



PATIENT

Monte Auyoub

SPECIES

Canine

BREED

Doberman

SEX

Neutered Male

AGE

7 Years

WEIGHT

95.8 Pounds

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Dr. Adrienne Waffle

HOSPITAL NAME

Torch Lake VC

REFERRING VET

Dr. Adrienne Waffle

INVOICE

33134

DATE

12/1/21

PRESENTING CLINICAL SIGNS

Was eating bully stick Friday and became anorexic and painful. Hx of pancreatitis. Being treated with IV fluids, Cefazolin, Cerenia and Buprenex.

Abnormal PE/Chem/CBC/UA Results: Painful cranial abdomen Pendulous abdomen Fluid wave
balotted Temp 99.8 pk <2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size owing to lack of urine distention. Sonographic assessment of the urinary bladder was limited owing to the lack of urine distention. No overt pathology, although potential for cystitis cannot be definitively excluded.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 7.6 cm. The right kidney measured 7.8 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The adrenal glands were not definitively visualized.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present with potential for subtle indistinct nodular changes. Areas of mild asymmetrical lateral and medial splenic capsule contour was present. A distinct splenic mass or other expansive pathology was not definitively evident. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver was mildly enlarged. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. No evidence of distinct hepatic masses or nodules. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. No evidence of gallbladder wall edema. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach was indistinctly visualized owing to regional perigastric omental artifacts. A subjective mild to moderate amount of retained ingesta/chyme was present, which presented overall non-shadowing. The visualized gastric walls were sonographically unremarkable.

The visualized segments of small intestine exhibited intact wall layering with primarily maintained 1:3 muscularis/mucosa ratio. No overt evidence of duodenojejunal mechanical/metabolic ileus, although



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segments of jejunum exhibited corrugation, potentially indicative of or secondary to inflammation and muscularis hypercontractility.

Normal visible colon wall layers were present with apparent formed feces in lumen.

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Pancreas

Sonographic assessment of the pancreas was limited given the presence of peritoneal free fluid and generalized increased omental artifact. The left pancreatic limb medial to the spleen exhibited mild subjective prominent size with hypoechoic to heterogeneous parenchyma.

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Free Abdomen

Generalized, mildly non-uniform hyperechoic mesentery was noted along with moderate cellular free fluid. Overt evidence of omental masses or associated lymphadenopathy was not definitively evident, although complete sonographic evaluation of the omentum and inner abdomen was limited owing to patient size, peritoneal free fluid, and increased omental artifact.

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ULTRASONOGRAPHIC FINDINGS

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- Generalized peritonitis exhibited by non-uniformly hyperechoic omentum and moderate cellular peritoneal free fluid
- Subjective hyperechoic to heterogeneous left pancreas – possible pancreatitis.
- Subjective gastric stasis and segmental corrugated jejunum, no overt evidence of mechanical gastrointestinal obstruction or visualized foreign body.
- Heterogeneous to indistinctly nodular spleen – non-specific, hyperplasia, hematopoiesis, age related/patient variant, splenitis possible, while the potential for non-specific splenic neoplasia cannot be excluded.
- Vacuolar hepatopathy pattern – subjectively benign.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend abdominocentesis, rapid cytospin cytology of the effusion to conserve cell integrity +/- culture and sensitivity if evidence of inflammatory cells are present. Pancreatitis is suspected, although subjectively, if present, the degree of pancreatitis was not overtly consistent with that which would result in severe peritonitis. If septic abdomen is confirmed, potential exploratory laparotomy for gross inspection of the gastrointestinal tract and abdominal viscera may be indicated given the patient's history. Likewise, if strong concern for intraabdominal bleed, exploratory laparotomy for further assessment (given the additional history of potential trauma) may be indicated. Coagulation panel prior to surgical considerations (if hemorrhagic effusion is confirmed) is recommended. Non-septic effusion (increased vascular permeability, decreased hydrostatic pressure) considered less likely given the lack of hepatic congestion and assuming normal albumin levels, while the possibility of undefined neoplastic effusion could not be definitively excluded. 3-view chest radiographs recommended to assess for thoracic pathology as well as cardiopulmonary status. Empirically, some or all of the following protocol may be considered pending effusion analysis.

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**Peritonitis Protocol
Colloids/Hetastarch**

10 to 20 mL per kilogram per hour and dogs
10 to 15 mL per kilogram per hour cats
(Can bolus first 1/3 of dose over 15 minutes)

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Plasma 10 mL / kilogram IV over 4 hours

Buprenorphine 0.02 mg/kg IV IM SC q4-6 hours **Or CRI Lidocaine** 30-50 ug/kg/min



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Dolasetron for nausea: 0.6-1 mg/kg/day Iv or PO

Famotidine 1 mg/kg IV IM p.o. dc s.i.d. /b.i.d.

