



**PATIENT**

Cole Jensen

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

7.8 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Amanda Stewart

**HOSPITAL NAME**

Bronte Village Animal  
 Hospital

**REFERRING VET**

Dr. Lowrey

**INVOICE**

72373

**DATE**

1/22/26

**PRESENTING CLINICAL SIGNS**

Last full exam done 9-18-25. Poorly regulated Diabetes Mellitus - Indicated by the blood glucose curve which showed persistent hyperglycemia throughout the day despite insulin administration.. Moderate generalized dental tartar - Noted on physical examination. Abdominal distension - Palpation was difficult due to the large size of the abdomen.

Current Medications - Prozinc insulin.

Abnormal PE/Chem/CBC/UA Results: See attached BW Primary Question to Be Answered in This Exam assess the pancreas and rule out concurrent inflammatory bowel disease.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.4 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.3 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

The right adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.32 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

**Liver**

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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**Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

*\*This change is diffusely significant but most prominent in the right limb where there is an almost coarse/nodular appearance to the pancreas.*

**Free Abdomen**

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

**ULTRASONOGRAPHIC FINDINGS**

- Chronic low-grade smoldering pancreatitis is suspected. Concurrent pancreatic nodular hyperplasia can't be ruled out. Infiltrative neoplasia affecting primarily the right limb of the pancreas can't be ruled out but is thought less likely.
- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling. *\*This change is very subtle and could be in large part normal patient variant in a senior cat.*
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the changes noted above, chronic low-grade smoldering pancreatitis could be making regulation of the diabetes mellitus difficult or challenging. Having said that, further recommendations are largely dependent on clinical signs versus a blood glucose curve, as the provided lab work and Fructosamine indicate fair control, and especially in-house glucose curves can be falsely affected by stress. If regulation is poor based on clinical signs, placement of a freestyle libre sensor could be considered. Additionally, a fine needle aspirate of the pancreas could be considered if patient's coagulation status is appropriate. Otherwise, based on patient's physical exam findings, weight loss may further aid control.



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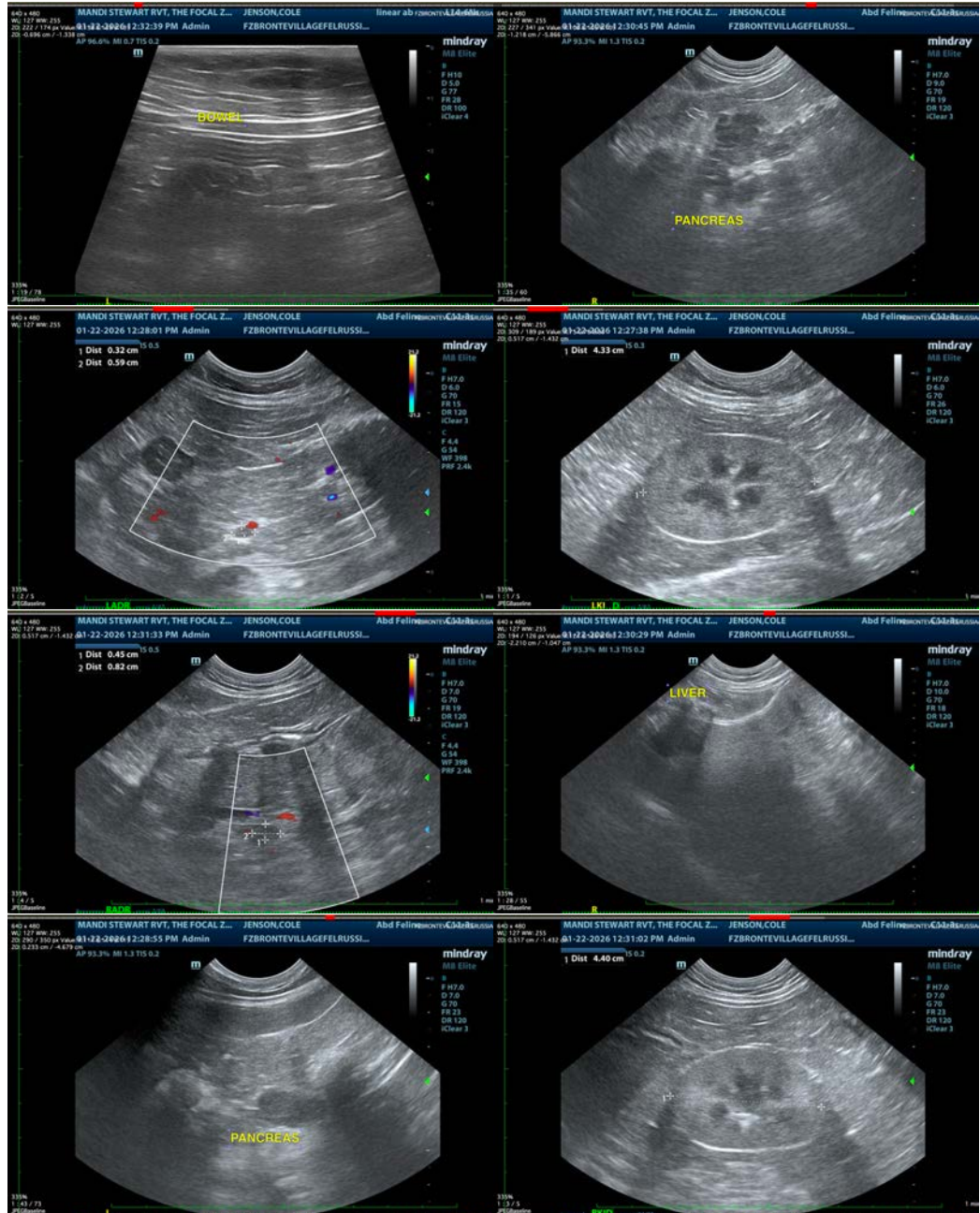
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM** info@sonopath.com