



PATIENT

Ginger Randles

SPECIES

Canine

BREED

Pug

SEX

Spayed Female

AGE

14 Years 6 Months

WEIGHT

19 Pounds

INTERPRETED BY

Eric Lindquist, DMV,
DABVP (CFM), Cert.
IVUSS

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue VC

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

36269

DATE

3/17/26

PRESENTING CLINICAL SIGNS

- Referral. Presents for progressive inappetence, significant weight loss, and decreased voluntary urination/defecation following recent dental procedure.
- Inappetence began three weeks ago; initial two days of decreased appetite.
- Diagnosed with UTI; treated with antibiotics, developed vomiting as adverse reaction.
- Anti-nausea medication administered; adverse reaction noted.
- Appetite stimulant prescribed; ineffective.
- Syringe feeding Royal Canin Liquid Recovery: 4–8 mL every 3 hours tolerated.
- Dental procedure performed Thursday; four teeth extracted.
- Fentanyl patch applied post-op, removed Sunday as directed.
- No current medications or supplements.
- Last bowel movement Wednesday pre-surgery; loose stool, likely due to liquid diet. No defecation since surgery.
- Urination only when physically taken outside; not self-initiated since surgery.
- Drinking frequency unchanged; increased volume per episode.
- Weight history: 26.7 lb (end of January), 21 lb, 20 lb, 19 lb (recent).
- Previous radiographs (morning of surgery): cardiomegaly, gas in colon, undulated splenic margins.
- Previous antibiotic injection administered at surgery.
- Albumin previously noted as low; no prior client notification.
- Current Treatment:
 - 03/03/2026: amoxicillin clavulanate 12.5 mg/kg PO Q12h
 - 3/6/2026: SQ fluids, Cerenia, Mirtazapine
 - 03/09/2026: hospitalization for IV fluids for the day
 - 03/12/2026: dental extractions, intraoperative atropine for hypotension, carprofen, fentanyl patch
- Abnormal PE/Chem/CBC/UA Results: Abnormals: Lethargic, minimal energy, prefers resting, Significant weight loss, sarcopenia, post-extraction, healing well, heart murmur, increased rate and effort ; BP: 124/64 (159), 97/74 (114), 107/75 (154) 3/17/26: Albumin < 1.0, BUN 37, Calcium 7.7, Total Protein 3.4, WBC 89.02, LYM 15.08, MON 7.47, NEU 66.10, RDWc 20.7 Pending chest rads rDVM: 03/03/2026: CBC neutrophilia 32,700/uL, Hypoalbuminemia 1.7 g/dL, Thoracic RADS: cardiomegaly



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ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex, and no evidence of pelvic dilation was present. Acute on chronic infarcts appear to be present with enhanced mesentery around the recent infarcts. Hypercoagulable state is likely. The kidneys measured 3.5 cm each.

Adrenal Glands

The **adrenal glands** were not visualized.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume, and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable. No evidence of passive congestion.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed an unremarkable stomach and small intestine regarding structure. There were minor areas of luminal fluid noted. There was no evidence of obstructive pattern. Curvilinear patterns were retained throughout the gastrointestinal tract. Areas of hyperperistalsis were noted. This is consistent with response to irritation. The colon was unremarkable. Enhanced mesentery and pockets of free fluid were noted associated with the small intestine. The gastric wall measured 1.0 cm in wall thickness.

Pancreas



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The **pancreas** was hypoechoic and irregular with undulating contour and enhanced surrounding mesentery, suggestive for pancreatitis.

ULTRASONOGRAPHIC FINDINGS

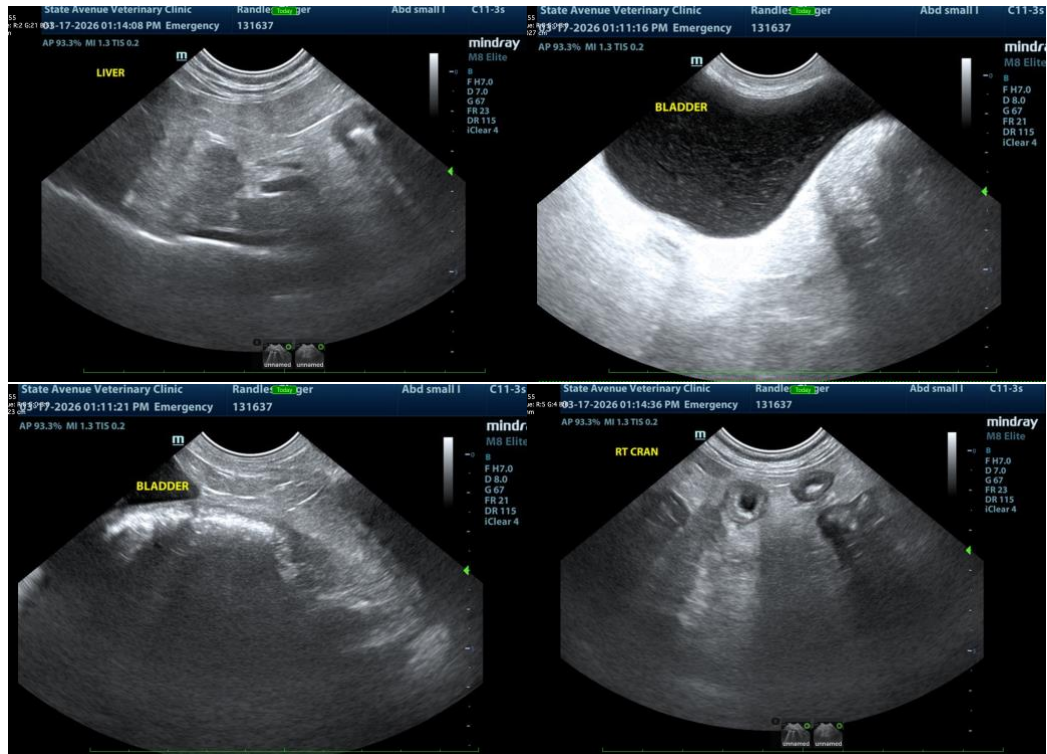
- Protein losing enteropathy with gastroenteritis/pancreatitis
- Chronic renal changes with acute infarcts
- Age-related hepatic changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt neoplastic criteria was noted, however, cannot rule out emerging round cell neoplasia in the intestinal tract. Plasma transfusion is likely in this patient's best interest. Full thickness surgical GI biopsies would be necessary for definitive diagnosis; however, some information may be able to be obtained through endoscopy of the upper gastrointestinal tract. Recheck sonogram after 72 hours of therapy and reassessment of the clinical status.

