

VETERINARY REPORT

INDEX

INTRODUCTION	3
CHRONOLOGY	4
EVALUATION	7
BRACHYCEPHALIC OBSTRUCTIVE AIRWAY SYNDROME (BOAS)	7
ASPIRATION PNEUMONIA.....	11
ACUTE RESPIRATORY DISTRESS SYNDROME AND NON-CARDIOGENIC PULMONARY EDEMA	14
CONCLUSION AND RESOLUTION	17
FAILURE TO ADAPT THE HOSPITALIZATION PROTOCOL TO THE PATIENT'S BRACHYCEPHALIC PROFILE	18
DELAY AND DEFICIENCY IN COMMUNICATION WITH THE OWNER AFTER THE PATIENT'S DECOMPENSATION	19
LACK OF DOCUMENTED DIRECT MEDICAL INTERVENTION	20
UNSUPERVISED EXTUBATION DURING TRANSPORT	21
REFUSAL TO RELEASE THE COMPLETE MEDICAL RECORD FOLLOWING FORMALLY CERTIFIED REQUESTS	23

INTRODUCTION

To the attention of the owner:

A detailed analysis of the veterinary care provided to a patient is essential in order to understand the clinical sequence of events, assess the quality of medical decisions made, and determine whether the actions taken were aligned with the standards expected in current veterinary practice.

The purpose of this report is to provide a technical, rigorous, and evidence-based evaluation of the medical care received by Arthas, an intact male French Bulldog born on May 14, 2019, weighing approximately 10 kg, and five years old at the time of the events. Arthas lived with his owner, the owner, in the state of Pennsylvania.

This analysis focuses on the clinical events that occurred on August 12, 2024, the date Arthas was admitted to Stewartstown Veterinary Services for a temporary boarding service. Less than one hour after his admission, the patient developed acute signs of respiratory distress and was subsequently referred to Mason Dixon Animal Emergency Hospital, where he was urgently intubated and admitted in critical condition. Due to the severity of his condition and the poor prognosis, euthanasia was indicated as a welfare measure.

This report is based on the review of the owner's testimony, medical records issued by the emergency hospital, a structured chronological sequence of the events, and partial clinical records provided by the treating veterinary clinic. Additionally, documentary evidence is included that confirms both the sending and receipt of a formal request for the complete medical records, which, to date, have not been fully provided.

Based on this material, the report will proceed to examine, using clinical and technical criteria, the patient's medical history, clinical progression, available records, and communication between the clinic and the family, in order to determine whether the care received by Arthas met the expected clinical and ethical standards in the context of a respiratory emergency in a brachycephalic patient.

As of the date of this report, partial medical records from the treating clinic and the full clinical documentation from the emergency hospital have been obtained. It has also been confirmed that the clinic received a formal certified request for the complete medical history, yet this information has not been provided in its entirety. This lack of

documentation limits the ability to reconstruct the clinical case more precisely and will be taken into consideration in the present analysis.

CHRONOLOGY

At 09:00 a.m. **on August 12, 2024**, Arthas, an intact male French Bulldog, five years of age and with no prior history of relevant respiratory conditions, was admitted to Stewartstown Veterinary Services for a temporary boarding service. According to both the clinic's internal records and the owner's testimony, the animal was received in good general condition, displaying anxious behavior but no significant clinical signs. An internal clinic note states that Arthas was carried to the kennel area by staff after refusing to walk on his own.

Less than one hour after admission, approximately between 09:45 and 10:00 a.m., clinical staff observed that Arthas had begun hyperventilating inside the kennel and was producing a sharp, abnormal respiratory sound, described by staff as similar to that of a "guinea pig." Loose stools were also reported, possibly secondary to stress. According to handwritten clinical notes, the animal was brought to the treatment area, where increased respiratory effort and bluish tongue coloration were observed, prompting immediate initiation of oxygen therapy. Staff noted that Arthas did not tolerate the oxygen mask, so free-flow oxygen was administered via hood.

During this same time frame, the clinic staff attempted to contact the owner. According to the owner's testimony, between 10:00 and 10:04 a.m., she received three phone calls from the clinic: two were missed and no voicemail was left. During the third call, answered at 10:04 a.m., the receptionist informed her only that the dog "was not adjusting well to boarding" and needed to be picked up, without communicating at that time that the animal was experiencing respiratory distress or any other serious clinical signs. This omission is documented both in the owner's testimony and in internal staff notes, where it is admitted that the cyanotic state was not mentioned to avoid alarming the owner.

At 10:15 a.m., the owner called Stewartstown Veterinary Services to inform them that the owner's family member, would be arriving within minutes to pick up Arthas. During that call, and for the first time, the clinic staff disclosed that the animal

was in critical condition, stating that "he was purple and on oxygen," which suggests central cyanosis. No further explanation was provided, and the call was ended.

