



PATIENT

Kobie Massey

SPECIES

Canine

BREED

Pit Bull Mix

SEX

Spayed Female

AGE

8 Years

WEIGHT

55.6 Pounds

INTERPRETED BY

Brittany Sinclair DVM,
 DACVECC

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

AEC of the High
 Country

REFERRING VET

Dr. Phipps

INVOICE

36379

DATE

3/27/26

PRESENTING CLINICAL SIGNS

- P transferred to ER from rDVM. Ate human multivitamins 2 weeks ago, periodically vomiting since, icteric this morning with red urine, not eating, still drinking
- P very aggressive- Propofol for Ultrasound- painful and waking up when probing pancreas
- On Kepra for seizures
- Abnormal PE/Chem/CBC/UA Results: Glob 4.7, ALT too high to read, ALKP >2000, GGT 41, Tbili 19.3, Chol 501, CPL 226 ALT 1499

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 bladder is significantly distended.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The right kidney measured 6.94 cm in length. Hyperechoic, shadowing foci present in right renal parenchyma and calyces consistent with nephrocalcinosis.

The left kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The left kidney measured 5.48 cm in length. Hyperechoic, shadowing foci present in left renal parenchyma and calyces consistent with nephrocalcinosis.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The left adrenal gland measured 2.66 cm in length and 0.66 cm at the caudal pole and 0.58 cm at the cranial pole. The right adrenal gland measured 2.8 cm in length and 0.70 cm at the caudal pole and 0.64 cm at the cranial pole.

Spleen

The spleen contains a roughly spherical somewhat poorly delineated slightly heterogenous capsular distending nodule, measuring approximately 1.9 cm x 1.6 cm.

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.



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Gall bladder is significantly distended with echogenic amorphous contents. The common bile duct is mildly distended at the level of the duodenal papilla measuring approximately 0.38 cm in diameter. There are no visible lesions or areas of mineralization visualized at the papilla or within the visible common bile duct.

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.

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. 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 visible pancreas was enlarged and somewhat hypoechoic with surrounding hyperechoic mesentery and scant effusion, consistent with peripancreatic peritonitis.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

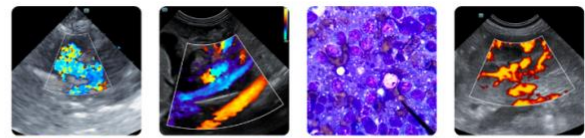
There was scant effusion around the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis with peripancreatic peritonitis
- Gallbladder distention with common bile duct distention to the duodenal papilla, consistent with posthepatic biliary duct obstruction- likely secondary to peripancreatic inflammation.
- Degenerative renal changes with mild nephrocalcinosis
- Distended urinary bladder

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.



