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REFERRAL NEWS

IN THIS EDITION:

Bath Veterinary Referrals

Rosemary Lodge
Veterinary Hospital
Wellsway
Bath
BA2 5RL

bathvetreferrals.co.uk
t: 01225 832521 (option 3)
f: 01225 835265
e:contact@bathvetreferrals.co.uk

Case Report – **Triaditis in a domestic short hair cat**

Federica Manna DVM CertAVP MRCVS

Clinical presentation

A 7-year-old, indoor-only, MN Russian short hair was presented with a 5-month history of intermittent vomiting (2-3 times per week) and progressive weight loss with anorexia that had been persisting for 3 days. Vomiting had gradually increased over the previous 2 weeks, and the cat had lost 1 kg. Vomiting was reported to occur a few hours after feeding and to consist of digested, bile-stained food with no blood. Vaccinations and worming were up-to-date. Defecation was normal. He was fed a balanced commercial dry diet.

On presentation the cat was quiet but alert, underweight (BCS 3/9, body weight 3.2 kg) and estimated to be approximately 7% dehydrated with dry pink mm. Oral cavity, ocular and lymph node examination was unremarkable; there was no palpable goiter. Cardiovascular and respiratory examination were unremarkable. Rectal temperature was 38.5°C. Abdominal palpation was unremarkable. Systolic blood pressure was normal.

The expulsion of bile confirms vomiting. In this case the cat had digested food in the vomit, indicating that the disease also involves the cat's stomach. Vomiting may occur as a result of gastric, intestinal, or systemic disease. Intermittent vomiting more often suggests a chronic alimentary tract disorder, for example inflammatory bowel disease, gastrointestinal neoplasia or hepatobiliary disease. The absence of polydipsia makes systemic disorders such as renal disease or diabetes mellitus unlikely. Gastrointestinal mass lesions, pancreatic masses and hepatomegaly could not be identified on physical examination, however cannot be ruled out. While abdominal pain has been reported in cases of pancreatitis, it is suggested in cats to be less consistent than in dogs with pancreatitis and is seen with other disorders, including cholecystitis or cholangitis. In this case abdominal pain was not detected.

Continued over...

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Spring update from BVR...

As I write this, Bath is at a standstill from the snow, but hopefully by the time you read this, the daffodils will be out and summer will be on its way.

Bath Veterinary Referrals continues to be busy thanks to all our referring vets, and for this reason we are currently looking to expand our team.

Two recent additions to the referral team are Edward Corfield and Federica Manna. Federica has recently gained her CertAVP, and is soon to be sitting her modules in small animal medicine. Similarly Edward will soon be sitting his CertAVP in surgery. These two enthusiastic young clinicians are helping the senior members of the team - Sam and Jon in surgery and myself and Lisa in medicine - by assisting with procedures and helping manage cases under supervision.

We are also lucky to have Stephen Collins, cardiology Specialist, visiting us regularly, complementing my RCVS Advanced Practioner status in cardiology, and we are happy to accept cardiology referrals, either for Stephen or myself.

I am currently interviewing for new referral clinicians, so watch this space!

Thanks as always for all your support, and feel free to email or ring for advice about cases. Also, if anyone wants to visit us to see practice, or to follow their own case through (useful for certificate casebooks) we are always happy to have visitors!

Alex Gough
Head of Referrals

A case of “Triaditis” in a domestic short hair cat continued.

Diagnostic investigations and results

Haematology revealed mild lymphopenia consistent with a stress response. Serum biochemistry showed a mild increased urea which could reflect the patient’s dehydration and a mild increased alanine transaminase and aspartate aminotransferase that could reflect early/mild hepatocyte damage due to a primary or secondary hepatopathy. Electrolytes were normal.

Urine analysis obtained via cystocentesis was unremarkable with a specific gravity consistent with concentrated urine. Fecal analysis was negative.

The feline pancreatic lipase immunoreactivity was consistent with pancreatitis. The feline trypsin-like immunoreactivity was within normal limits. Serum cobalamin and folate concentrations were within normal limits. Free and total T4 were normal.