For an additional charge, internal medicine consult can be utilized through SonoPath.com. You can select the internal medicine drop down at <http://spa.sonopath.com/>.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. <https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services>





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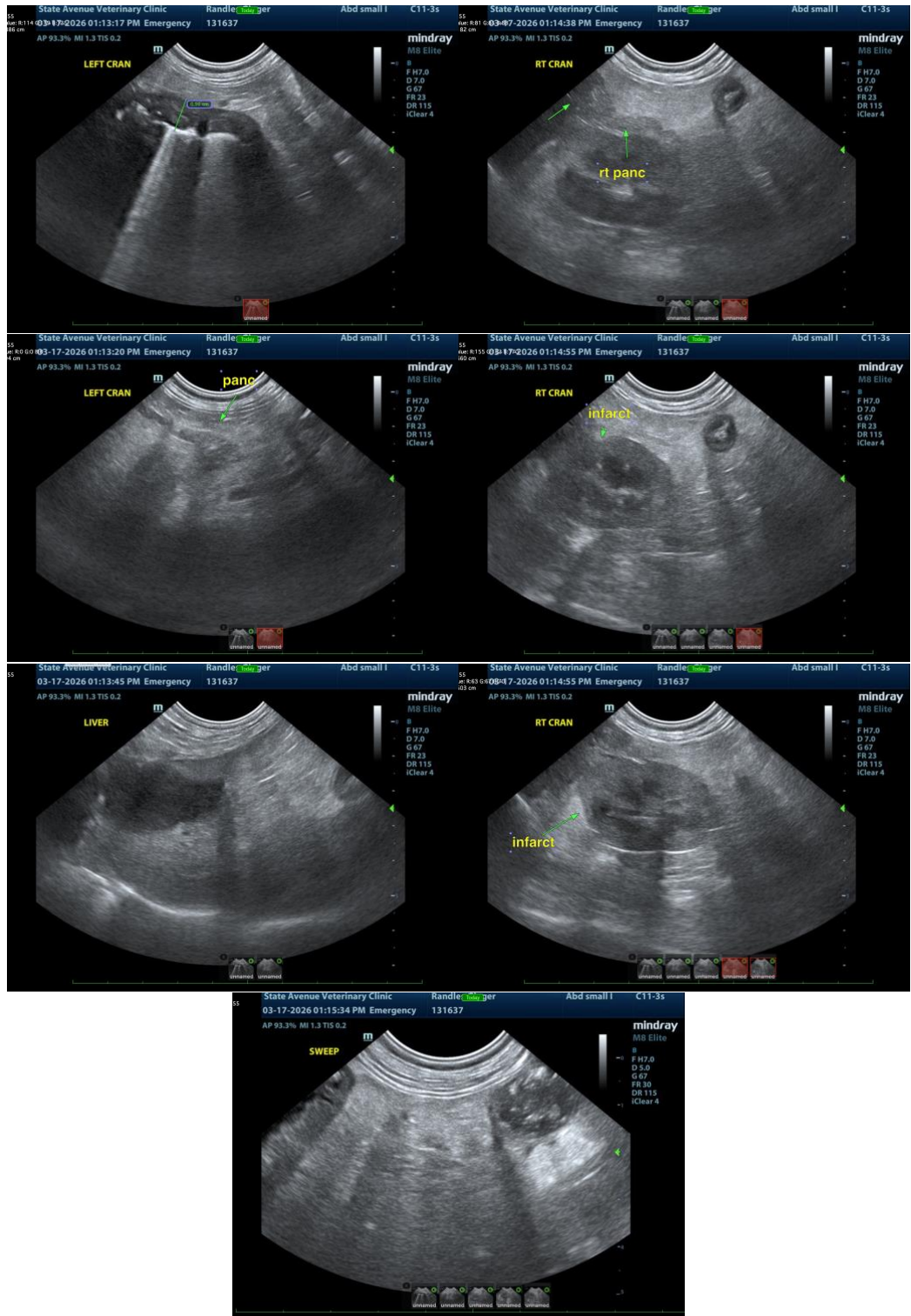
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,
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