Case Log #:14 Small Animal Internal Medicine    Lisa English    Case Report #1

**Signalment:** Gabby, an 11 year old Female spayed Chesapeake Bay retriever, 32.5 kg. Patient ID #: 15622

**History and Entering complaint:** Gabby presented to her general practice Veterinarian with pyrexia, vomiting and a painful mid-caudal abdomen. A complete blood count and serum biochemistry panel showed neutrophilia, monocytosis, lymphopaenia, hyperglobulinaemia, hypocalcaemia and an elevated Alkaline phosphatase, Aspartate amino-transferase and Amylase. Enrofloxacin and Amoxycillin-Clavulonic acid therapy was trialed with an initial good response however she did not continue to improve and was referred for evaluation by the Small Animal Internal Medicine team at the Veterinary Specialist Group on October 31st 2007.

**Initial Physical Examination:** On presentation Gabby was ambulatory, alert and showed response to stimuli.

She had a body score of 4/9, heart rate of 116 beats per minute with a grade 4/6 systolic heart murmur heard on auscultation, respiratory rate 48 breaths per minute with normal lung sounds on auscultation, temperature: 38.4°C, mucous membrane color was pink and her capillary refill time was less than 2 seconds.

Gabby’s teeth were in good condition. She had vomited food and antibiotics two days prior, had reduced water consumption and developed black and tarry diarrhea.

She was painful in her mid-caudal abdomen and tense on palpation, still able to functionally urinate and when walking was slightly ataxic in her hindquarters.

Gabby also had a slight clear discharge from her right eye.
Problem List/ Differential diagnosis: Endocarditis, Pylonephritis, Neoplasia, Dilated cardiomyopathy, Myxomatous valvular disease, Pancreatitis- Pancreatic abscess/pseudocyst, Primary Gastrointestinal disease- Neoplasia, Foreign body, Gastric ulceration, Infectious gastroenteritis or non-specific gastroenteritis. Prognosis was fair to poor.

Initial Diagnostic tests: Chemistry Panel (Appendix A), CBC (Appendix A), Urinalysis and Urine protein: creatinine ratio (Appendix B), Aerobic culture and Sensitivity- showing no growth.

Abdominal Ultrasound (Appendix C) Echocardiography (Appendix C), Thoracic Radiology (Appendix C).

Abdominal ultrasound showed a fluid filled stomach, enlarged pancreas and a 5cm diameter cystic structure originating from the right caudal aspect of the pancreas. This cystic structure was surrounded by hyperechoic tissue and a small amount of free fluid. Echocardiography and thoracic radiology showed findings were consistent with dilated cardiomyopathy. A low-grade peribronchial lung pattern was also noted.

Specialty care

Day 1

Subjective: She was ambulatory, responsive, walking with a hunched stance and slightly ataxic hindquarters.

Objective: She urinated normally post cystocentesis, but had passed no bowel motions over this day, she was offered no food due to her vomiting and her vital signs stayed within normal limits except for her tachypneic respiration rate.
Medications included: pimobendan (0.2mg/kg), given PO BID. Started for its vasodilatory and positive cardiac contractility effects.

benazepril (0.3 mg/kg), given PO SID. Used for its vasodilator and Angiotensin converting enzyme inhibitor effects to decrease vascular resistance.

Amoxicillin (20mg/kg), given IV TID. Used as a broad spectrum antibiotic to help prevent gastrointestinal translocation and incase of a pancreatic abscess.

Enrofloxacin (5mg/kg), given IV SID. Another antibiotic used incase of a pancreatic abscess.

Metoclopramide (0.2 mg/kg), given SC TID. Used for its prokinetic and anti-emetic effects.

Miropitant (1mg/kg), given SC SID. Used for its anti emetic effects, but should be used cautiously in cardiac and hepatic dysfunction patients.

Buprenorphine (0.02 mg/kg), given SC TID. Used for its analgesic effects and long duration of action.

Treatment included intravenous fluid therapy with 0.45% sodium chloride, used because of her cardiac compromise, to keep her hydrated but prevent fluid overload. 20mmol of potassium chloride /Lt was supplemented. The fluid therapy was initiated at maintenance (40ml/kg/day) and monitored carefully for signs of fluid overload such as tachypnoea, dyspnoea, respiratory noise, sudden weight gain, clear nasal discharge, and subcutaneous edema.