Sucralfate 0.5-1 g p.o. t.i.d. dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid

Clindamycin 10mg/kg IV p.o. bid

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Enrofloxacin 10-15 mg/kg IV p.o. s.i.d. dogs, 5 mg/kg Iv po Sid cats

Metronidazole 10-20 mg/kg IV p.o. b.i.d.

Dexamethasone physiological 1 mg/kg to treat adrenal burnout if long standing sickness, shock dose 4-10 mg/kg.

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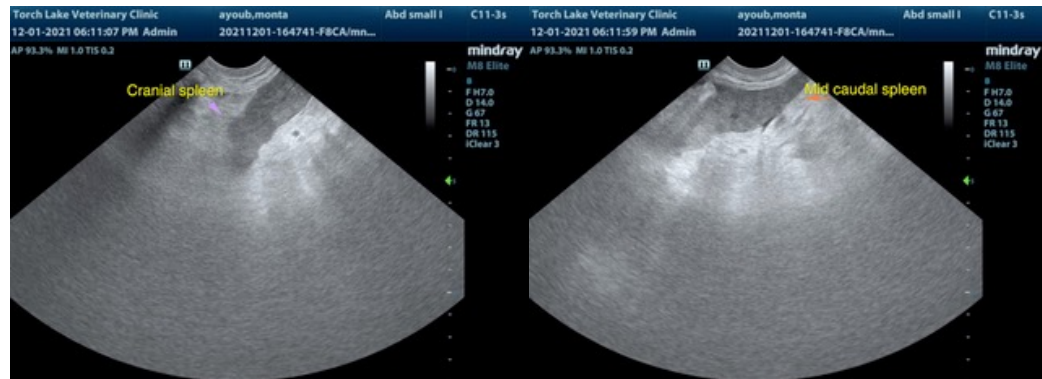