Abdominal ultrasound showed gall bladder distension, and marked distension and tortuosity of the common bile duct were observed (Fig 1). The pancreas appeared normal and all other abdominal organs had a normal size and appearance. Free fluid was not detected.

In order to further investigate the abdominal abnormalities, an exploratory laparotomy was performed to examine the alimentary tract directly and to obtain biopsies (liver, biliary tract, pancreas, full thickness intestine). The decision to perform surgery was based on a combination of ultrasonographic finding and chronicity of the disease. Prior to laparotomy, chest radiographs were taken as part of general assessment and were normal. Coagulation panel (aPTT/PT) was also performed as required prior to liver biopsy and was unremarkable. A surgical exploration confirmed a dilation of the biliary tract. Bile was collected for culture.

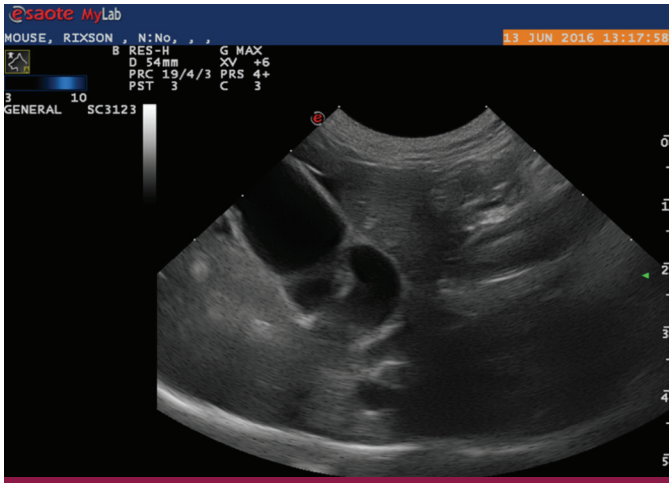


Fig 1. Abdominal ultrasound showing dilation of the bile duct and tortuosity.

Diagnosis

The histological evaluation confirmed the combination of pancreatitis, cholangitis and inflammatory bowel disease. Profuse growth of anaerobes, Enterococcus faecalis and Escherichia coli were obtained from the bile culture.

Treatment and outcome

Intravenous fluid therapy with isotonic crystalloid was initiated to correct the dehydration with metoclopramide as an anti-emetic added as a constant rate infusion. Maropitant was administered as an anti-emetic and ranitidine as a prokinetic and antacid.

Pain was not apparent on abdominal palpation. However, as pain can be difficult to recognise in cats, manifesting only as lethargy and/or anorexia, buprenorphine was administered.

Once the dehydration was corrected the surgery was performed and an oesophagostomy tube was placed during the surgery to allow the nutrition.

Following the exploratory surgery, the postoperative treatment included fluid therapy, pain relief and antibiotic treatment consisting of amoxicillin-clavulanate. The cat was discharged after five days of hospitalisation with famotidine at 0,5 mg/kg BID for four weeks, amoxicillin-clavulanate at 15 mg/kg BID, marbofloxacin at 2 mg/kg SID which was set up for a six-week period given the culture results. The oesophagostomy tube was removed on day 15 when the cat had a good appetite.

Over the following two months, the cat had normal appetite and gained weight. Routine bloods were run four weeks into the treatment and were normal.

Discussion and reflection

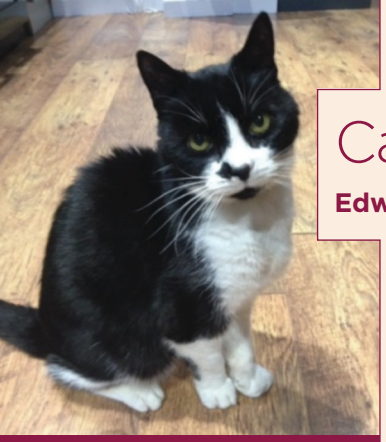
Serum pancreatic lipase (Spec fPL) has been shown to have a sensitivity of 79% and specificity of 82% for diagnosing feline pancreatitis. At the present, histological examination of the pancreas is considered to be the gold standard for the diagnosis of pancreatitis.

