



SUMMER 2019 REFERRAL NEWS

THIS EDITION

Anal sac adenocarcinoma with nodal metastasis in a male cocker spaniel

Canine Bilateral Rostral Mandibulectomy

Forelimb lameness in Spaniels could progress to elbow fracture

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Going home or to heaven? Anal sac adenocarcinoma with nodal metastasis in a male cocker spaniel.

Barbara Karolczak
MSc GPCertSAS MRCVS

Raise your hand if you have seen similar radiographs and advised the owner of a poor prognosis or euthanasia? I have - in my early clinical days, obviously offering referral surgery, chemotherapy or radiotherapy but certainly not being too optimistic. Often, this resulted in the owners deciding that their animal is euthanised. I hope that this case report sheds a more positive light on the treatment, outcome and prognosis of similar cases that you might come across at your own practices.

Clinical presentation:

Max, a 10-year-old, male neutered cocker spaniel presented to the referring vet in October 2018 with a history of constipation and straining. He was given lactulose which according to the client led to



Figure 1 Radiographs taken at referring practice

a mild improvement, however intermittent straining, constipation and occasional diarrhoea continued. A standard biochemistry and haematology blood panel revealed no abnormalities, although a quantitative cPLI test of 590ug/L confirmed concurrent pancreatitis. TLI was mildly elevated (39.2ug/L), although folate and cobalamin levels were normal. He was given Pro-Kolin and advised a bland diet, yet represented again in January 2019 for straining and producing very small faeces. This time a mass in his caudal abdomen was palpated. Orthogonal radiographs confirmed the presence of a large mass causing ventral deviation of the colon. An abdominal ultrasound was performed by a specialist in veterinary diagnostic imaging, which revealed a large, partially fluid filled mass, at least 7cm in length with a solid well-vascularised cranial pole in the sublumbar location, lying adjacent to the aortic bifurcation most consistent with the right medial iliac lymph node. A small nodule was also identified within the wall of the right anal gland.

Diagnostic investigations and results:

Max was referred to Federica Manna one of our medical clinicians. On presentation he was very bright and responsive, chest auscultation was normal and his temperature was 38.1°C. On examination, a small firm nodule was confirmed in the right anal gland. In-house bloods were unremarkable and blood gas analysis

Summer update from BVR...

Welcome back to Summer 2019 newsletter from the team at Bath Veterinary Referrals. I am pleased to say that Samantha Lane and Harriet Bice are both proud mothers of baby boys. We look forward to them coming back to the referral team. Sam will be resuming her soft tissue surgery from January 2020. In the meantime, Barbara Karolczak, Edward Corfield and I will continue to see soft tissue surgical referrals. We are also excited to welcome Michal Vlasin, European Specialist in Small Animal Surgery, who will be visiting once a week to perform advanced soft tissue surgery.

Whilst I continue to be busy with orthopaedic referrals, I have taken on the role of Head of Surgery and Clinical Director and will be looking to provide the best possible service for our referring vets, their clients and their pets. We are in the process of recruiting an experienced medical referral clinician, and in the meantime are grateful to have Andrew Jagoe lead the medical team. As always, we welcome feedback of how we can improve our referral service.

We recently upgraded our surgical endoscopy equipment to a stunning high definition camera system. This allows us to see even nicer detail such as cartilage lesions within joints. We continue to offer a range of key hole procedures including arthroscopy, laparoscopy and thoracoscopy.

We will shortly be resuming our series of lunch and learns - and opportunity for us to provide your team with food and CPD, and to put names to faces and answer your questions. If we haven't been in contact yet and you're keen for us to visit please let us know.

Back by popular demand - we are in the early stages of planning our next Bath Vet Referrals CPD events for early 2020. Watch this space!

Jon Shippam
Head of Surgery



showed a mild metabolic alkalosis, likely secondary to gastro-intestinal signs. Ionised calcium was 1.41mmol/L (1.12-1.4mmol/L).

An ultrasound guided fine needle aspirate of the enlarged iliac lymph nodes was performed under general anaesthetic and a CT scan with contrast enhancement was taken of the chest and abdomen. This confirmed a large oval structure ventral to the lumbosacral area and dorsal to the colon and prostate, measuring 4.5cm in diameter and 8cm in length. The cranial part of the lesion was solid and vascularised, however the majority of it was fluid filled and confined within a thin soft tissue capsule. There was no evidence of peripheral invasion. A second rounded structure was seen ventral to the left iliopsoas muscle and left to the aorta at the level of L5. This had a cystic structure, measuring 13mm in diameter. The thorax revealed a mild diffuse thickening of the bronchial walls and mild diffuse increase in interstitial lung opacity. All the mediastinal organs were normal and there was no evidence of lymphadenopathy.