According to the clinic's internal clinical notes, after observing progressive dyspnea and moist lung sounds, the following medications were administered:

- Furosemide (Lasix) IM – 50 mg
- Dexamethasone SP IM – 3 mg
- Torbugesic (Butorphanol) IV – 3.5 mg
- Diphenhydramine (Benadryl) IV – 25 mg
- Propofol IV – for sedation and orotracheal intubation

An intravenous catheter was then placed, and the patient was endotracheally intubated following propofol induction, with the goal of securing a patent airway and improving oxygenation. Two thoracic radiographs were also taken, which, according to the Clinic, were sent to Mason Dixon Animal Emergency Hospital, but were never provided to the patient's family despite subsequent requests.

Between approximately 10:30 and 10:50 a.m., and following instructions from the emergency hospital, the patient's transfer was coordinated. The owner's family member,

drove her personal vehicle to Mason Dixon Animal Emergency Hospital (MDAEH). According to a later route verification provided by the owner, the facility is approximately 7.3 miles from Stewartstown Veterinary Services, with an estimated driving time of approximately 14 minutes under normal traffic conditions. She then returned to Stewartstown, where the staff prepared the patient for transport. Arthas was placed in the vehicle along with a veterinary technician later identified by ^{the owner's family member} as Brittany Jones, consistent with the initials 'BJ' appearing in Stewartstown's narrative record of the transfer, with his endotracheal tube in place and receiving supplemental oxygen.

During the trip to MDAEH, a significant event occurred. According to the accompanying technician's account, Arthas began retching and emitting sounds consistent with emesis or regurgitation, raising concerns about the risk of secondary aspiration. At that moment, and without prior veterinary consultation, the technician decided to deflate the endotracheal tube cuff and remove the tube, using a damp towel to wipe the oral cavity and throat of secretions. There is no record indicating that this decision was discussed with or authorized by a veterinarian during transport.

At approximately 11:00 a.m., Mason Dixon Animal Emergency Hospital was notified that Arthas would be transferred from Stewartstown Veterinary Services. Although 11:00 a.m. appears in the Mason Dixon record as the admission time, the owner subsequently contacted the hospital to clarify this discrepancy. According to that clarification, the 11:00 a.m. timestamp reflects the time Mason Dixon was first notified of the incoming transfer and does not represent Arthas's physical arrival at the hospital.

At 12:22 p.m., Mason Dixon attempted to contact the owner. She returned the call at 12:24 p.m. According to the owner's chronology, she was informed of the seriousness of Arthas's condition and the poor prognosis. The Mason Dixon medical record documents the owner's decision to proceed with humane euthanasia, although the conversation itself is not independently time-stamped within the clinical notes.

According to the subsequent clarification obtained from Mason Dixon, Arthas physically arrived at the emergency hospital at approximately 12:29 p.m. The first recorded vital signs begin at that time. Upon arrival, the emergency team documented profound cyanosis and severe respiratory distress and proceeded with urgent re-intubation and oxygen support. The patient was described as quiet, mildly dehydrated, with cyanotic mucous membranes and dyspnea. A body temperature of 105.2°F was recorded at 12:29 p.m., followed by a respiratory rate of 180 breaths per minute at 12:31 p.m., consistent with severe respiratory compromise and hyperthermia.

The emergency assessment documented respiratory distress, brachycephalic airway disease, hyperthermia, and a diffuse alveolar pulmonary pattern, with aspiration pneumonia and non-cardiogenic pulmonary edema included among the principal differential considerations. The prognosis was considered guarded to poor, with concern that recovery could require mechanical ventilation.

Euthanasia was performed at 12:57 p.m. on August 12, 2024, through intravenous administration of sodium pentobarbital, following sedation with propofol. The patient passed away in the presence of the Mason Dixon medical team, in a controlled environment and without active suffering at the time of the procedure.

On August 17, 2024, five days after the incident, the owner went to Mason Dixon Animal Emergency Hospital to collect Arthas's belongings.

During that visit, she was informed that her dog's remains had been cremated alongside other animals, and that it would not be possible to retrieve his ashes individually.

According to the owner, this decision was made without her express consent or prior notification, causing additional emotional distress.

On April 20, 2025, drafted and sent a formal demand letter requesting the full release of Arthas's medical records, including clinical notes, diagnostic images, administered medications, and all documentation related to his stay at the clinic. In the letter, the owner explicitly cited her right, as the legal owner of the patient, to unrestricted access to all medical information under state veterinary regulations and professional ethical guidelines.

The letter was sent via certified mail with return receipt requested.

The document was received and signed on April 26, 2025, by a member of the Stewartstown staff identified as Ivy, a veterinary technician who was also involved in Arthas's care that day. The signed return receipt and a copy of the letter are included in the file provided by the owner.

As of the closing date of this report, the clinic has not released the complete medical record requested. The partial information provided includes scattered clinical notes, a medication sheet, a handwritten narrative entry dated August 12, and older records from previous visits, but does not include the thoracic radiographs taken that day, a formal clinical summary, or the full chart notes from the case file.

EVALUATION

BRACHYCEPHALIC OBSTRUCTIVE AIRWAY SYNDROME (BOAS)

Brachycephalic Obstructive Airway Syndrome is a group of anatomical abnormalities that affect dog breeds with shortened skull morphology, such as the French Bulldog, English Bulldog, Pug, and Boston Terrier, among others. These abnormalities lead to a chronic partial obstruction of the upper airways, with severity ranging from mild symptoms to life-threatening respiratory collapse.

