasia, such as splenic hemangiosarcoma, hemangioma, other primary splenic neoplasia, or less likely large splenic hematoma.

Suspect splenic fracture with mild subcapsular fluid between the splenic mass and head of the spleen.

Mild abdominal effusion and adjacent fat stranding. Differential diagnoses include hemoperitoneum, modified transudate, concurrent reactive inflammatory or metastatic change.



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Mild enlargement of a hepatic lymph node, which may represent reactive lymphadenopathy or possible metastatic involvement.

Small cystic lesion within the left medial hepatic lobe. Primary differential diagnoses include most a benign hepatic cyst, less likely metastatic lesion.

Mild enlargement of sternal lymph nodes, reactive versus metastatic.

Small pulmonary bulla and multiple subpleural mineralized foci, likely incidental changes. No CT evidence of pulmonary metastatic disease.

Mild esophageal dilation with an intraluminal heterogeneous structure, differential diagnoses include ingesta, small non-obstructive foreign material, or less likely an esophageal mural lesion.

Incidental renal cortical microcyst (left kidney).

Bilateral elbow osteoarthrosis.

Multiple small flank subcutaneous nodules and micronodules, differential diagnoses include benign cutaneous nodules (e.g., granuloma, sebaceous adenoma) or less likely metastatic lesions.

Small hypoattenuating lesion adjacent to the left tympanic membrane, possibly representing mild fluid accumulation, tympanic membrane inflammatory polypoid lesion, or early otitis media.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT examination demonstrates a very large splenic mass arising from the splenic body and tail, with marked abdominal displacement of adjacent organs, possible splenic capsular rupture/fracture, subcapsular fluid accumulation, and mild associated abdominal effusion. The imaging appearance is highly suspicious for splenic neoplasia, with hemangiosarcoma considered the primary differential diagnosis. However, benign splenic lesions such as hematoma or hemangioma cannot be excluded based on imaging alone.

The mild abdominal effusion and adjacent fat stranding may represent early hemorrhage, modified transudate, neoplastic effusion, or reactive inflammatory change. Abdominocentesis is recommended for further characterization.

No definitive pulmonary metastatic disease is identified on CT. However, mild enlargement of the sternal and hepatic lymph nodes warrants consideration of reactive lymphadenopathy versus metastatic involvement.

Surgical consultation for splenectomy is recommended, if clinically appropriate. Histopathological evaluation of the splenic mass is required for a definitive diagnosis.

Additional recommendations include clinical correlation and possible endoscopic evaluation if the esophageal intraluminal structure if clinical signs of dysphagia or regurgitation are present.

Monitoring or sampling of the cutaneous nodules may also be considered if there is clinical concern for metastatic disease.

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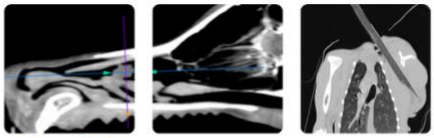

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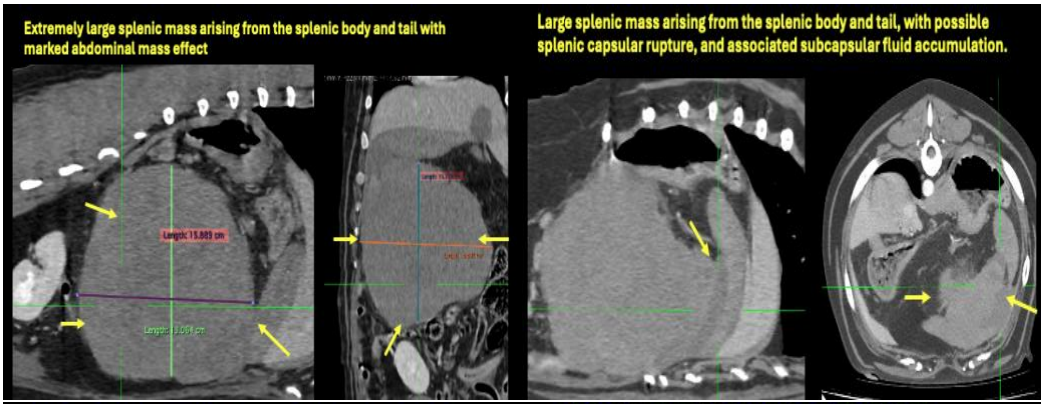

