



PATIENT

Kylee Campos

SPECIES

Canine

BREED

Min Schnauzer

SEX

MN

AGE

11 yrs

WEIGHT

33.8 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Karen Ebersole, DVM,
DABVP (Canine/Feline
Practice)

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Van Binsbergen

INVOICE

16716

DATE

4/28/23

PRESENTING CLINICAL SIGNS

Acute onset severe abdominal pain, not eating, lethargic. Hasn't eating in 3 days. In hospital on IVF. Abdomen painful even with Buprinex, + Murphy with any pressure on abdomen.

Abnormal PE/Chem/CBC/UA Results: PE: Depressed, tense, painful abdomen. WBC 6k, 3.6k Neutrophils, Bands suspected. BUN 29, Glob 4.9, ALP 977.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The residual prostate was free of pathology.

No overt medial Iliac or sublumbar lymphadenopathy/masses were 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 5.6 cm in length. The right kidney measured 5.8 cm in length.

Adrenal Glands

The left adrenal gland was not definitively visualized owing to increased peri adrenal omental artifact. The right adrenal gland was indistinctly visualized yet overtly normal in size, position, and shape measuring 2.6 cm length x 0.49 cm width at the caudal pole.

Spleen

The spleen exhibited overall normal size with generalized mild parenchyma heterogeneity. A solitary, nondisruptive perihilar hyperechoic nodule was present measuring 0.64 cm diameter.

Liver/ Gallbladder

The liver was moderately enlarged yet maintained a symmetrical to mildly swollen hepatic capsule contour with nonhomogeneous mild increased hepatic parenchyma echogenicity comparable to the spleen exhibiting moderate coarse echotexture. Normal hepatic vascular volume was noted. No visualized hepatic masses or nodules were noted. The gallbladder was non-distended in size containing anechoic content with moderate inspissated yet nonorganized hyperechoic gallbladder debris. No evidence of gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mildly prominent yet intact gastric walls secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained a moderate



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amount of retained anechoic fluid without evidence of overt gastric foreign material. No evidence of mechanical pyloric outflow obstruction was noted.

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The duodenum exhibited intact variably prominent wall layering with mild upper duodenal nonobstructive ileus pattern. The jejunum and ileum to the level of the colon exhibited intact wall layering with a maintained 1:3 muscularis / mucosa ratio. No evidence of jejunoileal mechanical / metabolic ileus.

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

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Diffuse enlargement of the pancreas with ill-defined, hypoechoic to heterogeneous parenchyma and asymmetrical contour was present. The surrounding omental fat around the enlarged to hypoechoic pancreas was echogenic indicative of reactive change, adhesions, focal peritonitis, or saponification. Mild localized free fluid was present around the abnormal pancreas. Peripancreatic to generalized hyperechoic omentum was noted.

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Pancreas

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No evidence of significant omental lymphadenopathy or definitively visualized omental mass was present. Mild to moderate volume peritoneal effusion was noted.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Enlarged irregular nonhomogeneous hypoechoic pancreas
- Hepatomegaly exhibiting mild nonhomogeneous hyperechoic parenchyma
- Moderate inspissated gallbladder debris - not overtly consistent with mucocele criteria
- Gastroduodenitis with gastric hypomotility
- Generalized peritonitis

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Secondary Findings

- Moderate chronic renal changes
- Being splenic nodule - consistent with benign myelolipoma

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Significant intraabdominal pathology with potential considerations including active possibly necrotizing pancreatitis with secondary hepatopathy, gastroduodenitis, and peritonitis with potential for neoplastic disease potentially deriving from the pancreas, i.e., carcinomatosis, lymphomatosis, or similar. Further clarification may include abdominocentesis for effusion analysis, cytology, and C/S if evidence of an inflammatory component. Correlation with a Spec cPL could be considered.

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Empirically, aggressive therapy for pancreatitis with as-needed hepato-gastrointestinal support, which may include analgesia, antibiotics, plasma expanders, etc., could be considered. An extremely guarded prognosis is indicated.



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Peritonitis Protocol

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Colloids/Hetastarch

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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

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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

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

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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