Anatomy and Pathophysiology of BOAS

Brachycephalic dogs have been selectively bred to possess shorter and wider skulls. However, this bone shortening is not accompanied by a proportional reduction in internal head structures (such as the tongue, palate, and soft tissues), creating a functional anatomical imbalance.

The primary abnormalities comprising BOAS include:

- Stenotic nares: narrow nostrils that impede airflow.
- Elongated soft palate: extends beyond the normal length, partially blocking the tracheal entrance.
- Tracheal hypoplasia: a narrower-than-expected tracheal diameter for the dog's size.
- Everted laryngeal sacculles: negative respiratory pressure causes small sacs in the larynx to invert inward, worsening the obstruction.
- Macroglossia and redundant pharyngeal tissues.

From a pathophysiological perspective, these dogs breathe with increased negative pressure and muscular effort, which causes chronic inflammation, repeated airway trauma, and eventually progressive collapse of structures like the larynx.

Common Clinical Signs

BOAS signs may appear as early as the first year of life and vary in severity. The most common signs include:

- Inspiratory stridor (harsh breathing noise).
- Excessive or noisy panting, even at rest.
- Exercise intolerance.
- Cyanosis (bluish mucous membranes).
- Syncope or collapse after excitement, exercise, or heat exposure.
- Inspiratory dyspnea with abdominal effort.
- Associated gastrointestinal problems like regurgitation or vomiting due to ongoing respiratory effort and increased intrathoracic pressure.

Signs often worsen during stress, high temperatures, or unsedated clinical handling.

Acute Decompensation: Respiratory Crisis in BOAS

A notable feature of BOAS is that dogs with only mild signs can rapidly decompensate in certain situations. The most common triggers of acute respiratory crises include:

- Intense emotional stress (such as hospitalization or separation from the owner).

- Hot or poorly ventilated environments.
- Sedation or clinical manipulation without appropriate monitoring.
- Vomiting or aspiration of gastric contents.

During these episodes, the animal experiences acute hypoxia, progressive respiratory effort, secondary laryngeal collapse, CO₂ buildup, disnea-induced hyperthermia, and eventually loss of consciousness or death if not managed promptly.

Clinical Diagnosis

BOAS is mainly diagnosed based on clinical signs and morphology, through:

- Compatible history and clinical signs.
- Direct observation of dyspnea and breathing sounds.
- Oral examination under sedation (to assess elongated palate, everted sacculles, etc.).
- Thoracic or tracheal radiographs (to identify tracheal hypoplasia or secondary pneumonia).
- Laryngeal endoscopy (in specialized centers).

It is also essential to rule out other respiratory conditions such as tracheitis, tracheal collapse, or concurrent heart disease.

Treatment and Clinical Management

BOAS treatment depends on the severity of the condition:

- Conservative measures (for mild to moderate cases):
 - Avoid heat, excitement, or strenuous activity.
 - Maintain ideal body weight.
 - Use a harness instead of a collar.
 - Use tranquilizers during stressful situations (under supervision).
- Surgical treatment (for moderate to severe signs):
 - Surgical correction of stenotic nares (e.g., alarplasty or alar wedge resection).
 - Soft palate shortening (staphylectomy or other palatoplasty techniques).

- Removal of everted sacculles.
- Temporary tracheostomy in severe or irreversible laryngeal collapse.

In cases of acute crisis:

- High-flow oxygen therapy.
- Controlled sedation.
- Endotracheal intubation and intensive care.
- Treatment of complications such as aspiration or pulmonary edema.

Prognosis

The prognosis for BOAS depends on severity and timing of intervention:

- When diagnosed and treated early, the prognosis is generally good.
- Brachycephalic breeds should never be considered “normal patients” during hospitalization and require continuous monitoring and tailored protocols.
- In decompensated cases or those with complications like aspiration pneumonia or laryngeal collapse, the prognosis can be poor to guarded even with intensive treatment.

In Arthas’s case, there is no prior formal diagnosis of BOAS, nor were there any persistent respiratory signs before admission. However, being a five-year-old French Bulldog, it is reasonable to assume he had typical brachycephalic anatomical features, even if they were not previously decompensated.

His acute respiratory decompensation less than an hour after being admitted to the veterinary Clinic, in the context of stress due to separation, confinement in a cage, possible hyperthermia, and emotional distress, is clinically compatible with an acute BOAS crisis, progressing to cyanosis, respiratory failure, and the need for intubation.

The lack of a prior diagnosis does not exclude the presence of the syndrome and highlights the importance of actively monitoring brachycephalic patients during hospitalization, even when no clinical signs have been previously reported.

ASPIRATION PNEUMONIA

Aspiration pneumonia is a pulmonary inflammation caused by the entry of gastric contents, food, saliva, or foreign material into the lower respiratory tract. In veterinary medicine, it represents a potentially life-threatening emergency, especially in patients with anatomical or functional abnormalities of the upper airway, such as brachycephalic dogs.