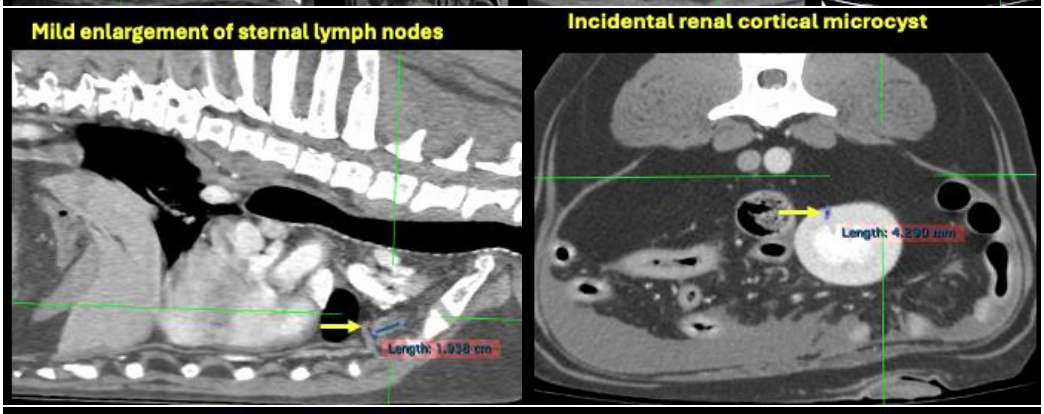

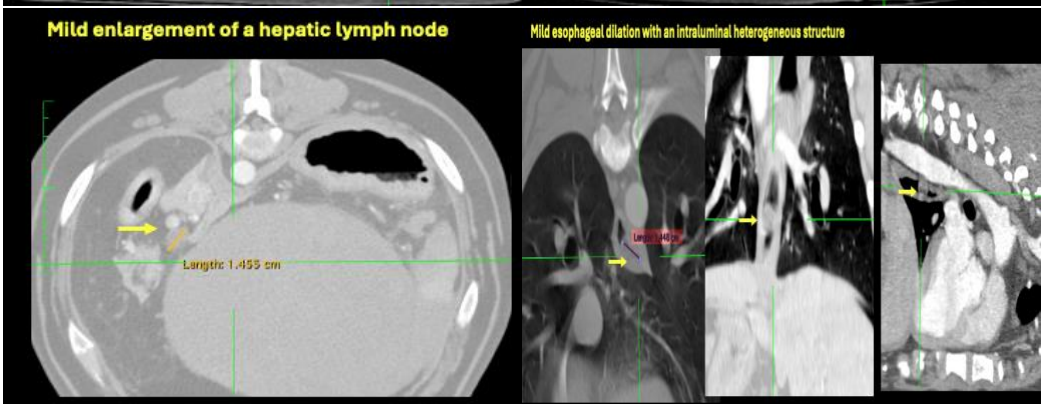

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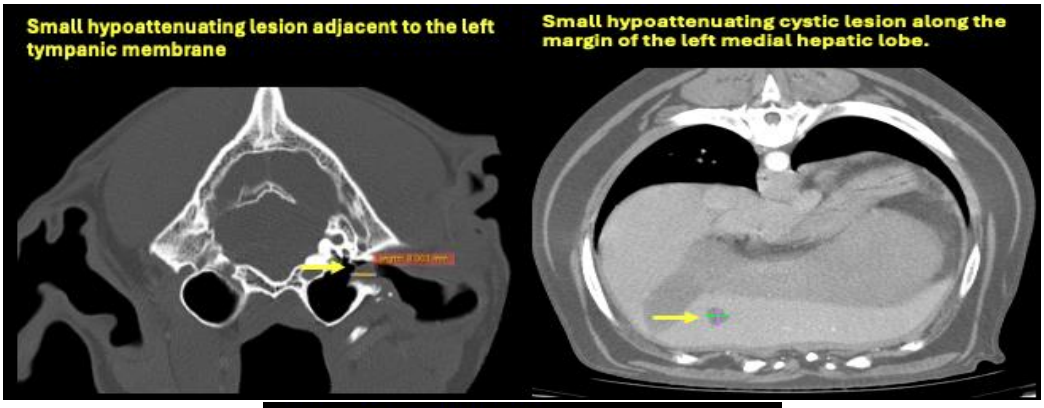

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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