It has been documented that neither inflammatory liver disease, nor inflammatory bowel disease result in pathognomic changes on blood tests. A recent study demonstrated that ALT was elevated in only 50% of cats with cholangitis. Similarly, alkaline phosphatase (ALKP) was elevated in 48% of cases, gamma glutamyltransferase (GGT) in 19% and total bilirubin (TBil) in 66% of cases, whereas aspartate transaminase (AST) was elevated in 96% of cases. However, as AST is nonspecific, the definitive diagnosis of inflammatory liver disease can prove challenging. In that study there was no difference between these parameters in cats with cholangitis alone, compared to those with cholangitis and pancreatitis. In this case the cat showed a mild increased ALT and AST without any change on ALKP, GGT and TBil showing that the accuracy of blood tests at identifying specific organ involvement is questionable, confirming the need to perform biopsy to arrive at a definitive diagnosis.

Concurrent inflammation of the intestines and/or liver appears to be a common problem in cats, therefore intestinal and hepatic biopsies should be collected in patients suspected of having pancreatitis for a more definitive diagnosis.

Nasogastric and oesophagostomy tubes can be used in cats with pancreatitis because of the risk for hepatic lipidosis.

*References available under request



Charlie

Case Report – **Feline Soft Tissue Sarcoma**

Edward Corfield BVSc MRCVS

Signalment

'Charlie' a 15-year-old male neutered Domestic Short Haired Cat

History

Charlie was presented to our first opinion team following the discovery of a 2.5 x 2cm diameter, firm and rapidly growing subcutaneous mass in the intrascapular area. The owner reported that over the previous few days Charlie had been lethargic and 'off-colour' with a decreased appetite.

The appearance of the mass prior to excision

Pre-Operative Assessment

Fine needle aspirates (FNA) of the mass were obtained and submitted for cytological analysis, the results of which were suggestive of cutaneous basilar epithelial neoplasia. Further histological assessment of the mass was advised to the client given character and location of lesion.

In view of Charlie's concurrent clinical signs, a blood sample was submitted for full haematology and biochemistry, the results of which were largely unremarkable. A conscious abdominal ultrasound was performed which was also unremarkable.

A premedication of acepromazine and buprenorphine was administered intravenously (IV). General anaesthesia was induced with propofol IV to effect and maintained with isofluorane by inhalation in 100% oxygen. Three 'Tru-cut' biopsies of the mass were obtained and submitted for histopathology. Charlie recovered without complication from the anaesthetic.

The histopathology results returned which indicated a diagnosis of high grade soft tissue sarcoma – *'Consistent with the location of the lesion, this mass represents a poorly differentiated soft tissue sarcoma with histological features indicative of an injection-site sarcoma. The mass would therefore be expected to behave in at least a locally aggressive manner and given the histological grade there would be some potential for metastasis from this site.'*

Thus, Charlie was referred to our surgical referral team and further staging and surgery were scheduled for the following day.

Surgery Report

A premedication of acepromazine and methadone was administered IV and general anaesthesia was induced as detailed above. Perioperative intravenous fluid therapy was commenced and regular perioperative blood pressure assessment was performed throughout the procedure. A CT scan of the thorax and cervical region indicated an apparently circumscribed mass extending to the tip of the underlying spinous processes and the tip of the right scapula. No evidence of local or distant metastasis was noted within the fields scanned.

A wide 'en bloc' excision of the mass was performed aiming to achieve 3cm skin margins and 2cm deep margins (including the dorsal 0.5cm of three spinous process and the tip of the right scapula). This tissue was submitted for histopathology.

Prior to wound closure a bupivacaine hydrochloride 'splash block' was instilled and an active suction drain was placed. Closure was performed with poliglecaprone 25 subcutaneous and intradermal sutures and placement of skin staples.

Post-Operative Care

Buprenorphine was continued for four days postoperatively during hospitalisation, guided by regular pain scoring. A 'pet t-shirt' was utilised to prevent patient interference with the surgical site until staple removal and support the drain. The drain was removed after four days. Meloxicam was continued until the staples were removed 10 days post-operatively. Charlie subsequently returned to a normal lifestyle and was not represented.

