

**PATIENT**

Ritchie Armstrong

SPECIES

Canine

BREED

GSD

SEX

NA

AGE

9.5yr

WEIGHT

30

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Brian Barnes

HOSPITAL NAME

Westview Veterinary
Hospital

REFERRING VET

Dr. Brian Barnes

**INVOICE
24266**

DATE
03/23/2026

PRESENTING CLINICAL SIGNS

Presented march 7 for xrays, showed OA in right hip. Started on metacam, accidental overdose of 0.5mg/kg given for 7 days, presented inappetant and had vomited. intracellular rods found on free abd fluid. renal values show evidence of acute kidney injury

Abnormal PE/Chem/CBC/UA Results: CBC wnl besides rbc high 9.6 (5.6-8.8) hgb high 222 (131-205) mcv low 60 (61-73) mchc high 384 (320-379) mono high 4.2 (0.16-1.1) eos low 0.02 (0.06-1.23) CHEM wnl besides sdma high 72 (0-14) creat high 529 (44-159) urea high 34 (2.5-9.6) phos high 3.89 (0.81-2.2) na low 139 (144-160) cl low 100 (109-122) alp high 300 (23-212) bili high 18 (0-15)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.7 cm in length. The right kidney measured 8.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was overtly normal in size, position and shape. The left adrenal gland subjectively measured 0.73 cm width at the caudal pole. The right adrenal gland was not definitively visualized, owing to increased peri adrenal omental artifact.

Spleen

The spleen exhibited mild folding with a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver presented mildly enlarged in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. Normal vascular volume. The hepatic and portal vasculature were normal in appearance. The gallbladder was non-distended in size with mild congealed to non-dependent, non-organized debris. No evidence of gallbladder wall edema was present. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.



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Gastrointestinal

The stomach presented thickened mildly hypoechoic wall. Empty lumen with lumen gas. Potential to suspected areas of gas within the stomach wall.

The small intestine presented overall intact visualized small intestinal wall exhibiting subjective mild altered wall layer ratio owing to propensity for mildly thickened muscularis layer. Segmental intestinal corrugation with overall empty intestinal lumen to the level of the colon was present.

The colon was empty in appearance with subjective mild thickened wall and mild colon gas.

Pancreas

The area of the pancreas was overtly normal in sonographic presentation, although indistinctly visualized owing to increased peripancreatic and omental artifact.

Free Abdomen

Generalized omental hyperechogenicity.

Moderate volume echogenic peritoneal effusion.

No obvious visualized omental masses or significant swollen mesenteric lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary

- Thickened empty stomach with mild lumen and suspect focal mural gas
- Prominent intact small intestinal wall exhibiting segmental corrugation
- Acute hepatopathy/ nephropathy
- Generalized omental hyperechogenicity and moderate volume echogenic peritoneal effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given evidence of reported septic abdomen, non-obvious potentially perforating gastrointestinal ulceration in conjunction with patient history is highly suspected. C/S of peritoneal effusion may be considered.

Given concurrent evidence of acute hepatopathy and renal injury, renal and gastrointestinal support including broad spectrum gastric protectants with assessment of renal response and empirical therapy for peritonitis is recommended.

UA with urine C/S if inflammatory sediment or UPC level if non-inflammatory proteinuria is recommended. Exploratory laparotomy is indicated if renal function can be stabilized and if persistent septic abdomen.

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)

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.

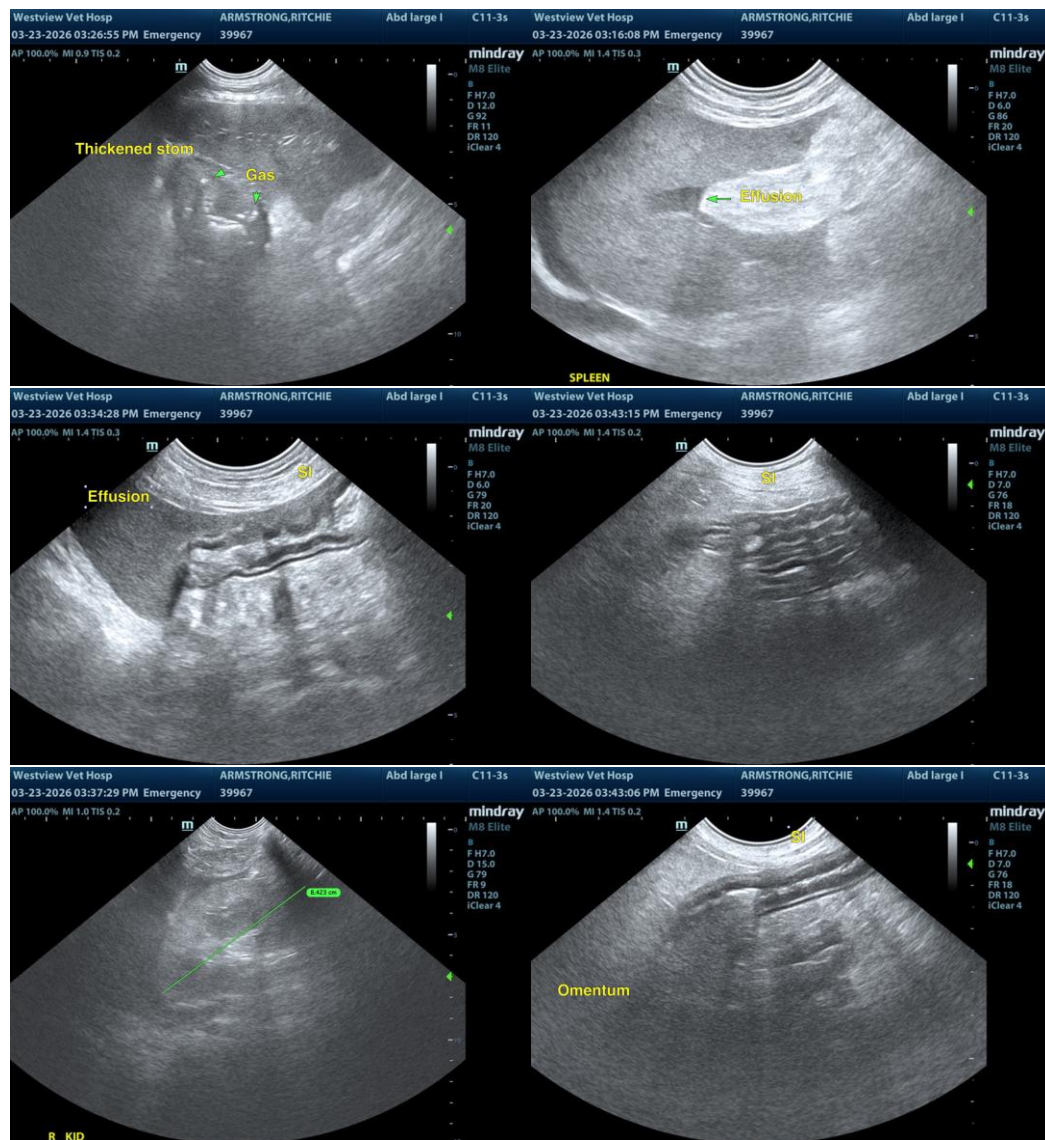
Sucralfate 0.5-1 g p.o. t.i.d. dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid

Clindamycin 10mg/kg IV p.o. bid

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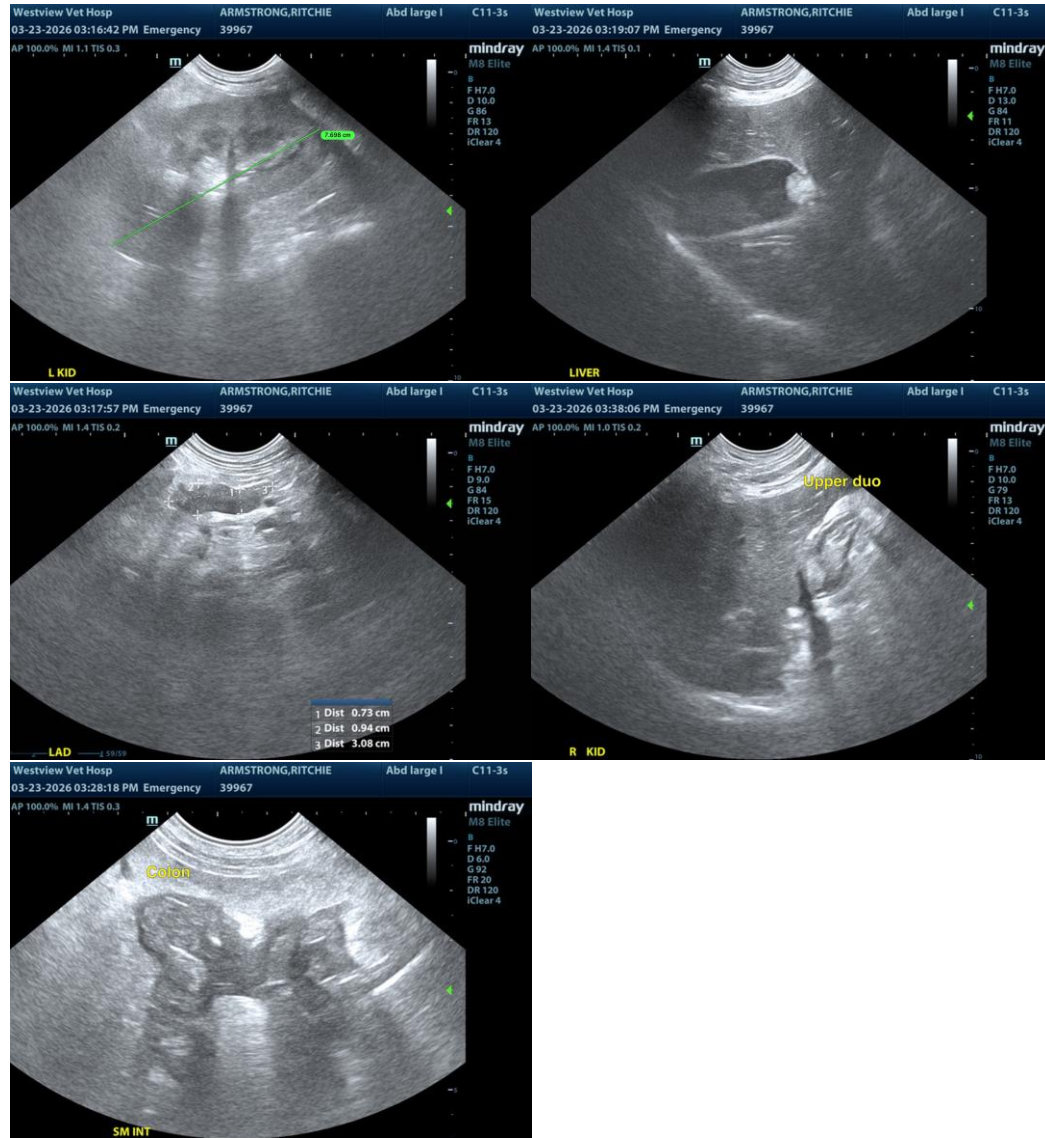
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@sonopath.com