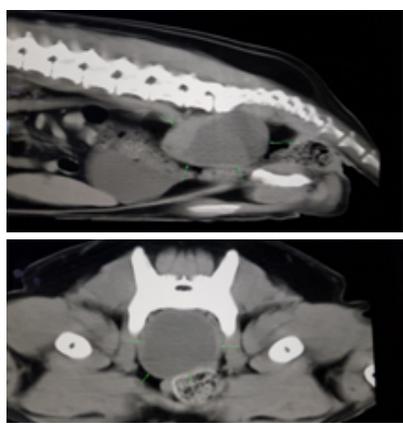


Figure 2 CT scan showing appearance of mass and ventral deviation of the colon.

The cytology results revealed no bacterial or fungal growth, however were consistent with the presence of an apocrine adenocarcinoma, likely metastatic from the right anal gland.

Treatment:

Surgery was strongly recommended to include excision of the right anal gland and enlarged iliac lymph nodes as this has proven to give the longest survival times and best quality of life.

In house full haematology, biochemistry, electrolytes were unremarkable and ionised calcium was <1.4mmol/L. A premedication of acepromazine and methadone was given intravenously, followed by induction with propofol and maintaining with isoflurane and oxygen. Intravenous fluid therapy with an isotonic crystalloid was initiated and pre-operative intravenous cefuroxime was administered. A midline coeliotomy was performed and both iliac and colic lymph nodes were carefully dissected off the adjacent large vascular structures. No haemorrhage was present and the abdomen was closed routinely. The right anal gland was thereafter removed with wider margins and the area closed routinely. The tissues were submitted for histopathology.

Max was discharged with robenacoxib 20mg SID, amoxicillin with clavulanic acid 250mg BID, both for 7 days and had a transdermal fentanyl patch applied for 3 days. The histology report confirmed complete excision and carcinoma in all submitted samples. Regular checks of ionised calcium levels, abdominal ultrasound and monitoring the site for recurrence were recommended.

Follow-up:

Max was reported to be doing very well 6 months post-surgery. The excision of the iliac lymph nodes dramatically improved his quality of life. His faeces remained normal, his did not require any further pain relief, his demeanour was very good and there was no visible recurrence of the tumour.

Discussion and conclusion:

Anal sac adenocarcinoma although being classified as an aggressive tumour with poor prognosis, surprisingly with appropriate treatment can have 1 to 3-year median survival times in patients (depending on the studies, TNM factors and treatment modality). I think this is a valid point to discuss with owners who would like to spend as much time as possible with their pets and give them a longer, higher quality of life. The median survival time is 17 to 31 months (in contrast to an earlier study suggesting MST of 6-12 months) and the mean disease-free interval is 400 days. Negative prognostic factors include lymph node metastasis, distant metastasis, larger primary tumour size and presence of hypercalcaemia. Most reports identify about 50% metastasis at the time of initial presentation. Dogs survive longest with multimodal therapy - surgery and chemotherapy (carboplatin, cisplatin, melphalan) and recurrence rates of 29-45% are reported.



Figure 3 Max 6 months post-operatively in the garden with his owner.

In one study removal of metastatic lymph nodes correlated with improved survival compared to those dogs where they were not removed. Another study showed that a MST of 20 months was achieved with surgery alone of the primary tumour and metastatic lymph nodes. Taken together, these findings of prolonged survival strongly suggest the need for more prospective controlled clinical trials to establish the "best" treatment modality and long term prognosis.



Barbara Karolczak
MSc GPCertSAS MRCVS

Canine Bilateral Rostral Mandibulectomy

Ted Corfield
BVSc CertAVP MRCVS

'Jack' a 5-year-old male neutered Lurcher was referred to Bath Veterinary Referrals following presentation to his referring veterinary surgeon (RVS) 10 days previously due to the discovery of an oral mass by the owner.