**Assessment:** Reassessment of adequate analgesia may have been needed. Other alternatives could have included: fentanyl CRI which would have given continuous pain control and had less cardiac contraindications than morphine sulphate.
Plan: The patient was withheld from food even after starting anti-emetics due to her receiving sedation for aspirate of the abscess/pseudocyst using ultrasound imaging early the next morning.

Day 2

Subjective: Gabby was still responsive but slightly depressed.

Objective: She showed no interest in urinating or defecating prior, but did urinate normally post procedure, and was still withheld from food until that time. She was slightly hypothermic (37.4°C) but this resolved by the afternoon. All other vital signs were normal. The medications remained unchanged.

Management of the patients IV catheter revealed no cellulitis or peri-vascular edema, remained patent and the fluid therapy plan remained unchanged. Despite her gaining 1 kg overnight, she showed no signs of over-hydration. Nutrition was introduced post procedure with small frequent meals of Hills Canine I/d® tinned and chicken up until 10pm that night, which had no complications.

Procedure 1: Sedation and drainage ultrasound guided percutaneous drainage of the pancreatic abscess/ pseudocyst.

Gabby’s pre-procedure blood tests were PCV 40 l/l, TPP 62 g/l, ACT 90 seconds, BMBT: 2mins and 10 seconds. She was sedated with 0.02mg/kg of buprenorphine by IV bolus, and transferred to have diagnostic imaging. Post drainage, she was slightly sedated still but able to lift her head, and was then transferred back to the ward for monitoring.
The fluid aspirated was a thick brownish fluid. A large number of degenerative were noted on cytology (Appendix D) suggestive of an inflammatory process. Although no infectious agents were noted on cytological examination a culture was performed.

**Assessment:** The patient showed clinical improvement compared to the previous day, however she remained depressed. Her analgesia regime was adequate and she was comfortable and settled.

**Plan:** Surgery tomorrow, (food was withheld from 10pm onwards) Resection of the right caudal pancreatic limb involving the cystic structure. Also, a jejunostomy tube will be placed at the same time.

**DAY 3**

**Subjective:** Gabby was quiet, but rouse able on stimulation.

**Objective:** Gabby urinated once during the morning and passed no bowel motions, this was not surprising due to the amount of food consumed. She appeared nauseas post-operatively.

She was bradycardic (Heart rate 52 bpm) and her heart was hard to auscultate, her mucous membrane color was pink and she had strong femoral and digital pulses. Her systolic blood pressure was 150mmHg, measured by using Doppler sphygmanometry.

Gabby’s buprenorphine transitioned to morphine sulphate, as a mu opioid agonist was deemed a better analgesic choice for surgery.

More padding was added to her bedding to prevent decubital ulcers and her bedding was constantly monitored for urinary and fecal material.

A second intravenous catheter was placed into Gabby’s right cephalic vein. Her pre-medication was administered, morphine sulphate 0.5mg/kg (16.5mg) SC. Half an hour later she was sedated with diazepam 0.2mg/kg (6.62mg) IV and anesthetized with Propofol 4mg/kg (132.4mg) by IV bolus.

Her intravenous fluid therapy was changed to 0.45% Sodium Chloride with no additives.

Gabby’s surgical fluid therapy rate was adjusted due to her dilated cardiomyopathy. This was set at 5ml/kg/hr so that she wouldn’t become fluid overloaded which would further exacerbate her cardiac compromise.

An IV dose of amoxicillin was given at induction, to achieve adequate blood levels peri-operatively. A morphine sulphate (0.1mg/kg) epidural was also attempted, using the lumbar-sacral space but aborted when Gabby became severely bradycardic.

Gabby was started on a dobutamine HCl constant rate infusion at 5-20mcg/kg/min and changed to a fentanyl constant rate infusion at 5-10mcg/kg/hr.

Dobutamine HCl was used over dopamine because it doesn’t release norepinephrine from the adrenal gland, but still increases the cardiac contractility, stroke volume and therefore cardiac output. Morphine was changed to Fentanyl to allow better control over the opioid receptors during her anesthetic, thus allowing the patient to be lighter and minimizing the cardiovascular depression.
A portable Electrocardiograph monitor and non-invasive Doppler sphygmomanometry were then utilized.

Her blood pressure and heart rate stabilized on the dobutamine and fentanyl and she was transferred to surgery.

Once extubated, Gabby was transferred back to the medical team who continued with post operative monitoring. She recovered well from surgery and was slowly weaned off the dobutamine CRI over an hour and a half. Her vital signs remained stable. An Elizabethan collar was placed as she recovered in case of self-trauma or trauma to the jejunostomy tube.