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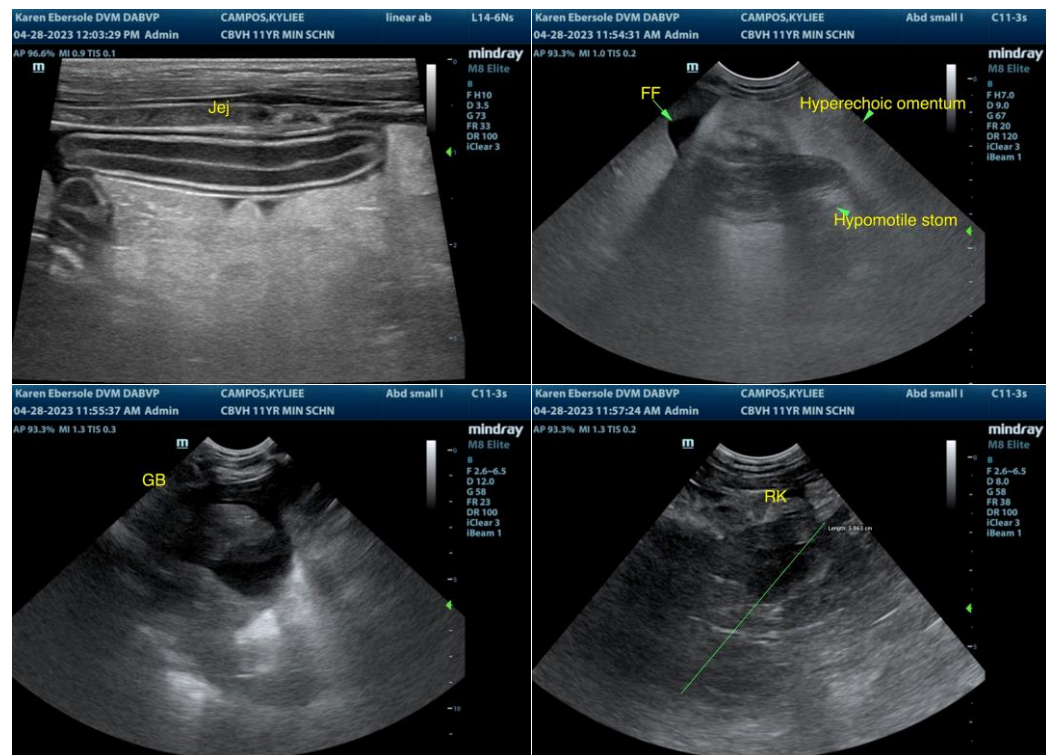
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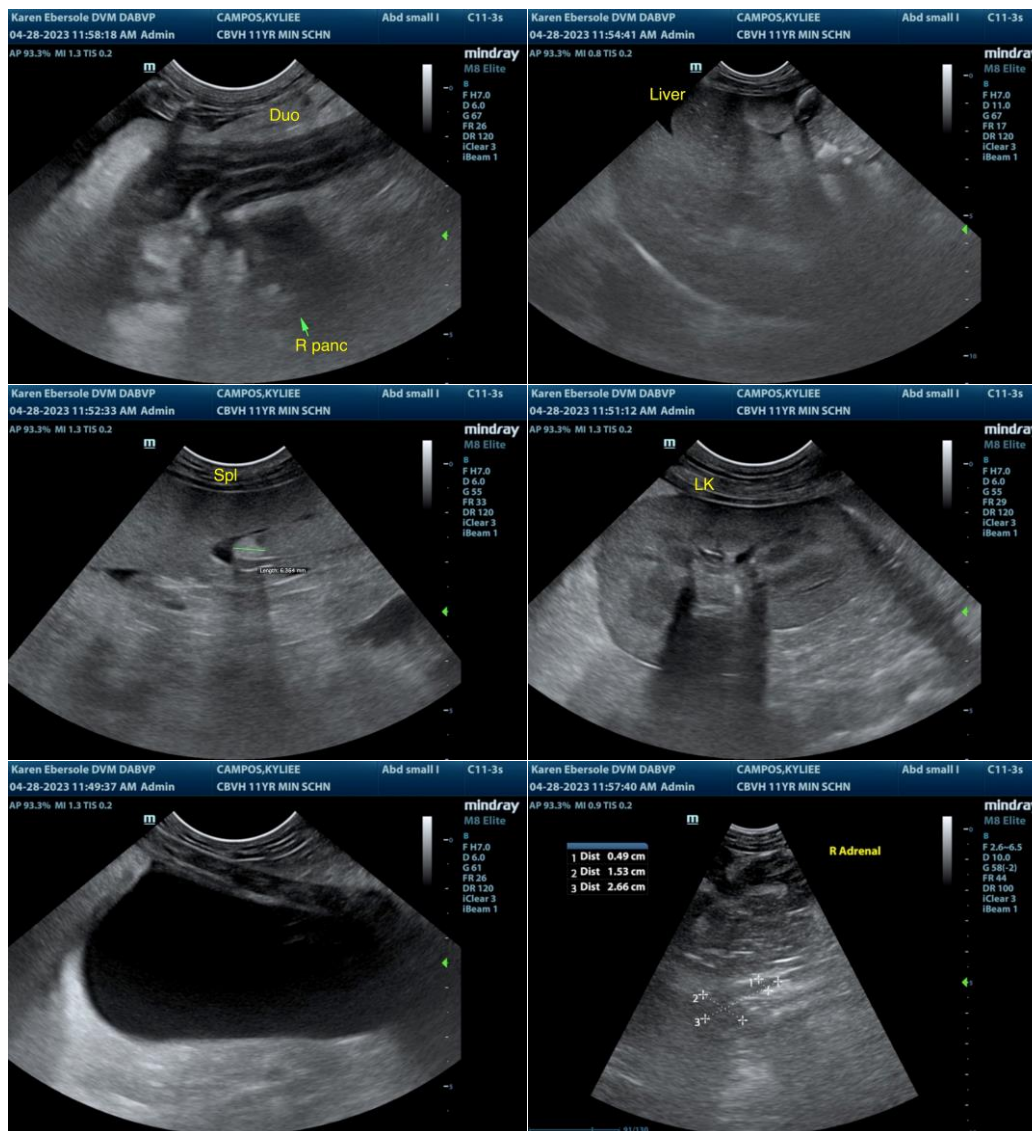
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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