In Arthas's case, aspiration pneumonia was listed as the primary diagnosis by the medical team at Mason Dixon Animal Emergency Hospital, based on clinical signs, radiographic findings, and the history of vomiting/regurgitation during transport.

Pathophysiology of Aspiration Pneumonia

The pathogenesis of this disease is based on the accidental entry of gastric or pharyngeal contents into the lungs, which may lead to different forms of lung injury:

- Chemical injury: The acidic pH of gastric contents causes direct damage to the alveolar epithelium, leading to inflammation and local necrosis.
- Secondary bacterial infection: Oropharyngeal flora or stomach contents may contain bacteria that proliferate in the inflamed lung tissue, resulting in infectious pneumonia.
- Mechanical obstruction: In some cases, food particles or foreign material obstruct segmental bronchi, collapsing pulmonary regions.

In all cases, the combination of inflammation, tissue damage, and exudate accumulation leads to impaired gas exchange, progressive hypoxemia, and increased respiratory effort.

The most common predisposing factors include:

- Prior vomiting or regurgitation.
- Sedation or anesthesia (due to depressed swallowing reflex).
- Neurological diseases (e.g., dysphagia, megaesophagus).
- Orotracheal intubation (especially if extubation is poorly managed).
- Gastroesophageal reflux.
- Incorrect positioning during transport or post-operative recovery.

Clinical Signs

Aspiration pneumonia may present acutely or subacutely, and its severity depends on the amount and type of aspirated material, the patient's immune status, and how quickly treatment is initiated.

The most common clinical signs include:

- Dyspnea (labored breathing) with a mixed (inspiratory and expiratory) pattern.
- Moist or productive cough (may not be present initially).
- Tachypnea and increased abdominal breathing effort.
- Audible pulmonary crackles on auscultation.
- Fever, although it may not appear in the early stages.
- Cyanosis in severe hypoxemia cases.
- Lethargy, anorexia, and recumbency.

In severe cases, it can quickly progress to Acute Respiratory Distress Syndrome (ARDS) or sepsis, both carrying a poor prognosis.

Diagnosis

The diagnosis of aspiration pneumonia is made by integrating several elements:

- Medical history and predisposing factors: presence of vomiting, recent sedation, invasive procedures, etc.
- Physical examination: dyspnea, fever, crackles, pale or cyanotic mucous membranes.
- Thoracic radiographs: the main diagnostic tool, which may show:
 - Alveolar or interstitial infiltrates.
 - Bronchoalveolar pattern in cranioventral lobes (a typical aspiration area).
 - Pulmonary consolidation.
 - In early stages, X-rays may appear normal, so follow-up imaging is recommended.
- CBC: may show neutrophilic leukocytosis with left shift if active infection is present.
- Pulse oximetry or arterial blood gas: to assess oxygenation status.

- Tracheal wash or bronchoalveolar lavage (BAL): to identify the infectious agent and guide antibiotic therapy, though empirical treatment is often initiated in emergencies.

Treatment

Treatment should begin as early as possible to improve the prognosis and includes:

- Respiratory support:
 - Oxygen therapy (nasal cannula, oxygen cage, intubation if needed).
 - Nebulization and chest physiotherapy in selected cases.
- Broad-spectrum antibiotics, especially if fever, leukocytosis, or radiographic evidence of infection is present. Empirical options include:
 - Ampicillin + enrofloxacin.
 - Second or third-generation cephalosporins.
 - Clindamycin + fluoroquinolone.
- Bronchodilators and anti-inflammatories as needed.
- IV fluid therapy to maintain perfusion and support immune function.
- Antiemetics if vomiting or reflux is suspected.

Management should be tailored to the patient's clinical response and imaging evolution.

Prognosis

The prognosis is variable and depends on the timing of intervention and the patient's initial condition:

- In mild cases treated early, recovery may occur in 3–5 days.
- In patients with pre-existing lung disease, massive aspiration, or severe hypoxemia, the prognosis is guarded to poor.
- If complicated by respiratory distress, sepsis, or requiring mechanical ventilation, the mortality rate rises significantly.

In Arthas's case, the clinical hypothesis of aspiration pneumonia was recorded as the primary diagnosis by the emergency hospital. A large amount of fluid was observed in the lungs, and the patient was re-intubated upon physical arrival at Mason Dixon in a cyanotic state without effective spontaneous breathing.

The immediate antecedents, including vomiting during transport and subsequent airway manipulation, are highly consistent with this type of pulmonary injury. Aspiration had already been suspected prior to transfer; however, extubation during an episode of active retching and vomiting removed an important degree of airway protection and may have facilitated additional aspiration during transport.

Given the severe hypoxemia, respiratory distress, and poor response to oxygen therapy, it is more likely than not that Arthas developed an acute and severe form of aspiration pneumonia, possibly complicated by non-cardiogenic pulmonary edema or ARDS. His rapid and fatal progression is consistent with this clinical interpretation.