**Assessment:** Previously bradycardic, post anesthesia, recumbent.

**Plan:** A feeding plan was formulated using Hills A/d® for the following day. (Appendix E)

Gabby was monitored hourly throughout the night. Same analgesic regime.

**DAY 4**

**Subjective:** Gabby was stable overnight, although restless this morning.

**Objective:** She had urinated in her bedding and had not passed any bowel motions. She was also not fed by mouth, instead fed via the jejunostomy tube late morning. The feeding regime was initiated with a third of her daily calorie requirement every three hours via the feeding tube. She had no vomiting or diarrhea.

Gabby’s medication regime was as follows: pimobendan 0.2mg/kg PO BID, benazepril 0.3mg/kg PO SID, amoxicillin 20mg/kg IV TID, enrofloxacin 5mg/kg IV SID, metoclopramide 0.2mg/kg
SC TID, maropitant 1mg/kg SC SID, morphine sulphate 1mg/kg SC q. 4-6(started late that night).

Gabby became dysphoric on fentanyl so after consultation with the clinician the fentanyl constant rate infusion was changed to intermittent buprenorphine injections. This was insufficient to control her pain and was transitioned to morphine sulphate later on that day.

Her ears and lower right lip became swollen during the morning so Gabby was given a dose of mepyramine maleate IV and monitored for any more signs of anaphylaxis, such as pyrexia, tachycardia, tachypnoea or more edema especially after medications were given. The culture results returned. (Appendix D)

**Assessment:** Previously painful, but resolved. Ambulatory, Responsive.

**Plan:** Feed two thirds of her daily energy requirements and monitor her analgesia level.

**DAY 5**

**Subjective:** Gabby was more responsive and more alert when outside.

**Objective:** She is urinating well, but had developed diarrhea. She tolerated feeding well so was increased to two thirds of her daily calorie requirement; she appeared slightly painful post feed.

She was still Nil per Os.

Gabby was still slightly bradycardic on auscultation, but her temperature and respiratory rate were normal, and her digital and femoral pulses were strong and steady. Her medications remained unchanged from the following day, and she continued on morphine sulphate every 4-6 hours.
No new facial swelling was noted and the previous swelling had resolved.

Gabby’s intravenous catheter in her right cephalic vein was still patent and allowed continuation of the previous fluid therapy regime.

**Assessment:** Responsive, bradycardic, ambulatory.

**Plan:** Monitor for vomiting- if none, introduce oral feeding with a commercial diet such as Hills prescription diet canine I/d® or lean boiled chicken in small frequent amounts. If not eating/unable to tolerate oral feeding her calorie intake would be increased to meet her full daily calorie requirement.

**DAY 6**

**Subjective:** Gabby remained responsive although slightly more depressed than the previous day. Her vital signs remained within their normal ranges. Her medications regime remained un-altered except for the addition of 50mg gabapentin PO SID, which was used stop wind up as Gabby’s pain score had elevated in the evening when she became very unsettled and a 100ug fentanyl transdermal patch placed on her epidural site. Morphine sulphate was continued until the following morning to allow the fentanyl to reach therapeutic blood levels. She ate chicken in the morning with two tablespoons offered first, then continued at three hourly intervals with no vomiting or nausea shown, until later when she became inappetant. Urination and defecation were both normal.

Gabby’s fluid regime was slightly altered as her previous fluids were changed to 0.45% NaCl and 2.5% Glucose with 10mmol potassium chloride/500ml.
**Assessment:** Although the treatment plan was working well, Gabby would benefit from increased stimuli.

**Plan:** Reassess the medication’s route of administration.

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**DAY 7**

**Subjective:** Gabby has improved clinically and is brighter and more active.

**Objective:** She had urinated and had no defecation noted despite being on a gastrointestinal prokinetic and being fed through her jejunostomy tube (this was stopped early morning). She ate lean boiled chicken enthusiastically, and was changed to oral food and medications. Her vital signs were all within normal limits except for mild bradycardia.

**Assessment:** Bright, alert and responsive. Tolerating oral feeding and medicating.

**Plan:** Discharge tomorrow.

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**DAY 8**

**Subjective:** Demeanor returned to almost normal.

**Objective:** She had urinated well but had diarrhea during the day. She lost a kilogram since the surgery. Her vital signs were within normal range. The histology results returned. (Appendix F) This showed pancreatitis and confirmed a pancreatic abscess with no evidence of neoplasia.

