



**PATIENT**

Polly Fortley

**SPECIES**

Canine

**BREED**

Yorkshire Terrier

**SEX**

Spayed Female

**AGE**

10 Years 6 Months

**WEIGHT**

Not Provided

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Creature Comforts  
Veterinary Service

**REFERRING VET**

Dr. Mary Van Horn

**INVOICE**

16558

**DATE**

05/28/26

**PRESENTING CLINICAL SIGNS**

Acute onset of dyspnea. HAC Dx'd 7/2025-on Trilostane dose inc 1/2026-recent purulent nasal and ocular d/c (chronic serous d/c). No murmur, no pulse deficits, sinus rhythm. Renal and bladder calculi, OA, hepatomegaly, cushingoid appearance. (rad report and rads attached for reference)  
BCS 6/9. Current Medications: Trilostane 30mg q24; Furosemide 7.5mg q8; Pimobendan 1.25mg am/0.625mg pm.

Abnormal PE/Chem/CBC/UA Results: ALT=725; ALP=1630; Toxic neutrophilia-17,680; HCT 21% non-regenerative.

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN**

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	--	--	1.3	1.32	39	73	0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (kg)	LAD LA MAX 4 Chamber	LVIDd Avg; 2D and m-mode short axis (cm)	LVIDs Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	149	2.1	2.1	NM	1.5	1.96	--

**Cardiac Presentation**

The echocardiogram in this patient demonstrated normal **left atrial** size based on 3 separate methods of LA evaluation. The cranial and caudal **mitral** valve leaflets presented normal linear structure, extension in systole, and union in diastole with normal kinesis. The **left ventricle** presented normal thicknesses with linear contour and was not dilated nor restricted. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. **Contractility** of the ventricular walls was adequate and in normal range for this patient evidenced by the fractional shortening measurement and subjective evaluation of the different regions of the myocardium. The **left ventricular outflow** tract demonstrated normal laminar flow and subjective structural integrity. The **right atrium** presented with minor enlargement with minor right ventricular hypertrophy. No evidence of masses was noted. **Tricuspid** valvular assessment demonstrated measurable insufficiency consistent with cor pulmonale and appeared compensated. **Pulmonary outflow** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. The cranial **mediastinum and pericardial and extra-cardiac regions** were free of masses in the visible window. The hepatic veins were not dilated. A comet tail lung pattern was noted through the diaphragm/B lines.



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***Urinary System***

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The **urinary bladder** revealed a sand accumulation measuring 0.8 cm. The bladder itself was unremarkable otherwise.

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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 his age patient. Medullary structure differed distinctly from that of the cortex. Dystrophic mineralization was noted and non-obstructive at this time. The left kidney measured 4.05 cm in length. The right kidney measured 4.05 cm in length.

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***Adrenal Glands***

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The **adrenal glands** appeared moderately enlarged and swollen. No evidence of focal capsular expansion or invasion into the phrenic veins was noted. No overt suspicion of neoplasia was noted. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH). If isosthenuria is persistently present and the patient morphologically suggests Cushing's disease then ACTH testing would be indicated. The left adrenal gland measured 2.76 cm x 1.3 cm width at the caudal pole and 1.03 cm width at the cranial pole. The right adrenal gland measured 2.77 cm x 1.16 cm width at the caudal pole and 1.07 cm width at the cranial pole. The left adrenal gland is mildly irregular; this may be simple hyperplasia owing to degenerative and hyperplastic phenomenon associated with Cushing's disease.

**WEIGHT**

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***Spleen***

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The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

***Liver***

**IMAGING PERFORMED BY**

Shari Reffi, CVT

The **liver** was uniformly swollen with mild, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

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***Gastrointestinal***

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Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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***Pancreas***

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Diffuse hyperechoic changes were present in the area of the **pancreas**. The pancreatic remodeling was evident with multifocal to diffuse hyperechoic changes. These changes are consistent with fibrosis, amyloid, saponification of fat and may contain areas of low-grade chronic active inflammation especially if pain on imaging (+ Murphy sign) was present +/- focal subxiphoid palpation reveals pain response. No overt masses were noted.

**ULTRASONOGRAPHIC FINDINGS**



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- Minor right-sided cardiac enlargement/cor pulmonale pattern. No evidence of right-sided failure. Concern for pulmonary disease.
- Age-related renal changes with nonobstructive mineralizations.
- Bilateral adrenal hypertrophy, consistent with PDH.
- Volume contracted spleen.
- Pancreatic fibrosis pattern.
- Non-specific inflammatory hepatopathy.
- Nonobstructive bladder calculi.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Assessment for thoracic pathology that may be increasing right-sided heart pressures is indicated, yet changes were fairly mild. The respiratory signs are non-cardiogenic at this time. There is no evidence of left-sided volume overload. Lasix therapy may be assisting with primary pulmonary edema, however, this is non-cardiogenic at this time as left atrial size is normal. The heart appears compensated. There is no evidence of clinical pulmonary hypertension at this time.

