Top Tips for Vets

When to Refer – Red Flag Signs & Symptoms

IVC UK Referral Network
https://bit.ly/ivcreferralguide

IVC Referral Network

How to look? When to look? When to worry? When to ring? Tips to avoid ophthalmological car crashes

Tim Knott BSc (Hons) BVSc CertVOphthal MRCVS
Clinical Director & Senior Veterinary Ophthalmologist

Top Tips

1. How to look?

a. Learn distant direct ophthalmoscopy – your 30second eye exam tool.
b. Learn to use your smart phone to image the eye. www.theeyephone.com:
c. Learn to use an indirect lens – come and visit us for hands on teaching session
d. Know how to perform a Schirmer Tear test

2. When to look?

a. Distant direct for all patients – quickly rule out cataract, corneal and (most) retinal disease.
b. Retinal exam in the older cat – your best tool in diagnosis and management of systemic hypertension
c. Red eyes? Blue eyes? Know your breeds predisposed to glaucoma
d. Ulcers – ALWAYS look for cause, let shape, position and breed guide you
e. Tear test all red eyes, all predisposed breeds, all diabetics and all small brachycephalic dogs.

3. When to worry?

a. Brachycephalic patients – all ulcers are complicated & dangerous
b. Ulcers –should heal within 7 days, deep ulcers are all potential corneal rupture in less than 6 hours, beware the comfortable ulcer.
c. Glaucoma and uveitis –no good causes, think enucleation +/- death!
d. Cataract – what's the cause? Will the lens rupture?
e. Sudden onset blindness.
f. When you're not sure

4. When to ring?.

a. Ulcers – all brachycephalics, when suspect deep, when suspect rupture.
b. Glaucoma – permanent blindness can be less than 6 hours away.
c. Cataract – when sudden onset and always when diabetic.
d. When you're not sure.

For advice, guidance or referral contact Tim at:

Rowe Referrals Eye Clinic
eyes@rowevetgroup.com
www.rowereferrals.co.uk
01454 521000

Surgical approach to the urethra

valereferrals

Michal Vlasin DVM PhD Dipl. ECVS MRCVS
Senior Surgeon Small Animal Soft Tissue Surgery

Top Tips

1. General stabilization with maintaining electrolyte balance (iv fluids).
2. Urine diversion (catheterization, cystocentesis, cystostomy).
3. Urinalysis mandatory.
4. Cultures + sensitivity testing.
5. Males – always check the prostate gland (USG + FNAB).
6. Females – obstruction often extraluminal (tumours, entrapment).
7. For mucosal defects, indwelling catheter for 7 to 10 days.
8. Longest urethra possible.
9. Urolithiasis – often life-long patient (diet, re-checks).
10. After urinary tract surgery, the patient MUST be able to urinate!!

For advice, guidance or referral contact Michal at:

Vale Referrals
Soft Tissue Surgery
01453 547934
referrals@valevets.co.uk
www.valereferrals.co.uk

Which heart cases need further work up? A case illustrated interactive discussion

valereferrals

Mark Patteson MA VetMB PhD DVC CertVR MRCVS
RCVS Specialist in Veterinary Cardiology

Topics

Please use your smart phone or Wi-Fi enabled tablet to see what decisions you would make in a series of cases. We will cover topics such as:

- When does a murmur matter?
- When should I record an ECG?
- When is a proBNP worth doing?
- I can't hear anything abnormal - what might I be missing?
- Is now the time to treat this patient?
- Should I do that?

Don't expect the answers now - we want to see what you think, but we will send the slides to you after the talk, so there is no need to try and write it all down. Just ask questions and vote (anonymously!)

For advice, guidance or referral contact Mark at:

Vale Referrals
Cardiology
01453 547934
referrals@valevets.co.uk
www.valereferrals.co.uk

The neurological examination

Alex Gough MA VetMB CertSAM CertVC PGCert MRCVS
Head of Referrals - Bath Veterinary Referrals

Top Tips

1. Take a full history – especially with regard to onset, progression, lateralisation, pain.
2. Consider signalment – many neurological diseases are more common at particular ages, or in particular breeds.
3. Observe the animal prior to handling to check gait, demeanour, behaviour.
4. Perform a full physical examination for concurrent diseases or diseases which may mimic neuro disease e.g. syncope from cardiac disease.
5. Perform neurological examinations frequently on healthy animals to get used to what is normal.
6. Develop a systematic approach that you can stick to (e.g. head to tail).
7. Aim to localise to a single lesion. If this isn't possible consider a multifocal or generalised disease.
8. Most useful reflexes to check are menace, proprioception, palpebral, deep pain, withdrawal reflex.
9. Don't confuse a local withdrawal reflex with a central response to deep pain (observed in the head).
10. Check for neck and spinal pain.