**Assessment:** Ready to be discharged.

**Plan:** Bandage the jejunostomy tube in place and arrange a discharge consultation with the owners.
FINAL OUTCOME

Gabby was discharged eight days after referral to Veterinary Specialist Group, when she was able to eat her normal amount of food, urinate & defecate normally and tolerate oral medication. Her owners had written and verbal discharge instructions which explained her conditions and why the different medications were used.

Discharge Instructions (Appendix G)

Relevant Specialist Nursing Techniques:

- Nursing the recumbent patient
- Nursing the Intensive care patient
- Feeding via Jejunostomy tube
- Anesthesia monitoring of a Dilated Cardiomyopathy patient.

References


  Butterworth-Heinemann

www.vin.com- Plumb Online

Pfizer Animal Health NZ-Cerenia® Technical Data Handbook
## APPENDIX A

### CHEMISTRY

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<tr>
<th>Test</th>
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1 Courtesy of Gribbles Veterinary Pathology, Mt Wellington, New Zealand.
## Hematology

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<tr>
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<tr>
<td>MONOS</td>
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<tr>
<td>ABSMONO</td>
<td>0.9</td>
<td>0.2-1.5 x10^9/L</td>
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# APPENDIX B

Urinalysis

## URINALYSIS

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<td>PRO</td>
<td>++</td>
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<tr>
<td>GLUC</td>
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<td></td>
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<tr>
<td>KETO</td>
<td>Negative</td>
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<tr>
<td>BILI</td>
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<td></td>
</tr>
<tr>
<td>BLOOD</td>
<td>Trace</td>
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<tr>
<td>UROB</td>
<td>Normal</td>
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<tr>
<td>WBC/</td>
<td>&lt;1/h.p.f.</td>
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**Urine Sediment**

- Red blood cells <1/h.p.f.
- No crystals present
- No Casts present
- No Bacteria seen.

## Urinary Protein creatinine Ratio

| Anion Gap | 22.4 | Ref Range: 15-25 mmol/ |

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<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Unit</th>
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<tr>
<td>U. Protein</td>
<td>1.406 g/l</td>
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<tr>
<td>Urine Creat</td>
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<tr>
<td>Protein: Creat</td>
<td>1.20 RATIO</td>
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Urine Culture: No growth
APPENDIX C

31/10/07

**Abdominal Ultrasound report for Gabby Fay. Patient number 15622.**

The urinary bladder and contents were unremarkable. There was no evidence of medial iliac lymphadenopathy.

Mild bilateral adrenomegaly was noted.

No renal sonographic abnormalities were noted.

The spleen was unremarkable.

No hepatobiliary abnormalities were evident.

The stomach contained a moderate amount of echogenic fluid. The gastric wall appeared normal as did the portions of small intestine imaged.

The pancreas was enlarged and hypoechoic. However, there was no evidence of peri-pancreatic fluid or hyperechoic mesentery surrounding the majority of the pancreas.

A large cystic structure was noted in the mid/caudal abdomen. This measured approximately 5cm and appeared to have a relatively thick, hyperechoic wall. Surrounding the cystic structure was hyperechoic tissue and possibly, a small amount of free fluid. The cystic structure appeared to originate from the caudal aspect of the right limb of the pancreas.

The sonographic findings were suggestive of a resolving acute pancreatitis with the development of a pancreatic abscess or pseudocyst. There was some indication of possible localized peritonitis.

Ultrasound guided aspiration of the cyst would be recommended.

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Report written by Dr D. Fry, Specialist in Small Animal Internal Medicine, Veterinary Specialist Group, Auckland, New Zealand.
31/10/07

Echocardiography report for Gabby Fay. Patient number 15622.

ECG monitoring did not reveal any significant arrhythmia.

Left ventricular dimensions markedly exceeded normal limits in both diastole and systole. The resultant fractional shortening was markedly reduced, averaging 16%.

Mild thickening of the mitral valve was noted and a large, centrally radiating, mitral regurgitant jet was noted.

Left atrial size was mildly increased with a left atrial to aortic ratio of 1.6:1.

Mitral valve EPSS was markedly increased.

Left ventricular PEP: ET ratio was mildly increased at 0.48.

No tricuspid or pulmonic regurgitation was seen.

Subjectively, there was no evidence of right-sided cardiomegaly.