ACUTE RESPIRATORY DISTRESS SYNDROME AND NON-CARDIOGENIC PULMONARY EDEMA

Acute Respiratory Distress Syndrome (ARDS) is a severe clinical condition characterized by diffuse impairment of lung function, associated with intense inflammatory damage to the alveolar epithelium and capillary endothelium. This leads to massive fluid accumulation in the alveoli and refractory hypoxemia.

Although its presentation may resemble cardiogenic pulmonary edema, in ARDS the heart is typically structurally normal. In veterinary medicine, ARDS and non-cardiogenic pulmonary edema (NCPE) often overlap clinically and share many causes and pathophysiological mechanisms.

In Arthas's case, upon emergency admission to Mason Dixon Animal Emergency Hospital, a severe radiographic pattern compatible with pulmonary fluid accumulation was documented, along with deep cyanosis and poor response to oxygen therapy, all clinical signs consistent with ARDS and/or NCPE.

Pathophysiology of ARDS and NCPE

Both conditions involve failure of the alveolar-capillary barrier, allowing protein-rich fluid (exudate) to leak into the alveolar space, directly interfering with gas exchange.

The main causes of ARDS in veterinary medicine include:

- Aspiration of gastric contents (as in aspiration pneumonia).
- Systemic sepsis or severe pulmonary infection.
- Thoracic or pulmonary trauma.

- Hypovolemic or distributive shock.
- Acute pancreatitis, burns, massive transfusions.

Non-cardiogenic pulmonary edema, while sharing the same final mechanism of fluid accumulation, may also arise from:

- Electrocutation, seizures, or extreme stress.
- Acute upper airway obstruction (as in decompensated BOAS).
- Sudden or improper extubation after prolonged ventilation.
- Pulmonary flooding due to alveolar overdistension.

In Arthas's case, several of these factors are present: acute upper-airway compromise, extreme stress, vomiting/regurgitation with aspiration risk, recent sedation and airway instrumentation, and extubation during transport without a veterinarian physically present.

Clinical Signs

Signs of ARDS/NCPE present suddenly and severely, and include:

- Severe, acute-onset dyspnea.
- Generalized cyanosis.
- Tachypnea with marked use of accessory muscles.
- Diffuse, moist pulmonary crackles.
- Cough.
- Lethargy, recumbency, loss of consciousness.
- Bradycardia or tachycardia depending on the phase.

Animals with ARDS may be intubated and still have poor oxygenation, as oxygen diffusion across alveolar fluid is severely impaired.

Diagnosis

Diagnosis is based on:

- Thoracic radiographs: diffuse alveolar infiltrates, severe interstitial pattern, loss of lung field definition.

- Arterial blood gas: severe hypoxemia ($\text{PaO}_2 < 60 \text{ mmHg}$) that does not improve with supplemental oxygen.
- Assessment of underlying causes: infection, sepsis, trauma, aspiration, etc.
- Echocardiography: may help rule out cardiogenic edema if suspected, though not always available in emergency settings.

Treatment

ARDS and non-cardiogenic pulmonary edema require intensive and specialized care.

Priorities include:

- High-flow oxygen therapy: oxygen cage, nasal cannulas, or mechanical ventilation if needed.
- Mechanical ventilation with PEEP (positive end-expiratory pressure) to keep alveoli open and facilitate gas exchange.
- Controlled sedation and stress reduction.
- Treatment of the underlying cause, if identified (antibiotics, anti-inflammatories, shock management, etc.).
- Diuretics such as furosemide may be used in selected cases but should be evaluated individually, since the issue is not of cardiac origin.
- Cautious fluid therapy, monitoring perfusion and oxygenation parameters.

This treatment requires an intensive care setting, continuous monitoring, and trained personnel.

Prognosis

The prognosis for ARDS is very guarded, with mortality rates exceeding 50% even with advanced support. Poor prognostic indicators include:

- Delay in initiating treatment.
- Refractory hypoxemia.
- Presence of sepsis or massive aspiration.
- Limited access to mechanical ventilation.

The prognosis improves if the underlying cause is identified and treated early, and if the patient responds quickly to oxygen therapy.

In Arthas's case, his clinical state upon arrival at the emergency hospital included deep cyanosis, apnea, and the need for intubation and assisted ventilation, all of which are consistent with an advanced ARDS picture.

The accumulation of fluid in the lungs, described by the Mason Dixon veterinary team, together with the suspected aspiration of vomit and the inappropriate removal of the airway during transport, are well-recognized risk factors for the development of non-cardiogenic pulmonary edema and ARDS.

Despite emergency measures taken, including reintubation, the prognosis at that time was extremely poor, and the veterinary team informed the owner that recovery was highly unlikely. The decision to proceed with euthanasia was made due to the lack of clinical response and progressive deterioration of the patient.

CONCLUSION AND RESOLUTION

Given that my knowledge of the facts of the case is limited to the representations made in the owner's statement and the medical records, my opinion is qualified and limited.

I am a licensed veterinarian. My specialty field is general veterinary practice. Although my education and work experience occurred outside of the United States, my education and knowledge are equivalent to that of a United States licensed veterinarian.