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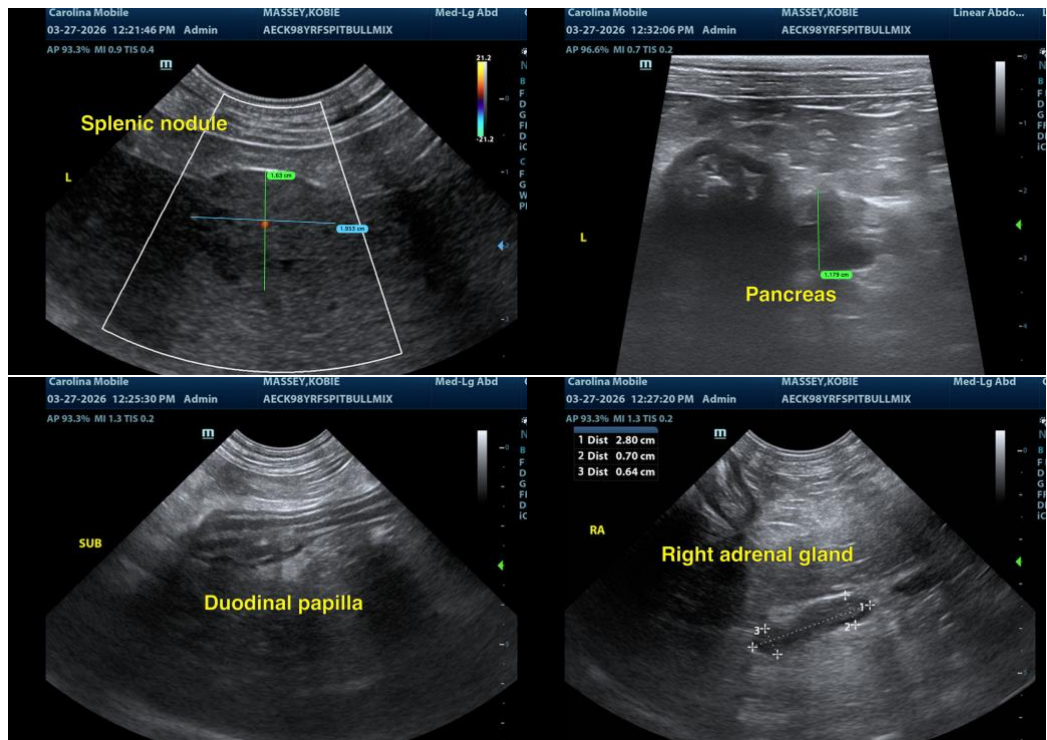
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The severity of inflammation around the duodenal papilla appears to be causing a posthepatic biliary duct obstruction. Abdominal explore with plan for stenting of the duodenal papilla to relieve obstruction should be considered. This procedure is not without significant perioperative morbidity and mortality, and aggressive treatment for severe pancreatitis with careful monitoring of blood work for worsening of liver values, as well as serial AFAST examinations to monitor for development of worsening abdominal effusion could alternatively be considered.