The RVS noted the presence of a firm non-painful mass on the lower mandible extending from the level of the lower left lateral incisor to the caudal aspect of the lower left canine tooth that was displacing the lower left lateral incisor. Food prehension and mastication were unaffected. The RVS had performed thoracic and mandibular radiographs which revealed no evidence of thoracic metastases but demonstrated alveolar bone destruction correlating with the gross extent of the mass. Results of an incisional biopsy of the mandibular mass were consistent with a diagnosis of squamous cell carcinoma. Jack was referred for further treatment.

Following a consultation at Bath Veterinary Referrals, a computed tomography (CT) scan of the thorax was performed which revealed no evidence of pulmonary metastasis. A further CT scan of Jack's head (Figure 1) was also performed to guide surgical planning which revealed the bony change to be more widespread than previously suspected from the radiographs, extending to the lower right lateral incisor.

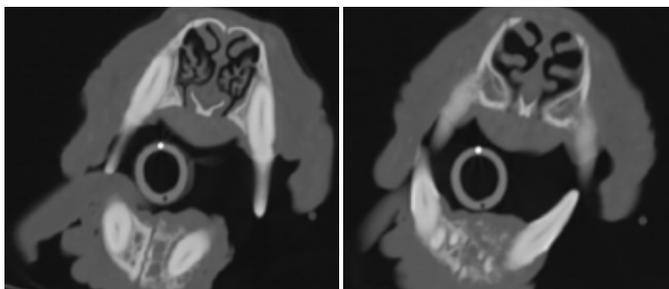


Figure 1 - Images from the CT scan of the skull demonstrating mandibular lesion location

As such, following pre-anaesthetic antibiotic and analgesic administration (including bilateral rostral mandibular nerve blocks), a bilateral rostral mandibulectomy was performed. The mandibular transections were performed using an oscillating saw to allow removal of at least 1cm of normal bone from the tumour margins as measured from the CT images (caudal to teeth 306 and 406 (modified Triadan system) respectively). Prior to closure, a v-shaped section of the rostral skin of the lower lip was removed to eliminate redundant skin following the mandibulectomy. The wounds were closed routinely. The excised tissues were submitted for histopathology which confirmed a diagnosis of squamous cell carcinoma and demonstrated complete excision with tumour free margins.

Jack's recovery from the anaesthetic was uneventful and he commenced drinking and eating soft food soon after recovery. The following day he was comfortable on oral medication so he was discharged to his owners with

instruction to feed soft food only for the first 2 weeks and to hand feed where necessary. He did well post-operatively and his sutures were removed after 14 days. The client was advised to represent Jack to the RVS 3 months post-operatively and every 6 months following for routine monitoring for local recurrence.

Treatment options for mandibular tumours include surgical management, radiation therapy, chemotherapy and other systemic therapies. Surgical management was appropriate in this case as squamous cell carcinoma, especially in the rostral oral cavity, has been shown to have a reasonable chance of being cured with aggressive surgery alone.

This case highlights one example of how our on-site CT scanner can greatly improve the clinical outcomes of cases referred to us. Plain radiography (whilst readily available to many first opinion practices) is fairly insensitive for delineation of bone destruction, making it an unreliable tool for surgical planning. It is also relatively insensitive for identification of pulmonary metastasis. Conversely, CT is a much more sensitive imaging modality for identification of pulmonary metastasis and assessment of bony and soft tissue margins. Thus, a bilateral rather than unilateral rostral mandibulectomy could be correctly selected, guided by the CT findings that the tumour extended across the mandibular symphysis, which was not grossly apparent.



Ted Corfield
BVSc CertAVP MRCVS

ZERO Referral Consultation FEES for any UK forces staff



supporting British Armed Forces

Any UK Forces members with family pets referred to and treated at Bath Veterinary Referrals will have their initial referral consultation fee waived. All they need to do is bring some suitable ID and we will do the rest.

Forelimb lameness in Spaniels could progress to elbow fracture

Jon Shippam
BVSc CertSAS MRCVS

Spaniel breeds, particularly Springer Spaniels, are known to be at risk of developing spontaneous elbow fractures such as lateral condylar and Y fractures. It was noticed that some of these dogs had a history of forelimb lameness prior to the fracture developing. This led to the discovery of radiographic lucencies which became known as incomplete ossification of the humeral condyle (IOHC). It was thought that the growth plate persisted from puppyhood, acting as a weakness that could cause discomfort and ultimately fracture.

As advanced imaging such as CT has become more popular it is common to image the contralateral limb and a case was reported in which no fissure was seen but when imaged on a later occasion due to forelimb lameness a fissure was identified. It has also been described where a partial humeral intracondylar fissure has progressed to a complete fissure (see Figure 4) that was associated with lameness that resolved following placement of a transcondylar screw (see Figure 5).