I have reviewed the standards of practice in the United States and determined that I use equivalent standards of veterinary practice as in the United States. Further, I use the same continuing education and research materials to diagnose and treat animals. Full details of my qualifications and experience entitling me to give expert opinion evidence in this case are attached as appendix 1.

Based on a detailed review of the partial medical records provided by Stewartstown Veterinary Services (Stewartstown, Pennsylvania), the clinical documentation from Mason Dixon Animal Emergency Hospital (Shrewsbury, Pennsylvania), as well as the structured testimony of the patient's owner, the owner, elements have been identified that justify a thorough technical review of the clinical and administrative management carried out on August 12, 2024, during the brief stay of Arthas, a male French Bulldog born on May 14, 2019, at the aforementioned veterinary clinic.

According to the available information, Arthas was admitted for boarding service at 9:00 AM and developed an episode of acute respiratory decompensation in less than an hour. This led to a series of emergency clinical actions, including oxygen therapy, sedation,

intubation, and transfer to the emergency hospital. Upon arrival at Mason Dixon, the patient was re-intubated in a state of profound cyanosis and with no effective spontaneous breathing. He was diagnosed with a condition consistent with aspiration pneumonia with significant pulmonary fluid accumulation, in a clinical context suggestive of acute respiratory distress syndrome (ARDS). The patient was euthanized a few hours later due to an extremely poor prognosis.

It is also documented that, despite the issuance of a formal, certified request for the complete release of the patient's medical record, the treating clinic has not provided such documentation by the time of this report's completion. This limits the ability to conduct a retrospective clinical analysis on several critical aspects of the initial management.

On this basis, the following key evaluation points will be presented regarding the clinical practices observed, contrasting them with currently accepted professional standards in small animal veterinary medicine, and assessing whether they may have influenced the unfavorable outcome of Arthas.

FAILURE TO ADAPT THE HOSPITALIZATION PROTOCOL TO THE PATIENT'S BRACHYCEPHALIC PROFILE

Arthas was admitted to Stewartstown Veterinary Services on August 12, 2024, at 9:00 AM for temporary boarding. As outlined in the clinical evaluation, brachycephalic dogs have a clear anatomical predisposition to upper airway obstruction, hypoventilation, and hypoxia under conditions of stress, heat, sedation, or confinement, circumstances that must be strictly considered during hospitalization.

According to the collected data, Arthas began to show signs of acute respiratory distress within 45 minutes of admission. Despite this rapid decompensation, there is no indication in the provided medical records of any specific protocol for intensive clinical observation, environmental control (temperature, humidity, stimuli), or preventive measures adapted to his anatomical profile and known breed-related risks. Additionally, no records were provided regarding vital signs during his stay at the clinic before the acute event, nor was there any pre-admission evaluation to verify whether the patient exhibited early signs of dyspnea, anxiety, or hypoxia at intake.

The absence of these elements, coupled with the rapid progression to cyanosis, emergency intubation, and critical transfer, indicates that an appropriate preventive protocol was not applied, nor was risk-proportional monitoring performed. Brachycephalic dogs should be housed in quiet areas, with frequent observation, strict

environmental control, and immediate availability of oxygen therapy, as even minor physiological alterations can quickly lead to decompensation in this population.

Given that Dr. Elizabeth Preston was the veterinarian in charge at the time of admission and that no documented actions were taken to prevent a foreseeable event related to breed-specific conditions, this is considered a deviation from standard practice due to failure in anticipating and monitoring known clinical risks.

It is more likely than not that the absence of a preventive management protocol adapted to brachycephalic syndrome directly contributed to the episode of acute respiratory decompensation suffered by the patient within the first hour of hospitalization.

DELAY AND DEFICIENCY IN COMMUNICATION WITH THE OWNER AFTER THE PATIENT'S DECOMPENSATION

On August 12, 2024, Arthas was admitted at 9:00 AM to Stewartstown Veterinary Services. According to the chronological testimony of the owner, ^{the owner,}

the clinic did not attempt to contact her until 10:00 AM, one hour after admission, despite later statements by Dr. Elizabeth Preston indicating that the dog was already experiencing respiratory distress just 15 minutes after being kenneled.

The calls placed at 10:00 AM and 10:02 AM included no voicemail messages or clinical details, and it was not until 10:04 AM, during a brief one-minute phone conversation, that the owner was told Arthas “wasn’t adapting well to boarding” and “needed to be picked up.” At no point during this initial call was an acute respiratory condition or a potentially critical clinical status mentioned.

The true severity of Arthas’s condition was not disclosed until 10:15 AM, when the owner called back to report that ^{the owner’s family member} was en route to retrieve the dog. It was at that point that she was abruptly informed, “your dog is purple and on oxygen.” This statement was delivered without prior warning, without adequate context, and without any clarification regarding medical decisions, prognosis, or the need for immediate veterinary intervention.

Despite the fact that the clinic had known for at least 30 minutes that the patient was cyanotic and required oxygen therapy, there was a delay in providing direct, clear information to the owner. No documented communications from Dr. Preston were recorded during that interval, suggesting that the situation was managed by auxiliary staff during a critical clinical event.