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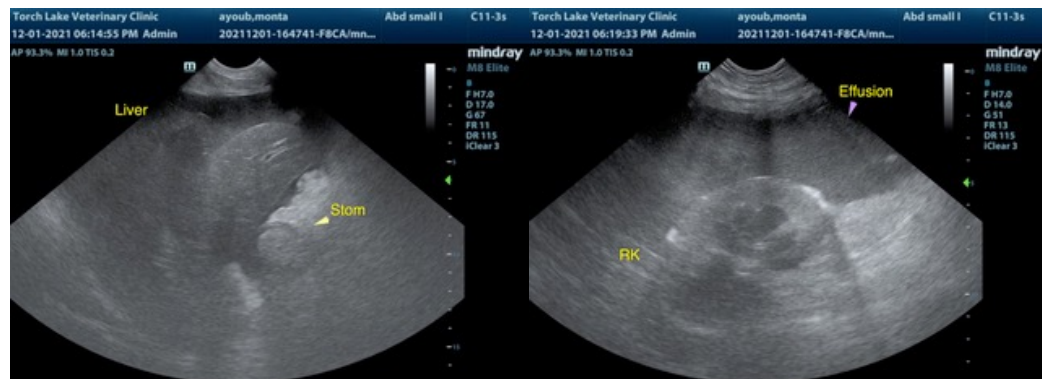
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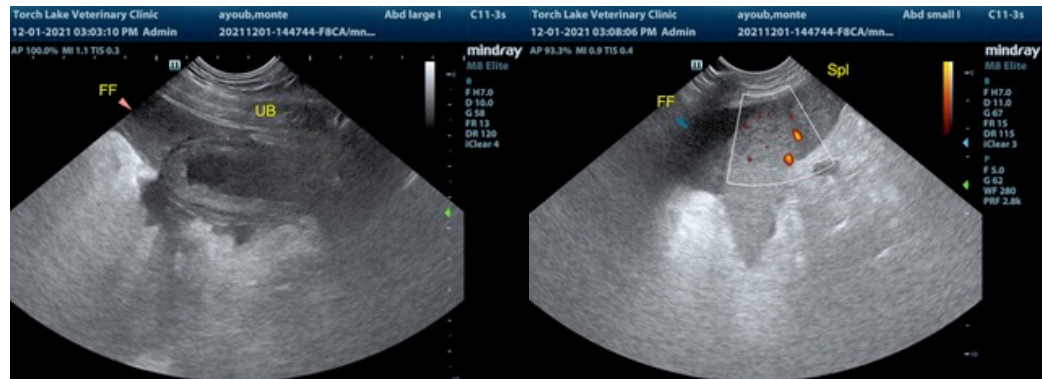
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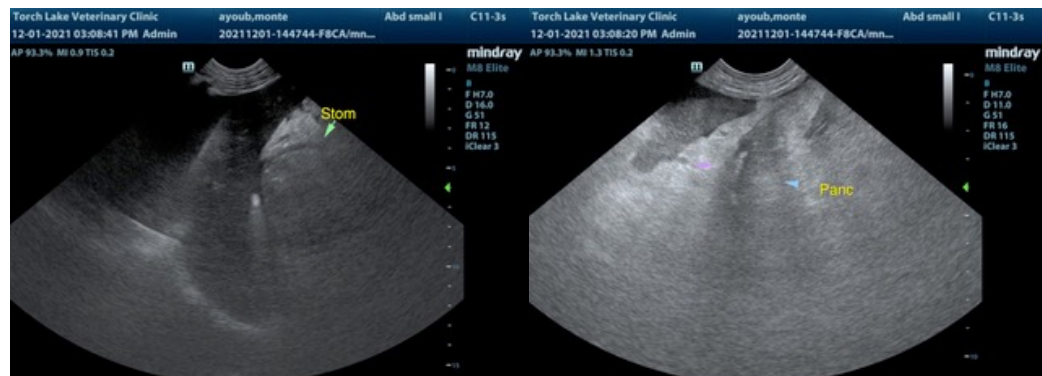
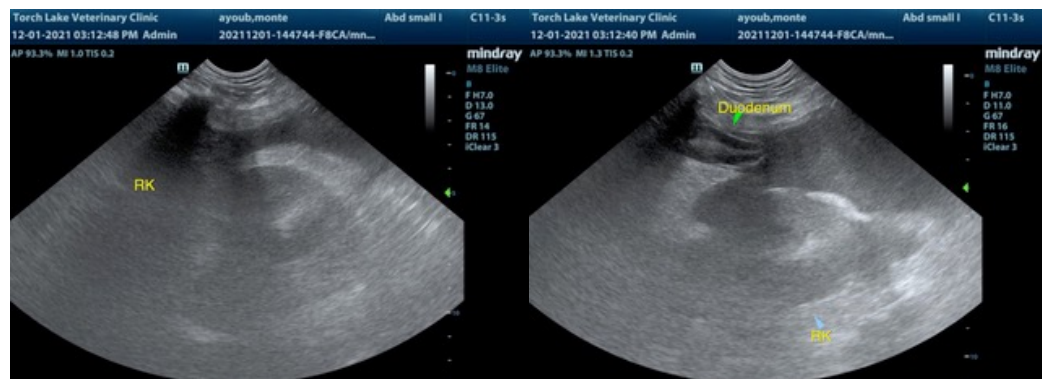
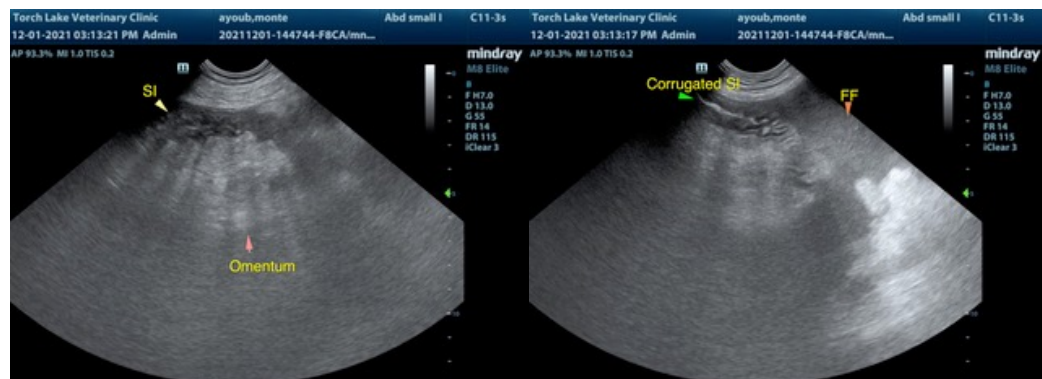
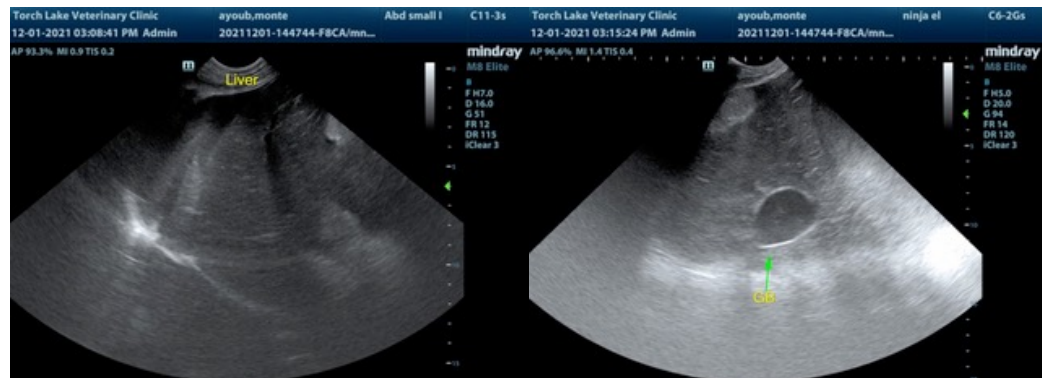
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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info@SonoPath.com

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