The echocardiographic findings were consistent with either dilated cardiomyopathy or volume overload cardiomyopathy secondary to mitral valve disease. The overall impression was more supportive of the former.

There was no support for infective Endocarditis.

31/10/2007

Thoracic radiology report on Gabby Fay. Patient number 15622.

Cardiomegaly is identified. Increase in both the craniocaudal and base-apex cardiac dimension is

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5 Report written by Dr D. Fry, Specialist in Small Animal Internal Medicine, Veterinary Specialist Group, Auckland, New Zealand.
6 Report written by Dr C. Warman, Specialist in Radiology, Veterinary Specialist Group, Auckland, New Zealand.
recorded. Increased sternal contact is recorded. The intrathoracic trachea is displaced dorsally. Splitting of the mainstem bronchi can be identified in the lateral images. The dorsoventral view reveals increased prominence of the right ventricular outline, the left ventricular outline and the left auricular outline.

A low grade peribronchial lung pattern is recorded. There is no evidence for bronchiectasis.

Whilst the pulmonary vascular pattern is prominent, significant dilation of the vessels is not identifiable.

DX: cardiomegaly with suspected all 4 chamber cardiac enlargement.
APPENDIX D

Cytology on fluid filled cyst/pseudocyst/ abscess

Description of lesion: Pancreatitis and fluid filled cyst/pseudocyst/ abscess.

Site: Pancreas

Specimen: Brownish thick fluid

Cellular yield: High

Cytological description:

The cellularity was high and the cellular preservation fair. There was a moderate amount of pink, amorphous, granular background material. A large population of moderately lytic neutrophils were scattered throughout.

Diagnosis: Marked suppurative inflammation.

Interpretation: Although bacterial organisms were not observed, sepsis can’t be ruled out. The poor cellular preservation may have precluded identification of micro organisms.

Culture pending....

Microbiology on fluid cyst/pseudocyst/ abscess

Microscopy: GRAM STAIN: Moderate numbers of leukocytes and no organisms seen.

Culture: No growth from aerobic or anaerobic culture.

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Jejunostomy tube Feeding Plan and Protocol

PLAN:

BER = 30 x (body weight in kg) + 70

IER = Illness factor X BER

<table>
<thead>
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<tr>
<td>1.25</td>
<td>Cage rest, post operative.</td>
<td>BER:30 x 33 + 70 = 1060</td>
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<tr>
<td>1.25-1.35</td>
<td>Post Trauma</td>
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<td>1.35-1.5</td>
<td>Trauma, cancer</td>
<td>Hills A/d® has 180 kcal/can</td>
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<td>1.5-1.7</td>
<td>Sepsis</td>
<td>1378 kcal÷ 180kcal/can = 7.65 cans/day</td>
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<td>1.7-2.0</td>
<td>Major Burns</td>
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Jejunostomy tube Feeding Protocol

Patient: Gabby Fay

RULES:

1. Only ever place BODY TEMP fluids/food down the tube.
2. Inject the fluids/food SLOWLY (i.e. food meal over 10 minutes; water over a minute)

METHOD OF FEEDING THROUGH JENUNOSTOMY TUBE:

1. Food syringe – filled with BODY TEMP food (to warm put the food syringe with the slurry into a bowl of warm water for 10-15mins to warm up).
2. Flush tube with 5mls of body temp water.

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Veterinary Specialist Group – Client Handout Forms.

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3. Attach the food syringe – feed slurry over 10 minutes. Any faster and the animal may vomit.
4. Once finished feeding, flush the food in the tube with 5ml body temp water. (This keeps the tube clean and easy to move fluids/slurries through next time)
5. If any vomiting occurs, record it and let intern/resident know before administer the next feed.

______’s FEEDING REGIME IS AS FOLLOWS:

BER = either \[70 \times (\text{BW in kg})^{\frac{2}{3}}\] OR \[30 \times (\text{BW in kg}) + 70\] = …

IER = Illness Factor x BER = …

FIRST DAY: 1/3 IER – divided in 8 feeds/day
Day 1: Mix ___ can of _________ + __________ water → feed ___ml per feed.

SECOND DAY: 2/3 IER – divided in 8 feeds/day
Day 2: Mix ______ can of ________ + _________ water → feed ____ml per feed.