From a medico-legal perspective, early, clear, and honest communication with the patient's legal owner is a non-negotiable professional duty, especially in emergency situations. Partial disclosure or symptom minimization not only compromises the owner's ability to make informed decisions but also delays interventions that could be decisive in the course of the case.

In this specific situation, the lack of timely information prevented the owner from effectively fulfilling her role as the patient's legal guardian and even caused confusion during the transfer, as she was unaware that her dog required urgent hospitalization until he was already en route to the emergency hospital.

Given that Dr. Elizabeth Preston was the attending veterinarian responsible for the patient, and that the calls were made under her direct supervision, this is considered a case of professional negligence due to omission in communication, both in form, content, and timing.

It is more likely than not that the delay and poor quality of communication with the owner contributed to a lost diagnostic and therapeutic opportunity, as well as to an increased clinical risk for the patient during the acute episode.

LACK OF DOCUMENTED DIRECT MEDICAL INTERVENTION

In the clinical case of Arthas, the available information indicates that following his admission at 9:00 a.m. on August 12, 2024, at Stewartstown Veterinary Services, the patient began to show signs of severe respiratory distress within the first 45 minutes. According to subsequent testimony by Dr. Elizabeth Preston, Arthas experienced an episode of dyspnea and abnormal respiratory sounds approximately 15 minutes after admission, clearly indicating that it was a potentially critical situation from a very early stage.

Despite the severity of this presentation, no clinical documentation signed by Dr. Preston or any other veterinarian has been provided to confirm direct evaluation of the patient during this episode. The only available notes are fragmentary, lacking specific timestamps or comprehensive medical structure, and were presumably written after the fact. There is no record of physical examinations, monitoring of vital signs, sequential clinical decision-making, or differential diagnoses, all of which are part of the minimum documentation standard in veterinary medicine.

Furthermore, during the entire deterioration process, including sedation, oxygen administration, intubation, and preparation for transfer, no documents indicate real-time

supervision by the attending veterinarian. The medical intervention appears to have been delegated to technical staff, which constitutes a significant deviation from accepted clinical protocols for managing respiratory emergencies in brachycephalic animals.

Attending a critically ill patient requires immediate and continuous assessment by a licensed veterinarian. The absence of detailed clinical records or a professional signature during an episode with a fatal outcome severely compromises the traceability and transparency of the medical act. Moreover, the patient's clinical evolution and the rationale behind the decisions made before transfer were not properly documented.

It is more likely than not that the absence of documented, direct, and continuous medical supervision by Dr. Elizabeth Preston during the critical phases of Arthas's respiratory episode represented a lost clinical opportunity, both for patient stabilization and for urgent therapeutic decision-making.

Therefore, this constitutes a deviation from standard veterinary practice due to the omission of direct medical oversight during the initial management of a life-threatening Emergency, especially serious given the patient's high-risk anatomical profile.

UNSUPERVISED EXTUBATION DURING TRANSPORT

Once a diagnosis of respiratory distress was established in Arthas on August 12, 2024, Stewartstown Veterinary Services decided to transfer the patient to Mason Dixon Animal Emergency Hospital, concluding that they lacked the necessary resources for continued stabilization. The transfer was not arranged via a specialized veterinary transport service; instead, the patient's family was asked to collect oxygen therapy equipment from the referral hospital and bring it back to Stewartstown for use in a private vehicle.

During this process, Arthas was sedated and intubated, then placed inside the family vehicle in a portable oxygen unit, accompanied solely by a veterinary technician identified by the owner's family member as Brittany Jones. This identification is also consistent with a narrative entry in Stewartstown Veterinary Services' records signed with the initials 'BJ,' in which the author states that she accompanied Arthas during the transfer and removed the endotracheal tube.

The attending veterinarian, Dr. Elizabeth Preston, did not participate in the transport or accompany the patient, delegating this responsibility to technical staff.

While en route, according to the Stewartstown narrative entry signed 'BJ,' Arthas began retching and producing vomit, raising concern for further aspiration. The technician then decided to deflate the endotracheal tube cuff and remove the tube.

In a critically ill, sedated patient, the decision to extubate should be made under direct veterinary direction, in a controlled environment, and only once it has been confirmed that the animal has adequately regained protective airway reflexes, swallowing ability, an effective spontaneous respiratory pattern, and appropriate oxygenation.

In brachycephalic dogs, these precautions are even more critical, as their naturally narrower airways can lead to severe hypoxia within seconds if compromised.

In this case, Arthas was under sedation, lacked active monitoring during transport, and there is no indication that any professional assessment was made to determine whether he was capable of maintaining his airway on his own. The veterinary technician proceeded with extubation in a non-medical setting (a moving vehicle), without emergency support or veterinary evaluation, and there is no documentation establishing that the decision to extubate was made under direct veterinary instruction.

Shortly after this intervention, and as documented in the records from Mason Dixon Emergency Hospital, Arthas arrived showing signs of severe cyanosis and acute respiratory distress. He was immediately reintubated, and large amounts of fluid were found in the airway, consistent with pulmonary aspiration.

