



PATIENT

Apollo Szczepanowski

SPECIES

Canine

BREED

Min Pin

SEX

Neutered Male

AGE

11 Years

WEIGHT

6.1 kg

INTERPRETED BY

Brittany Sinclair DVM,
DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Snelgrove VC

REFERRING VET

Dr. Ioannou

INVOICE

35013

DATE

12/22/25

PRESENTING CLINICAL SIGNS

History: Was here on Friday for supportive care and we sent to the emergency clinic over the weekend QAR Tense abdomen, painful response elicited on cranial abdominal palpation 5% dehydration; slightly tacky MM, absent skin tent Today - Apollo is still vomiting Current Medications Vit B12, Emavert, Comfortan, Provable - all given on Friday

Abnormal PE/Chem/CBC/UA Results: See attached Values Elevated amylase, lipase and CPLI as well as ALKP Radiographic Findings None Primary Question to Be Answered in This Exam Is this just pancreatitis or is there something else going on.

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 were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 4.58 cm in length. The left kidney measured 4.66 cm in length.

Adrenal Glands

The left adrenal gland was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.87 cm in length and 0.42 cm at the cranial pole and 0.49 cm at the caudal pole.

The right adrenal gland is visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. The right adrenal gland measured 1.50 cm in length and 1.11 cm at the cranial pole and 0.49 cm at the caudal pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and 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 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. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended



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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 with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The entire visible pancreas is significantly enlarged and hypoechoic with a somewhat irregular capsular structure. No specific masses, nodules or fluid accumulations were visualized. Surrounding mesentery is severely hyperechoic.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

The mesentery and omentum are diffusely hyperechoic throughout the abdomen, consistent with peritonitis.

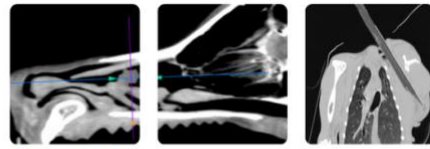
ULTRASONOGRAPHIC FINDINGS

- Severe pancreatitis
- Peritonitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with severe pancreatitis. The prognosis of acute pancreatitis is largely dependent on the severity of clinical signs and response to treatment. Mortality is reported as high as 25% and secondary organ dysfunction and systemic inflammatory response syndrome can occur as inflammation progresses. Ultrasonographically, pancreatic inflammation is severe in this patient. Ultimately the need for hospitalization for treatment is based on the patient's cardiovascular stability, pain and appetite. Hydration and enteral nutrition are key factors in positive outcomes and if these cannot be achieved on an outpatient basis, hospitalization for 24-hour care is strongly recommended.

Treatment for pancreatitis is entirely supportive and involves fluid support, GI support - anti-nausea (ondansetron, cerenia 2mg/kg PO SID), appetite stimulation (mirtazapine, elura), analgesia