The incidence of complications relating to the placement of transcondylar screws has been reported as high, with surgical site infections (SSI) occurring in over 40% of cases. It was suggested that because transcondylar screws were typically placed via a lateral approach, changing to a medial approach might reduce the incidence of complications. Much lower rates of SSI have been reported with transcondylar screws placed from a medial approach. However, medial to lateral screw placement carries a greater risk of inadvertently penetrating the joint and therefore requires greater care at surgery.

Because of the risk of humeral intracondylar fissures progressing to elbow fractures such as the Y fracture, we recommend early investigation in Spaniel breeds with forelimb lameness. Although radiography has been reported as having good success in diagnosing humeral intracondylar fissures, the absence of a fissure on radiography does not rule out the condition. CT is the gold standard which gives a definitive diagnosis and differentiates easily between partial and complete fissures.

We recommend treating humeral intracondylar fissures with transcondylar screws placed mediolaterally and have had very good success with this technique. Elbow dysplasia, medial coronoid fragmentation and medial compartment disease are not uncommon differentials in Spaniel breeds with forelimb lameness, and we would recommend CT to investigate and rule out humeral intracondylar fissures.



Figure 4 CT showing humeral intracondylar fissure. Normal contralateral elbow.

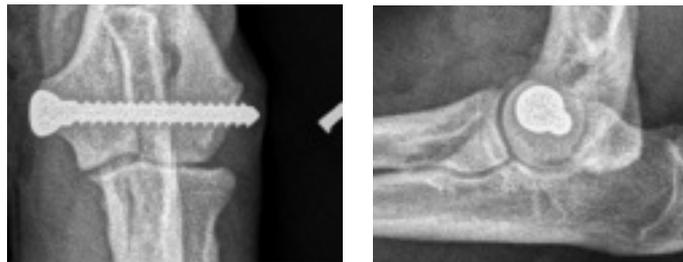


Figure 5 Transcondylar screw.



Jon Shippam

BVSc CertSAS MRCVS
RCVS Advanced Practitioner in
Small Animal Surgery

OUTPATIENT CT STARTING AT £800

We have updated our prices for this service, which includes general anaesthetic and specialist interpretation.

- Single area with interpretation - £800 (e.g. elbows, or thorax without contrast)
- Two areas with contrast and interpretation - £1200 (e.g. thorax and abdomen, or cervical spine and thoracolumbar spine)
- Three or more areas with contrast and interpretation £1500 (e.g. head, thorax, abdomen or carpus, elbow, shoulders, neck)

Typically, a case will be admitted and discharged by one of our referral nurses and the specialist radiologist report will be sent to your practice, usually within 4 working days. However, not all cases are suitable so please ring to discuss if you have a case you feel would benefit from this service.

Pituitary Mass

Jenny Lambert

BVM&S CertVOphthal MRCVS - Ophthalmology

A 10-year-old FN Labrador presented for an ophthalmological exam with a two-day history of unilateral ptosis and dilated pupil, and a six-week history of lethargy. After a normal initial examination (aside from the signs noted above) and normal bloods and urine, it was opted to image the brain. Sadly, this showed a large pituitary mass pressing on the oculomotor nerve.

Pituitary masses can be functional or non-functional and can originate from any group of cells within the pituitary. Tests can be performed to check for over production or deficiency of hormones, while imaging is useful to identify the extent of the mass. Pituitary masses are usually benign and many functional masses can be treated medically. Non-functional tumours (and some functional tumours) can be treated with radiotherapy or surgery.

In practice most pituitary masses are identified when Cushingoid signs are noted or when the animal presents with visual deficits (this dog was visual and was not Cushingoid based on blood and urine results). It is worth remembering that pituitary masses may present with many alternative clinical signs including: lethargy, seizures, acromegaly, diabetes, milk production, thyroid signs, irregular seasons, oculomotor signs, visual deficits or Cushingoid signs.

FIXED PRICE TTA

with 12 months guarantee

We are now offering a TTA surgery for the set price of £3900, which is inclusive of the general anaesthetic, surgery, pre and post-operative radiographs and 6 weeks follow up radiographs. The 12-month guarantee includes free management at Bath Vet Referrals of any complications that occur after surgery (including radiographs and revision surgery).