Blood pressure measurements are warranted. Primary respiratory protocol based on radiographic findings and CBC path review +/- bone marrow aspirate would be ideal. Thromboembolic disease should be considered as a potential or primary respiratory disease, however, this would not explain the anemia.

The abdomen appears largely compensated and stable from a structural standpoint with the exception of the left adrenal irregularity. Serial blood pressure is warranted. If hypertension is an issue, urine metanephrine level is indicated.

If the dyspnea was episodic, it is possible that the patient passed calculi from the kidneys to the bladder and pain-related dyspnea may be an issue, however, if dyspnea is a persistent issue, primary respiratory disease or thromboembolic shower should be considered as potentials.

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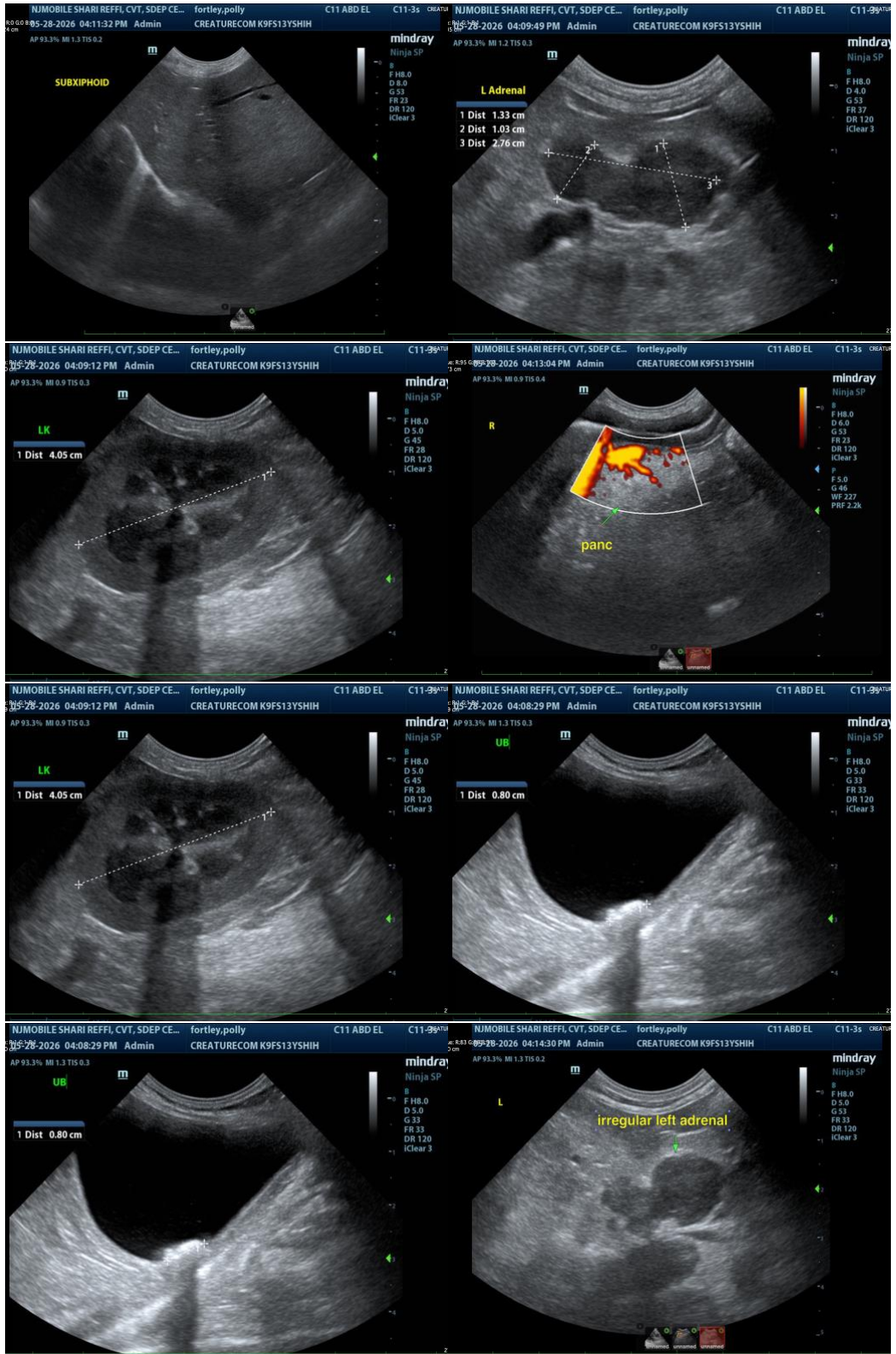
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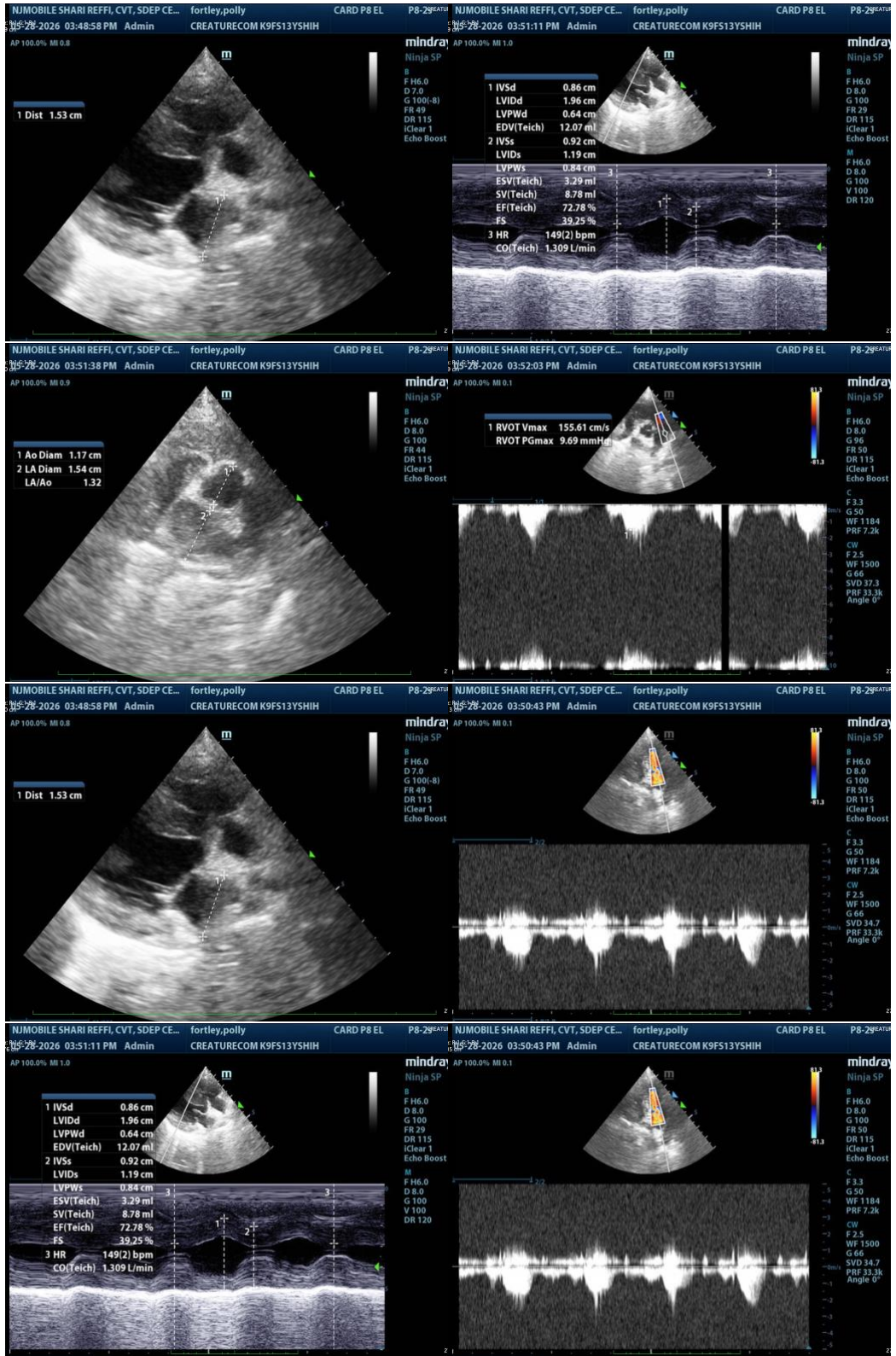