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 (buprenorphine, gabapentin) and enteral nutrition as needed (syringe feeding, NG tube placement, etc.). Panoquell 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 and concurrent posthepatic biliary duct obstruction, 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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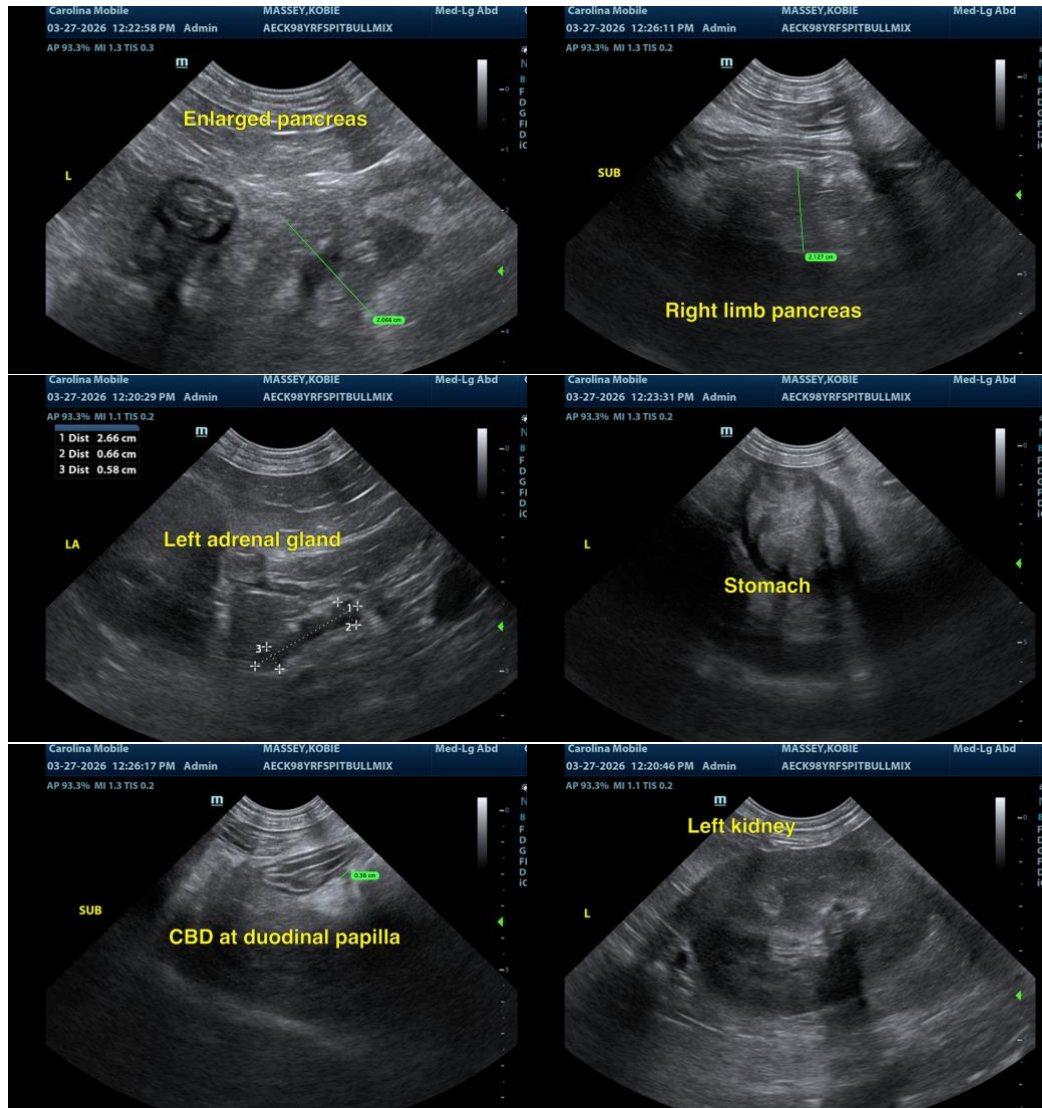
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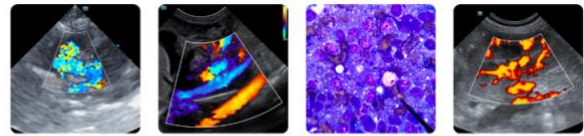
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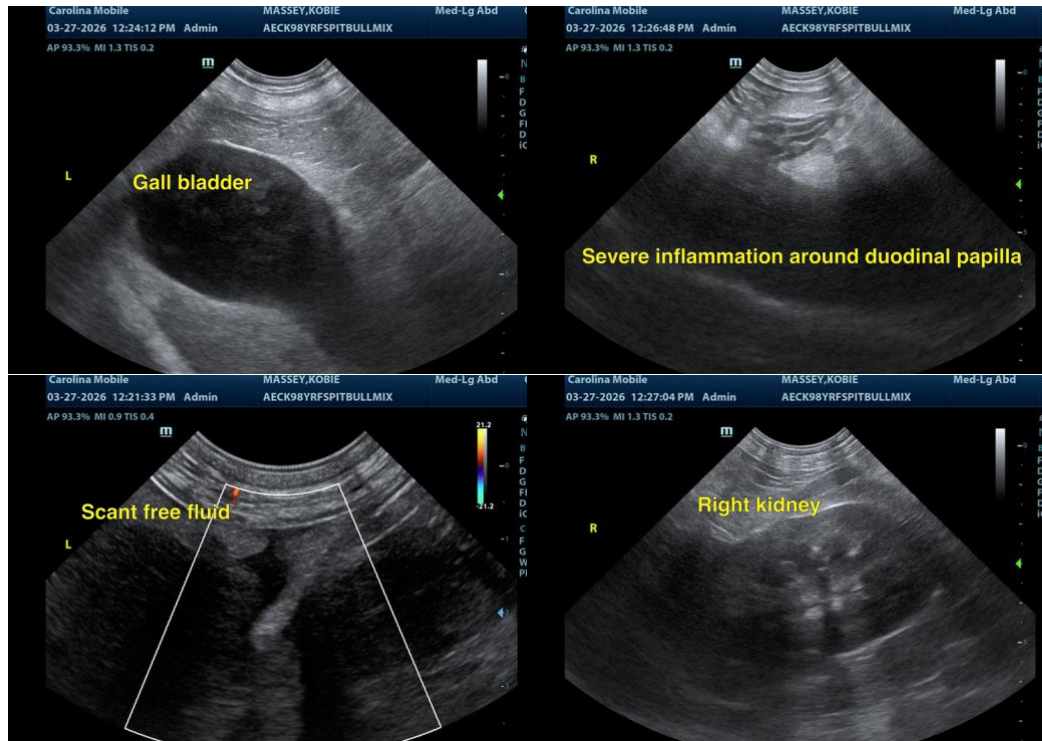
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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