



## PATIENT

Cremita Lugo

## SPECIES

Feline

## BREED

Domestic Longhair

## SEX

NM

## AGE

8Y

## WEIGHT

18.5lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Jose L. Alvarado Bruno,  
CVT - CT Scan Technician

## HOSPITAL NAME

Veterinary Image  
Center

## REFERRING VET

Lionel Ricci, DVM/Irene  
Vazquez, DVM, MS,  
DACVIM (Oncology)

## INVOICE

75027

## DATE

5-18-26

## PRESENTING CLINICAL SIGNS

Patient was referred for CT for large cranial abdominal mass suspected to be originating from liver; r/o neoplasia vs inflammatory vs infectious vs other.

Abnormal PE/Chem/CBC/UA Results: CBC --- mild decreased (5.04), HCT mild decreased (23.6), HGB mild decreased (7.2), WBC mild increased (22.40) CHEM --- ALP mild decreased (10)

## COMPUTED TOMOGRAPHIC STUDY OF THE ABDOMEN

A pre- and post-contrast CT study of the abdomen is provided for review totaling 2 series. One pre-contrast series of the abdomen (soft tissue algorithm). One post-contrast series of the abdomen (soft tissue algorithm).

## COMPUTED TOMOGRAPHIC FINDINGS

The liver is markedly enlarged, with diffusely rounded margins. Occupying the right medial liver lobe and likely involving the gallbladder and possibly a small portion of the right lateral liver lobe, there is a large cavitory cystic mass containing heterogeneous internal septations and a mild contrast-enhancing capsule. The lesion demonstrates focal loss of capsular definition and interruption of the adjacent hepatic contour, consistent with rupture. Due to the poorly defined margins secondary to rupture, precise measurement is difficult; however, the lesion measures at least 8.8 x 7.7 cm in maximal extension.

An additional cavitory cystic lesion is identified in the papillary process of the caudate lobe, measuring approximately 1.5 cm, also exhibiting focal loss of capsular definition suggestive of rupture.

Additional smaller hypoattenuating cystic lesions are identified multifocally throughout the hepatic parenchyma, measuring approximately 0.3–0.5 cm. The hepatic parenchyma also demonstrates mild heterogeneous attenuation with multifocal hypoattenuating regions.

The gallbladder and cystic duct cannot be clearly delineated due to the regional mass effect. The common bile duct is partially identified and appears preserved in the region of insertion in duodenum.

There is a large volume of free abdominal fluid resulting in marked abdominal distension, compatible with peritoneal effusion.

The spleen is mildly enlarged with mildly rounded margins and homogeneous attenuation.

The large hepatic cavitory lesion causes leftward displacement of the stomach and adjacent abdominal viscera. The stomach is otherwise within normal limits.

The intestinal loops are displaced due to the marked abdominal effusion; however, their wall thickness, luminal distension, and distribution are preserved.

The pancreas is within normal limits.

The abdominal lymph nodes and adrenal glands are unremarkable.

The kidneys are within normal size limits; however, there are multifocal mild cortical irregularities and cortical retractions, more pronounced in the left kidney.

The urinary bladder is unremarkable.



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The descending colon is mildly gas distended and contains heterogeneous fecal material, within expected limits.

Mild lumbar and lumbosacral spondylosis deformans.

## COMPUTED TOMOGRAPHIC DIAGNOSIS

- Marked hepatomegaly associated with a large cavitory cystic hepatic mass centered in the right medial liver lobe, likely involving the gallbladder and possibly partially extending into the right lateral liver lobe. The lesion contains heterogeneous internal septations and demonstrates focal capsular discontinuity and loss of hepatic contour, consistent with rupture.
- Additional smaller multifocal hepatic cystic lesions are present, including a ruptured cystic lesion in the papillary process of the caudate lobe. Differential diagnoses for the hepatic lesions include hepatic cystic neoplasia (including biliary cystadenoma/cystadenocarcinoma, cystic hepatic carcinoma, or cholangiocarcinoma), cavitated hepatic neoplasia with hemorrhage or necrosis, complex hepatic cysts, less likely hepatic abscessation.
- Marked abdominal effusion, most likely secondary to rupture of the hepatic cavitory lesions.
- Mild splenomegaly.
- Mild bilateral renal cortical scarring, more pronounced in the left kidney, compatible with chronic renal cortical infarcts or mild degenerative nephropathy.
- No evidence of regional abdominal lymphadenomegaly or obvious metastatic disease within the scanned regions.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The tomographic findings reveal severe cystic cavitory hepatic disease, characterized by a large ruptured cavitory lesion involving the right medial liver lobe and likely the gallbladder region, associated with marked abdominal effusion. Additional smaller cystic hepatic lesions are also present, including another possible ruptured lesion within the papillary process of the caudate lobe.