Diagnosis

The histological results from the tissue submitted confirmed the diagnosis of a high grade soft tissue sarcoma with histological features indicative of an injection-site sarcoma. The histopathology report confirmed that excision was complete although neoplastic cells extended to within less than 1mm of the deep aspects of the sample.

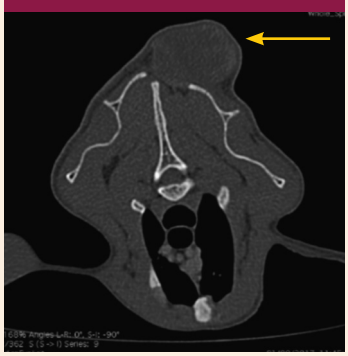
Discussion

This is a useful case to reflect upon highlighting two important points to consider when approaching similar masses:

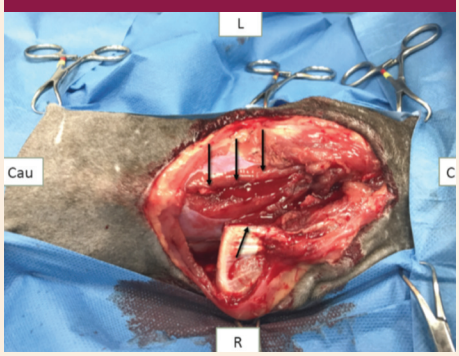
1. The correlation of cytology and histopathology results - and need to interpret results carefully in light of the clinical presentation. The planned surgeries for the two diagnoses are very different and would have lead to surgical failure in this case. If there is concern regarding the validity of a cytological diagnosis (e.g. where a FNA is performed) then a larger sample (e.g. biopsy) may yield more reliable results.
2. The importance of thorough surgical planning - despite the apparently extensive surgery in this case only margins less than 1mm on deep aspect were achieved. These masses are often surprisingly invasive.

Thanks to Alasdair Hotston Moore for case details and images.

The appearance of the mass (yellow arrow) on CT scan

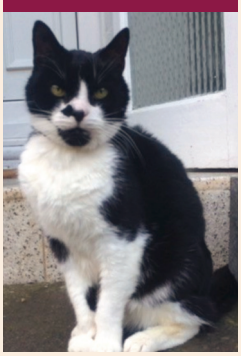


Intraoperative view (indicating the cut ends of the three spinous processes and the right scapula)



Wound appearance immediately post-operatively

Charlie five months post-operatively



Cases recently seen

Patent ductus arteriosus, severe vertebral malformation causing hindlimb ataxia in a Rottweiler, puppy Episodic Falling of the Cavalier King Charles Spaniel, third degree heart block as a cause of seizures in an elderly Labrador and third degree heart block in a cat.

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

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 personalised 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

Our clinicians

Alex Gough MA VetMB CertSAM CertVC PGCert (Neuroimaging) MRCVS – Head of Referrals

Jon Shippam BVSc CertSAS MRCVS - Orthopaedic Surgeon

Jenny Lambert BVM&S CertVOphthal MRCVS - Ophthalmology

Lisa Gardbaum BVetMed CertSAM MRCVS - Internal Medicine

Samantha Lane BVSc BSAVAPGCertSAS MRCVS – Soft Tissue Surgeon

Federica Manna DVM CertAVP MRCVS - Assistant to Internal Medicine

Edward Corfield BVSc MRCVS - Assistant Referral Surgeon

Organising a referral is simple

To make a non-urgent referral please email **contact@bathvetreferrals.co.uk** or call the team on **01225 832 521**, **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 with the team regarding an appointment. Where possible we will see emergency cases on the same day they are referred to us. Tel: **01225 832 521**, **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 contacted us, with your permission we will speak with the client directly to book a convenient appointment.

We ask that you forward any client history to us as soon as possible using the email address above.

Free Radiograph Reading

To receive a free radiograph interpretation please email your images to **contact@bathvetreferrals.co.uk**.

One of our experienced clinicians will email in response at their earliest convenience.