



## PATIENT

Moco Muldowney

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

12 Years

## WEIGHT

11 Pounds

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Julia Bakker, DVM

## HOSPITAL NAME

Orange Blossom VI

## REFERRING VET

Molly Caldwell, DVM

## INVOICE

35908

## DATE

12/15/25

## PRESENTING CLINICAL SIGNS

History: Recheck for diabetes mellitus. Owner reports that she increased the Vetsulin to 6 units BID the day before Thanksgiving (Wednesday). He seemed to be doing well initially, but now she is noticing increased urination again. This morning, the litterbox had a large amount of urine. Appetite and water intake have remained increased. Bowel movements are normal. No coughing, sneezing, vomiting, or ocular/nasal discharge. The owner's primary concern today is the staggering in his back legs. She had hoped it would resolve as he adjusted to the insulin, but it has persisted. Moco is currently on Royal Canin Glycobalance (PD) wet and PR dry food. Owner is attempting some weight loss by decreasing the amount of dry food offered. He continues to receive prednisolone once weekly for previous history of IBD.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

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.

Multiple cortical anechoic cysts of various sizes are present in the kidneys. Overall echogenicity is increased (hyperechoic cortex) as the result of acoustic enhancement from the cysts and kidney shape is distorted. Both kidneys measure slightly enlarged due to the presence of multiple cysts. The left kidney measures 5.49 cm. The right kidney measures 5.47 cm. Trace pyelectasia is present bilaterally.

### *Adrenal Glands*

Left adrenal gland is normal in size (0.47 cm at cranial pole and 0.44 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.31 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. Multiple small anechoic cysts are also present in the liver, with a representative cyst measuring approximately 0.6 cm x 0.8 cm in size. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

### *Gastrointestinal*



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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 moderate to severely 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.

### *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

- Polycystic kidneys- Cysts may be inherited or acquired and may be a subclinical incidental finding or the result of chronic degenerative kidney disease. This finding should be interpreted in combination with breed (inherited polycystic renal disease is more common in some breeds including, but not limited to, Persian cats, cairn terriers and bull terriers), laboratory findings and clinical signs.
- Moderate inflammatory bowel disease 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.
- Concurrent chronic low grade smoldering pancreatitis is suspected.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the ultrasound findings described above, chronic low grade smoldering pancreatitis, potentially the concurrent suspected inflammatory bowel disease, and/or even early or emerging chronic kidney disease, could be complicating management of the reported diabetes mellitus. Management of the concurrent diseases may be complicated and a full consultation and/or referral to a veterinary internist may be helpful. In the meantime, if it's possible to further taper prednisone and/or discontinue prednisone, and manage the suspected IBD with diet, cobalamin, other supportive measures, that could be helpful.



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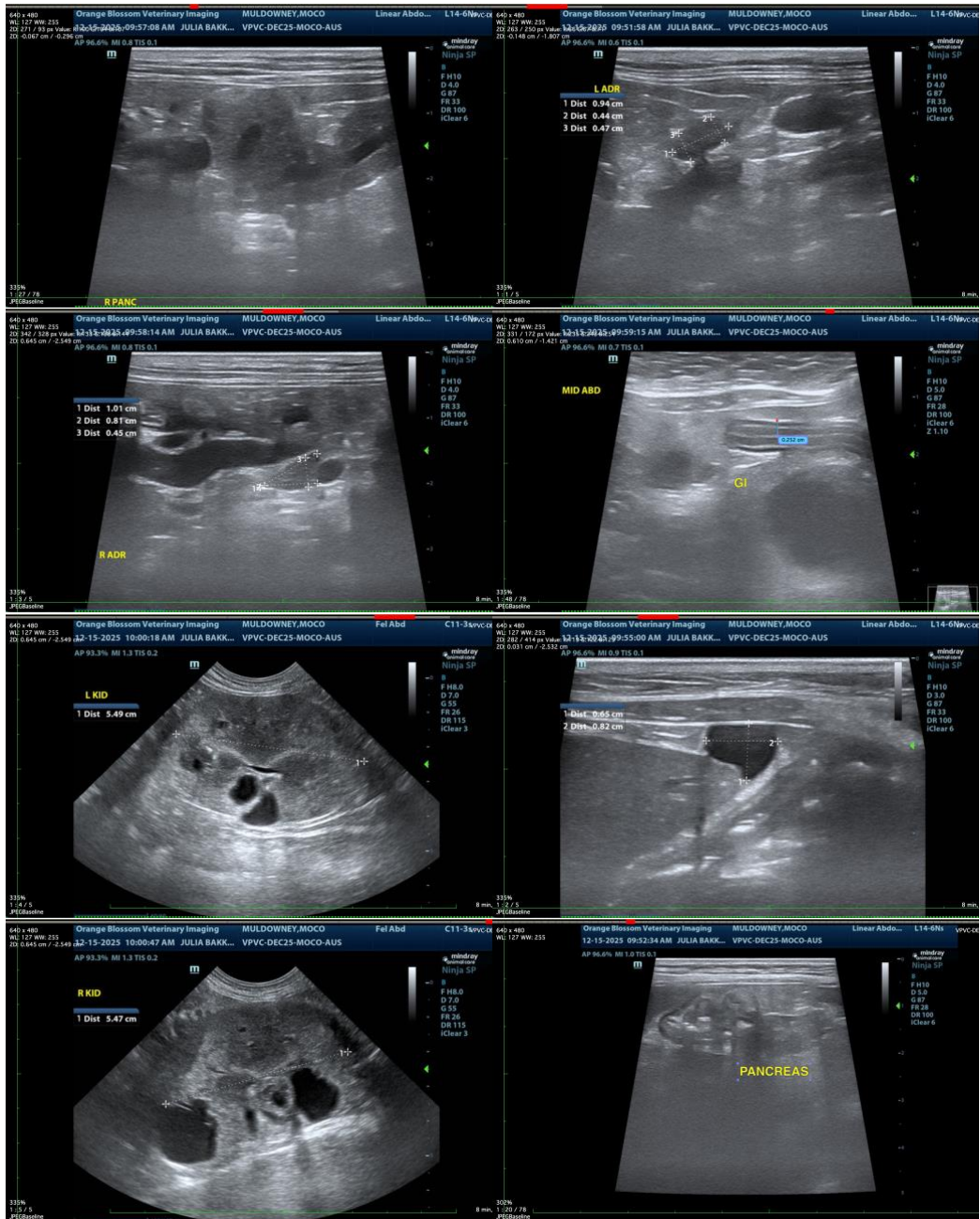
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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info@sonopath.com

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