Michal Vlasin

European Specialist in Small Animal Surgery

DVM PhD Dipl.ECVS, MRCVS

We are very pleased to have Michal visiting Bath Vet Referrals to manage advanced soft tissue surgery cases such as portosystemic shunts. Michal completed his ECVS residency in Vienna in 2014, then worked in referral practice and completed his Diploma in Small Animal Surgery in 2019.



Jenny Lambert

BVM&S CertVOphthal MRCVS -
Ophthalmology

RCVS Advanced Practitioner in
Veterinary Ophthalmology



BRAIN MRI FOR £1000

We are currently performing brain MRI on an outpatient basis for a special offer of £1000, including general anaesthetic and specialist interpretation. However, a consultation is not included – this is intended to help clinicians manage their own cases while keeping costs down as low as possible.

Why choose Bath Veterinary Referrals?

- We pride ourselves on giving you the highest level of service.
- We strive to enhance your reputation, looking after your clients and their pets in a way you would be proud of.
- We offer a caring, friendly and personalized service. We keep clients and referring vets informed at all times.
- We have a superb team of night nurses and night vets, a flagship hospital and the very latest equipment.

Types of referral seen

- Internal medicine
- Soft tissue surgery
- Endoscopy/laparoscopy
- Medical and surgical oncology
- Ophthalmology
- Neurology
- Cardiology
- Orthopaedic and fracture repair
- Onsite MRI/CT scanning
- Hydro/physiotherapy





'IVC REFERRAL CHARTER'

- We will make initial contact with your client within one working day of you notifying us of the referral.
- We will get back to you within 1 hour for an emergency referral request although we will try to ensure this is with the relevant vet, this may not be possible, and it may be with a member of our admin team.
- We will give your client all appropriate information about their referral, including discussion of costs, before the day of referral. We politely ask that you ensure that all relevant clinical records and a brief summary of your reason for referral have been sent by you before the pet's case is seen. Please ensure there are no insurance claims pending.
- If we recommend different treatment from that planned at referral, this will be handled in a sensitive and professional manner, involving discussion with you if this is possible or appropriate.
- We will contact the client on the day of any procedure or surgery to report on progress.
- At the time of discharge, all written advice given to clients will be emailed to you; to include discharge information, medication and next appointment.
- A full written report of our work will follow to you within 4 working days (by post or email).
- Any radiographs, ECGs, or advanced scanning images you send to us for reporting will be replied to you by email within 5 days of receipt. Lab test results from samples taken while your patient was with us will be reported within a similar time scale.
- We will not register as a first opinion client any client that you refer to us within 12 months of referral.

Organising a referral is simple

To make a non-urgent referral please email contact@bathvetreferrals.co.uk or call the team on **01225 832521, option 3.**

To make an urgent referral please call one of our Referral Administrators who will be happy to take down the case details and speak to the team regarding an appointment. Where possible we will see emergency cases on the same day they are referred to us. **Tel: 01225 832521 option 3.**

To request advice on a case from one of our clinicians, please email or call the team using the details above.

Once you have requested a referral we will speak to the client directly and book a convenient appointment. We will confirm with you when an appointment has been made, and ask that you forward the client history including lab results and radiographs (in DICOM format where possible) to contact@bathvetreferrals.co.uk.

Free radiograph reading

To receive free radiograph interpretation please email your images (in DICOM format where possible) to contact@bathvetreferrals.co.uk. One of our experienced clinicians will respond by email at their earliest convenience.



OUR CLINICIANS

Jon Shippam BVSc CertSAS MRCVS RCVS Advanced Practitioner in Small Animal Surgery, Clinical Director, Head of Surgery - Orthopaedic surgeon

Lisa Gardbaum BVetMed CertSAM MRCVS RCVS Advanced Practitioner in Small Animal Medicine – Internal Medicine

Jenny Lambert BVM&S CertVOphthal MRCVS, RCVS Advanced Practitioner in Veterinary Ophthalmology – Ophthalmology

Samantha Lane BVSc BSAVAPGCertSAS MRCVS RCVS Advanced Practitioner in Small Animal Surgery – Soft Tissue Surgeon

Barbara Karolczak MSc GPCertSAS MRCVS – Soft Tissue Surgeon

Anna Ellams BVMS CertAVP(VA) MRCVS – Internal Medicine Clinician

Federica Manna DVM CertAVP MRCVS – Assistant to internal Medicine

Edward Corfield BVSc CertAVP MRCVS – Assistant referral surgeon