The primary differential diagnoses include cystic hepatic neoplasia with rupture, cavitated hepatic neoplasia with hemorrhage or necrosis, complex hepatic cysts, less likely hepatic abscessation.

Given the evidence of rupture and extensive abdominal effusion, correlation with abdominal fluid analysis (cytology and biochemical analysis) is recommended.

Surgical consultation is advised; however, resection carries high risk given the lesion size, location, extent of involvement, and evidence of rupture.

Histopathological confirmation is essential.



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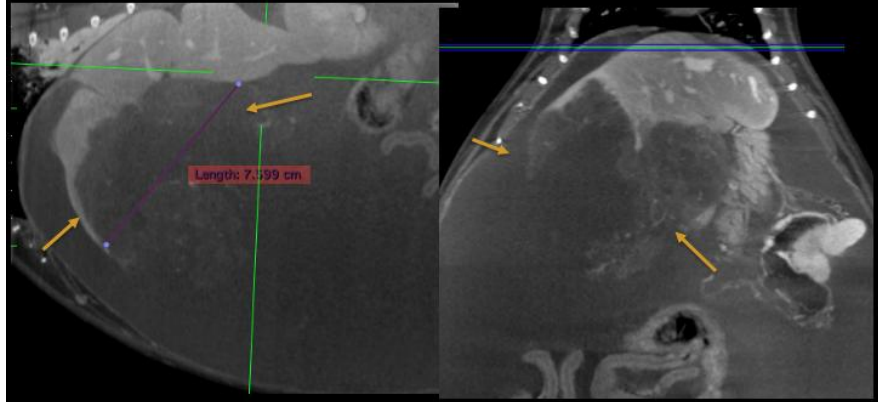
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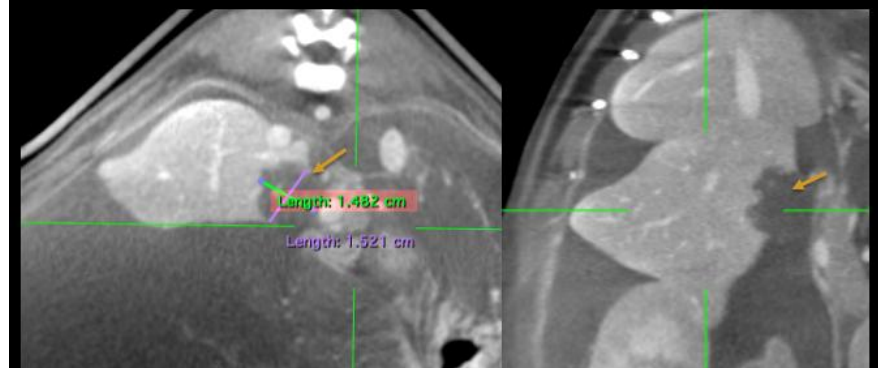
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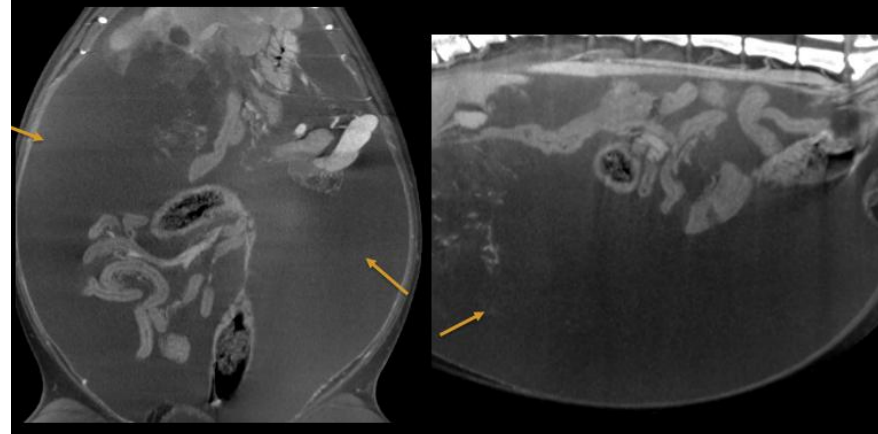
**Fig. 1. Marked hepatomegaly with a large cavitory cystic mass centered in the right medial liver lobe containing internal septations and capsular disruption consistent with rupture.**



**Fig. 2. Small cavitory cystic lesion within the papillary process of the caudate lobe with focal capsular discontinuity suggestive of rupture.**



**Fig. 3. Large volume peritoneal effusion causing marked abdominal distension and displacement of abdominal viscera.**





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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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