THIRD DAY AND EVERY FOLLOWING DAY: FULL IER – divided in 8 feeds/day
Day 3: Mix ______ can of ______ + _______ water → feed ___ml per feed.
APPENDIX F

Histology on the pancreatic mass

Gross Examination: Pancreatic mass- 100 x 70 x 45mm tissue

Histopathology: The tissue is composed of pancreas and peripancreatic adipose tissue. In the peripancreatic adipose tissue there is a large area of necrosis and saponification surrounded by numerous degenerate neutrophils. Encompassing this area are bands of early granulation tissue and then bands of fibrosis. The bands of fibrosis surround and separate the remnants of atrophied pancreatic tissue. There are small infiltrates of lymphocytes, macrophages and neutrophils throughout the pancreatic tissue and in the adipose tissue at the margins of the tissue submitted.

Morphologic Diagnosis: Pancreatic mass- Necrosuppurative pancreatitis and peripancreatitis, severe, regionally extensive, chronic-active.

Comment: This is an abscess as you had thought. There were no neoplastic cells seen in the tissue submitted. This may be a result of a previous pancreatitis, blocked duct or infection.

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APPENDIX G

Discharge Instructions for Gabby.11

Gabby had pancreatitis and a pancreatic abscess. The culture on the abscess has returned negative- this means that it was a sterile abscess. As she was on antibiotics when we cultured the fluid we cannot guarantee that she did not have a bacterial infection. We will be continuing on the antibiotics for a week.

Gabby is now prone to pancreatitis. Pancreatitis is inflammation of the pancreas. The pancreas is the organ which produces all the digestive enzymes. It is very painful and causes dogs to go off their food, vomit, develop diarrhea or just appear painful in their belly. Gabby should be fed a low fat diet from now on. This means no human food treats (sausages, fat off-cuts from meat, cheese, butter e.t.c) and should be kept on a low fat commercial dog food. Initially a diet of boiled chicken/ rice/ pasta or Hills science diet I/D® for the first few days with a transition onto a weight management diet. Your vet clinic will probably have a favorite brand they can recommend.

Gabby has a jejunostomy feeding tube in place. This has been bandaged in and hopefully you will not need to use this if she is eating well by herself. This will need to stay in until her sutures are removed. If she chews at this tube she will need to have an Elizabethan collar placed.

Gabby also has dilated cardiomyopathy. This means that her heart is much bigger than it should be and that the heart walls are much thinner than they should be. These thin walls do not contract properly causing a decreased output (can cause weakness, collapse.

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lethargy) or congestion behind the heart (coughing, difficulty breathing or a distended abdomen, inappetance, vomiting and diarrhea.) Gabby is going to be on heart medications for the rest of her life.

**Antibiotics**

- **Clavulox® 500mg tablets:** Give 1 ¼ tablets by mouth twice daily until finished. May be given with food.

- **Baytril® 150mg Tablets:** Give one tablet by mouth once daily until finished. May be given with food. This is given at night-time.

**Heart Medications**

- **Vetmedin® 5mg capsules:** Give one capsule by mouth twice daily. THIS MUST BE GIVEN ON AN EMPTY STOMACH 1 hour before food.

- **Fortekor® 20mg tablets:** Give half a tablet once a day. This is given at night-time, and may be given with food.

**Antinausea Drug**

Maxalon® 10mg Tablets: Give one tablet two to three times a day. Given 20-30 minutes before feeding.

**Pain relief medications**
- Fentanyl Patch® 100ug: This is a morphine-like drug that is administered in a patch form—much like nicotine patches. This is on her back and is covered with a light dressing. It is important that she doesn’t chew at this patch! It is important that little kids don’t have access to this patch also. It will provide pain relief until Saturday. We hope she doesn’t require further pain relief after this. You are welcome to leave this on until her revisit or you are welcome to remove it and dispose of it. It is adhesive so just pull it off gently. Do not touch the adhesive side.

- Gabapentin 50mg Capsules: This is an anti-seizure medication that also has good pain relief when combined with an opioid (Fentanyl). She only has two more doses of this remaining. This is given at night also.

Gabby will need a revisit in 1 week if all is going well. We would recommend a repeat abdominal ultrasound examination at this time to assess her pancreas. Her sutures will be removed at this time. It would be best to drop Gabby off in the morning and pick her up later in the afternoon once the ultrasound is done. Please call our reception team on 845 5455 to make an appointment that suits. If Gabby is not doing well, we will need to see her sooner. Please call reception on the weekdays or the Animal Emergency Centre on Weekends/Nighttime (8492121).