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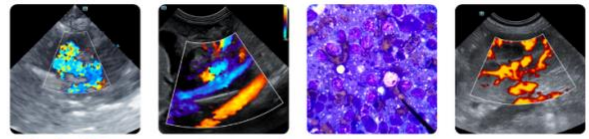
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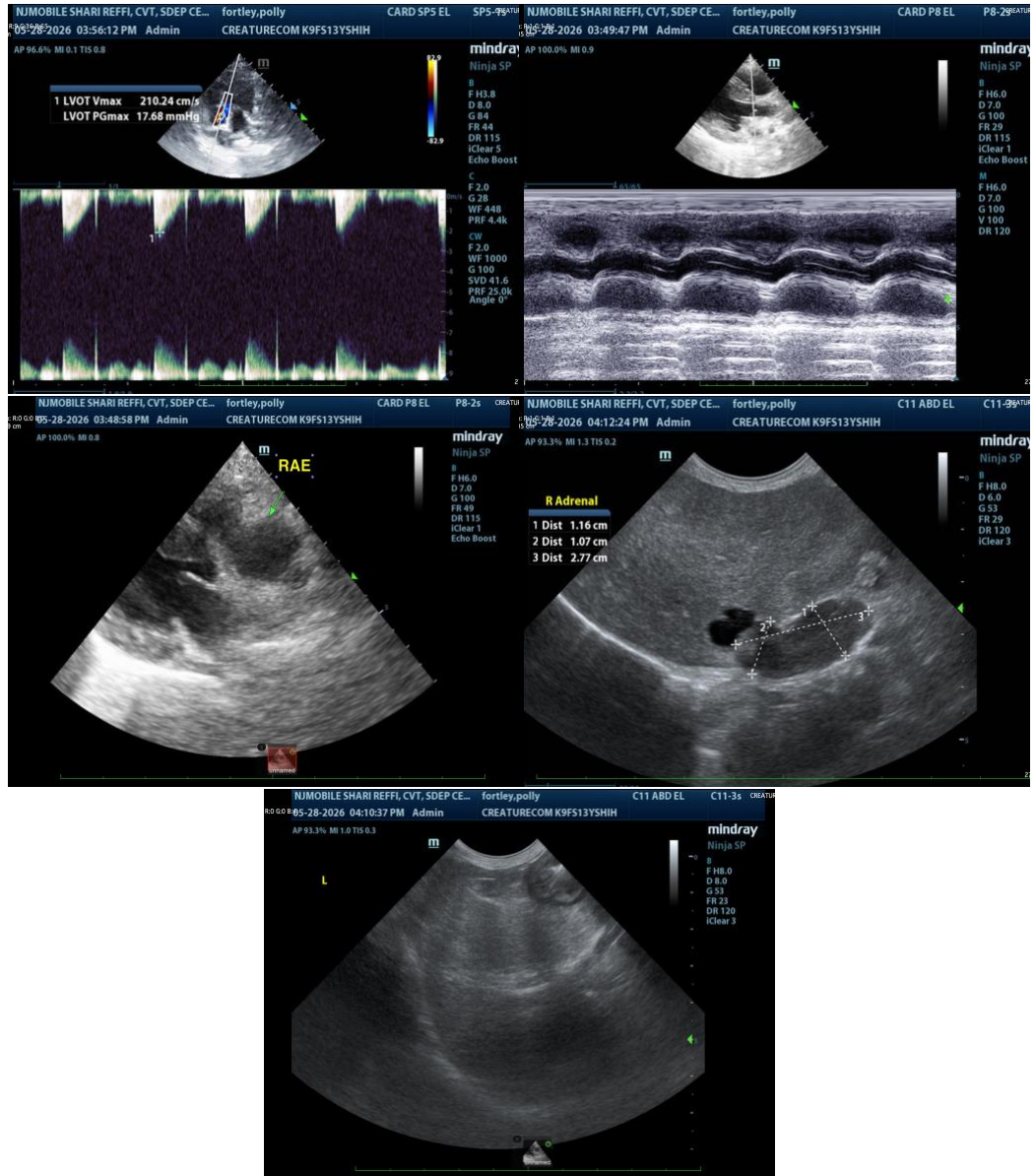
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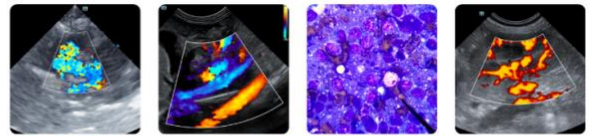
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

CEO, Owner, Founder -- SonoPath.com

[info@SonoPath.com](mailto:info@SonoPath.com)



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