Under normal conditions, a correctly positioned endotracheal tube with an appropriately inflated cuff provides substantial protection against aspiration of gastric contents, although it does not eliminate this risk completely.

Premature extubation in a sedated or unstable patient eliminates this protection, making any subsequent vomiting highly likely to result in aspiration. This precisely matches the clinical picture observed upon arrival at the emergency hospital, where severe aspiration pneumonia was considered a major contributor to the patient's critical respiratory condition and poor prognosis.

This intervention constitutes a clear case of clinical malpractice, as it involved a medical procedure (extubation) performed by unauthorized personnel, outside of a clinical setting, and without the required medical evaluation. Moreover, it reflects improper delegation of duties by Dr. Elizabeth Preston, who, as the case's responsible veterinarian, allowed a critical patient to be transferred under the sole supervision of technical staff, without the presence of a veterinarian.

It is more likely than not that the inappropriate extubation performed by an auxiliary staff member during transport directly contributed to the pulmonary aspiration of gastric contents, triggering acute respiratory distress syndrome and, ultimately, the patient's death.

REFUSAL TO RELEASE THE COMPLETE MEDICAL RECORD FOLLOWING FORMALLY CERTIFIED REQUESTS

According to the documentation provided by the owner, the legal owner of Arthas, multiple attempts were made to obtain the full clinical record of the patient following his death on August 12, 2024. These attempts included emails, verbal requests, and a certified letter with return receipt, dated April 20, 2025, sent directly to Stewartstown Veterinary Services, formally demanding the full release of all medical records.

Despite having been formally notified and having signed for receipt of the request, the clinic has not provided the complete clinical record to date. The only documents received by the owner are partial and fragmentary, lacking detailed progress notes from the day of the incident, signed medical entries from Dr. Elizabeth Preston, and complete information on administered treatments, monitoring, vital signs, sedation or intubation justifications, or diagnostic results such as radiographs or lab tests.

The repeated refusal of a veterinary clinic to release a patient's complete medical history, even after a formal, certified request, constitutes a direct violation of ethical and legal standards in veterinary practice. In the state of Pennsylvania, as in most U.S. jurisdictions, veterinary records are the property of the clinic, but access and copies must be provided without undue restriction to the legal owner of the animal, who has the right to obtain all clinical information related to their pet.

Lack of documentation transparency not only violates this right, but also obstructs independent case review, and raises serious concerns about the integrity of the records and the clinic's willingness to cooperate with professional oversight mechanisms.

Furthermore, the fact that Dr. Preston's account has changed multiple times, and that inconsistencies exist between her verbal statements and the scant documentation provided, reinforces the suspicion that the original medical record has been altered or that key portions have been deliberately omitted.

It is more likely than not that the repeated refusal by Dr. Elizabeth Preston and Stewartstown Veterinary Services to provide the complete medical record was intended

to hinder independent analysis of their clinical performance and to avoid exposure of possible serious errors or omissions.

This conduct is therefore considered a serious ethical violation and a direct obstruction of the owner's right to clearly understand the circumstances surrounding the death of their animal.

the reviewing veterinarian concludes that there is a

reasonable probability that the clinical management of the patient Arthas

a male French Bulldog, under the responsibility of Dr. Elizabeth Preston, DVM, at Stewartstown Veterinary Services (Pennsylvania, USA), involved acts of veterinary professional negligence, as the care provided did not meet the accepted standards of monitoring, oversight, and clinical responsibility expected in contemporary veterinary practice.

Specifically, four critical areas of negligence have been identified:

1. The absence of a hospitalization protocol tailored to the respiratory needs of a brachycephalic patient, who required early and specialized care upon admission.
2. The delayed and deficient communication with the owner during a life-threatening emergency, which compromised the legal guardians' ability to act with complete and timely information.
3. The lack of documented, direct medical intervention by the responsible veterinarian during the patient's clinical deterioration, with management of a critical situation being delegated to non-licensed technical staff.
4. The improper extubation carried out by a veterinary assistant during transport while the patient was sedated and unstable, which most likely facilitated massive pulmonary aspiration, leading to acute respiratory distress syndrome and the patient's death.

These events are further compounded by the unjustified and repeated refusal by Dr. Preston and Stewartstown Veterinary Services to release the full medical record, even after a formal certified request by the owner, an infringement of the ethical and legal principles of transparency and access to medical information.

In this context, it is more likely than not that the clinical omissions and decisions identified directly contributed to the acute deterioration and death of Arthas, preventing timely stabilization, hindering effective medical intervention at critical moments, and seriously

affecting the owner's right to understand the circumstances and to receive competent, diligent veterinary care.

These actions, both by commission and omission, constitute a clear deviation from accepted clinical, ethical, and technical standards, and collectively define a scenario of professional negligence with foreseeably avoidable fatal consequences, affecting both the welfare of the patient and the legal and emotional rights of the owner.

This opinion is subject to modification should additional information be provided and is intended exclusively for the use of the requesting party. This opinion is not to be published without the express permission of the undersigned.

Originally issued on June 15, 2025.

Amended on August 10, 2026, to incorporate factual clarifications received after issuance of the original report