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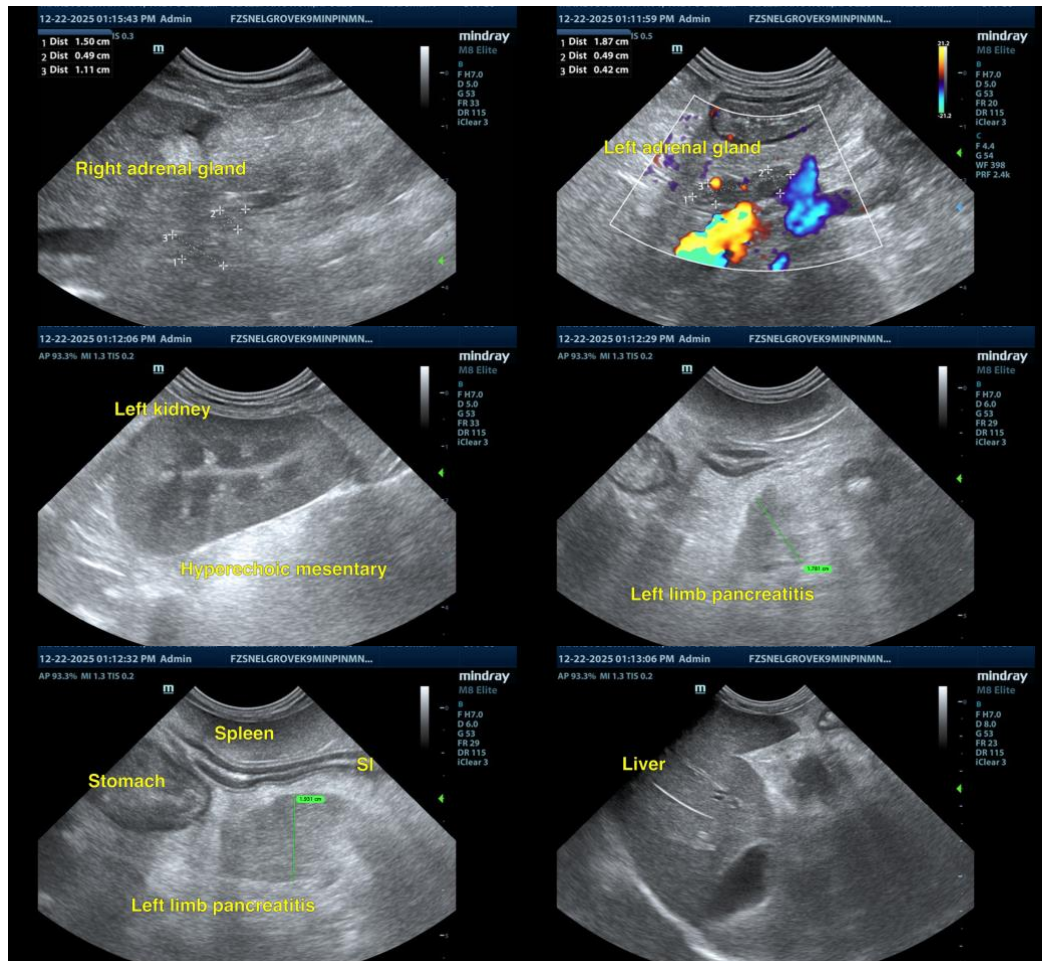
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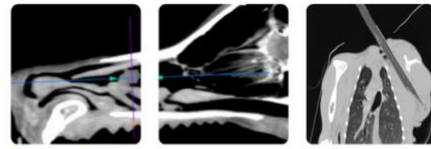
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(buprenorphine, gabapentin) and enteral nutrition as needed (syringe feeding, NG tube placement, etc). Panoquel could be considered if available and deemed clinically warranted. Antibiotics are generally not warranted for acute pancreatitis as it is usually sterile, however given the severity of inflammation, I would use antibiotics (ex unasyn +/- fluoroquinolone) in this case. Intravenous antibiotics are preferred to ensure absorption and decrease GI side effects of oral antibiotics which can lower appetite compromising treatment and recovery. Anti-inflammatory steroids may be tried in an attempt to reduce inflammation if traditional supportive care is inadequate. Serial imaging is indicated to monitor response to treatment.





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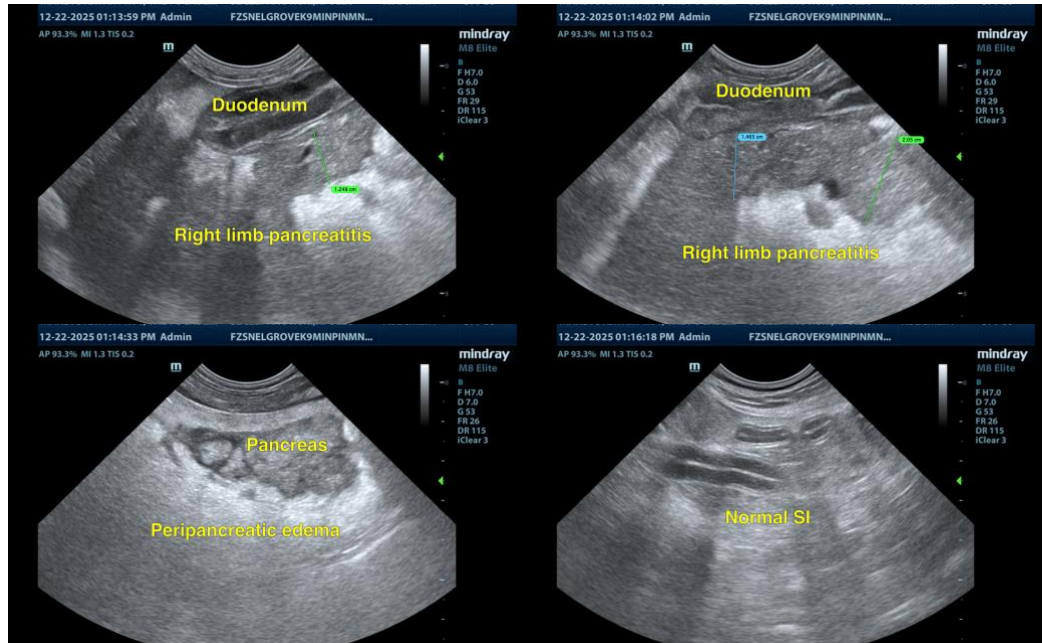
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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