



PATIENT

Molly Levitz

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

15 Years

WEIGHT

8.8

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Heather Platzer

HOSPITAL NAME

Hershire Animal
Hospital

REFERRING VET

Erika Gallisdorfer,
DVM

INVOICE

72948

DATE

2/12/26

PRESENTING CLINICAL SIGNS

Recently acquired from a neighbor about 2 weeks ago - initially had been transitioning well, isolated to bathroom while acclimating, senior panel bloodwork done 5 days ago - WNL; 4 days ago rapidly decreased in appetite and energy - minimal improvement on cerenia, mirataz and elura; Started having soft stool 24hrs ago

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in right renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 3.3 cm in length. Right kidney measures 3.64 cm in length.

Adrenal Glands

The adrenal glands are not definitively visualized, but the area of the adrenal glands and surrounding vasculature appears normal.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

There are multiple fluid-filled loops of jejunum with some back and forth motion as well as gas shadowing. There is no visible shadowing foreign material. Small intestinal loops are generally thickened with a mildly prominent muscularis layer.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.



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Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Free Abdomen

Ileocolic and mesenteric lymph nodes are prominent and hypoechoic. No free fluid noted.

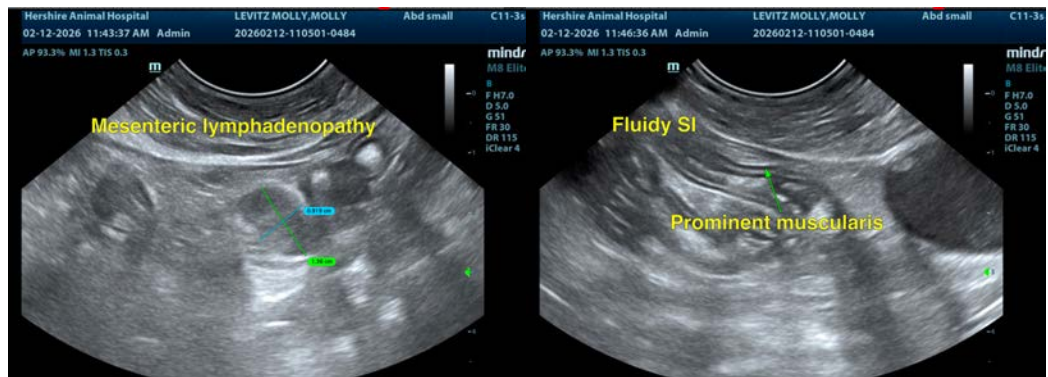
ULTRASONOGRAPHIC FINDINGS

- Gastroenteritis with slightly thickened muscularis layer.
- Degenerative renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

GI changes are consistent with nonobstructive gastroenteritis and in the absence of chronic GI signs, acute gastroenteritis is most likely. While the pancreas appeared sonographically normal, pancreatitis cannot be definitively ruled out. Consideration for dietary indiscretion, food sensitivity/allergy, toxin, infectious (bacterial, viral, parasitic) or mild inflammatory bowel disease is reasonable. Treatment is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition as needed. Antibiotics are generally not warranted. Serial imaging is indicated if clinical signs are not resolving. Current chem/lytes/CBC, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen PCR, and empiric broad spectrum deworming and treatment with probiotics should be considered as clinically warranted. Ultimately GI biopsy may be required for more definitive diagnosis.

Empiric treatment for gastroenteritis includes maintenance of hydration with fluid support and GI support as needed (anti-nausea, appetite stimulant, analgesics if indicated). If initial treatments are unsuccessful, treatment for IBD could be considered which includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, and continued GI support as needed. Treatment with steroids (budesonide vs prednisolone) may be required – biopsies should be acquired prior to treatment with steroids.





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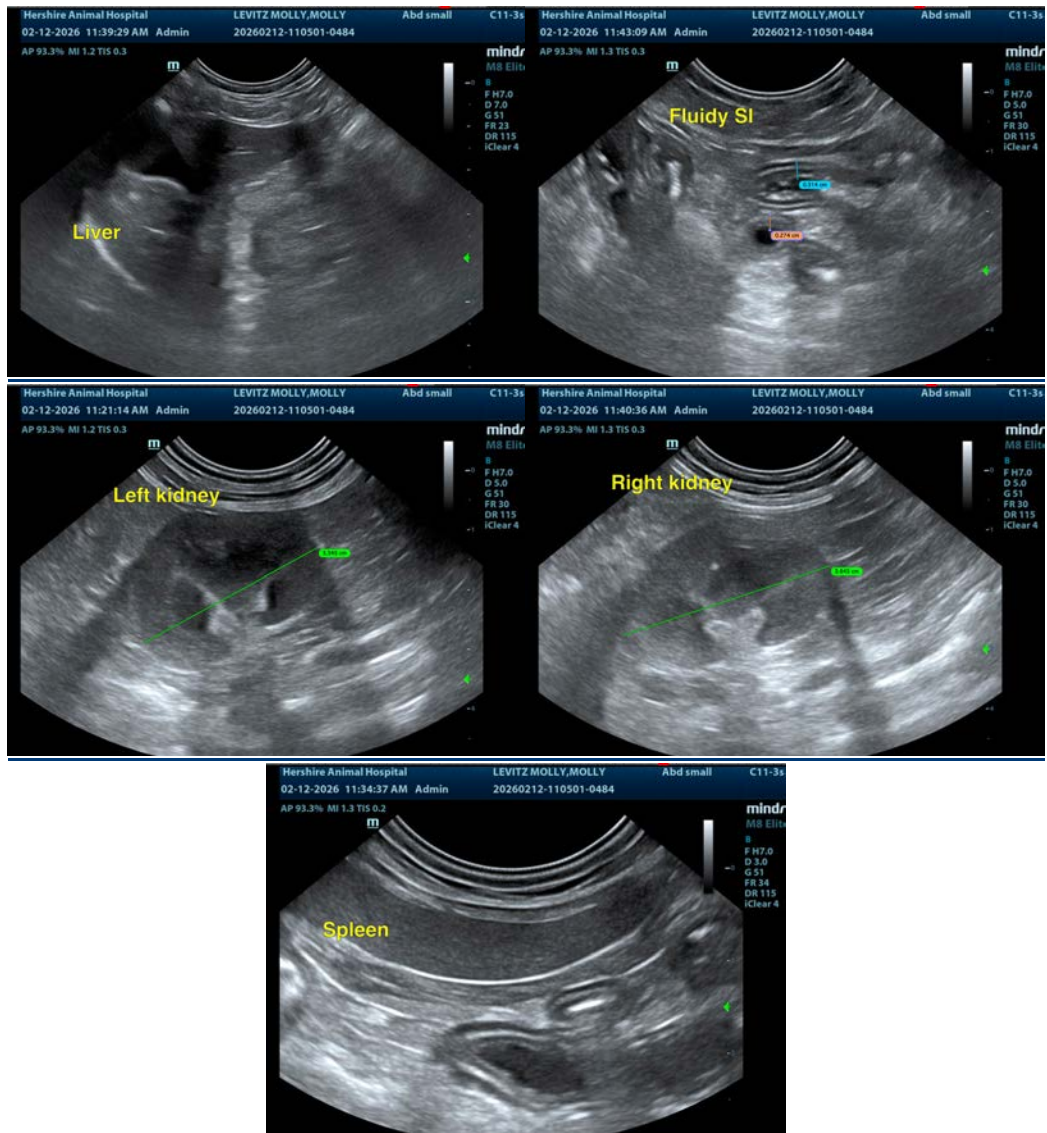
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com