When should a neuro case be referred urgently:
- Paraplegia or tetraplegia with loss of ability to stand.
- Uncontrollable cluster seizures or status epilepticus
- Severe obtundation or stupor.

When should a seizure case have referral for advanced imaging:
- If less than 1 year or greater than 6 years of age at onset of first seizure.
- If is neurologically abnormal between fits.
- If seizures can't be sufficiently controlled with standard medications

For advice, guidance or referral contact Alex at:

Bath Vet Referrals
alex.gough@bathvetreferrals.co.uk
www.bathvetreferrals.co.uk
01225 832521

You've got a fracture case. Do you fix it or should you 'phone a friend?

Mark Owen BVSc CertSAO MRCVS
Orthopaedic Surgeon

Historically, fracture management was a case of meticulously re-assemble all the pieces of a broken bone, and then stabilise all those rebuild fragments with something that will hold them together long enough for the fracture to heal. The mantra was quite simply one of 'Anatomical Reconstruction and (thereby) Rapid Return to Function'.

Contemporary fracture care does still recognise situations where anatomical reconstruction is required, however, the philosophy is now one of restoring spatial orientation of the joints at either end of the fractured bone, recognising the forces that will act to disrupt that repair, the biological capabilities of the fracture and protection of the vascular support and cytokines that will drive the fracture healing.

Key decision making criteria that will be introduced will be:

1. What forces act on this fracture and what fixation will address those needs?
2. Does this fracture require an accurate anatomical rebuild?
3. Recognising the important biological factors.
Is this a young patient?
An old patient?
A sick patient?
Is the soft tissue envelope compromised?

Understanding the fracture biology will identify whether the fracture fixation can be flexible and short term, or does the biological challenge require fixation that is both robust and durable in order to ensure successful fracture healing.

4. Implant specific fractures.
Reference will be made to the LEAP Plate project and custom 3D printed implants.
5. Immediate post-operative support. The 'add-on' fracture care techniques that reduce patient morbidity.

What role can Negative Pressure Wound Therapy play in small animal fracture management?
To begin this short session, some of the AO golden guidelines will be outlined and then, using actual clinical cases, participants (yes that really does mean you) will be invited to discuss and consider which of the core principals of fracture management need address and decide:

Can you fix this fracture for yourself, or should you 'phone a friend?

For advice, guidance or referral contact Mark at:

Rowe Referrals
Orthopaedics
01749 831414
ossicle@me.com
www.rowereferrals.co.uk

How to cope with your scope - and tips for removing foreign bodies.

valereferrals

Myra Stevenson BVM&S Cert SAM MRCVS
RCVS Advanced Practitioner in Small Animal Medicine
&
Sian Blakey BVetMed CertAVP (SAM) MRCVS
Internal Medicine Clinician and Oncology Assistant

Top Tips for Endoscopy

- Gastroscopy
  - o Patients should be positioned in left lateral to facilitate entrance into the pylorus and duodenum.
  - o Gastric over inflation can make it more challenging to enter the duodenum.
  - o Having the appropriate equipment can be key for successful removal of oesophageal foreign bodies (i.e. very large grabbers!) - gastric biopsy forceps are rarely sufficient.

- Bronchoscopy
  - o Bronchial foreign bodies can be challenging – don't spend hours removing the material in bits and pieces!
  - o Consider using an endoscope rather than a bronchoscope.
  - o Cytology brushing are a valuable addition to BALF analysis.

- Cystoscopy in the bitch
  - o Patients should be positioned on their back with legs held upwards.
  - o The gold standard method of diagnosing ectopic ureters.
  - o You never know what you might find! (foreign body, double vagina.....)

For advice, guidance or referral contact Myra or Sian at:

Vale Referrals
Myra Stevenson

Internal Medicine
Vale Referrals
01453 547934
referrals@valevets.co.uk

Vale Referrals
Sian Blakey

Internal Medicine
Vale Referrals
01453 547934
referrals@valevets.co.uk

Decision making in cataracts

valereferrals

Brian Patterson BVM&S Cert VOphthal MRCVS
RCVS Advanced Practitioner in Veterinary Ophthalmology

Top Tips

1. An opacity of the lens (cataract) obscures 'eye shine' – distant direct ophthalmoscopy is the screening tool of choice to detect lens opacities and is aided by pharmacological dilatation.
2. Progression of cataracts includes changes in the size of the opaque area, additional location of opacities and increase in density of opacities. Repeat evaluations and accurate record keeping are required to determine progression.
3. Functional vision is the ability to undertake necessary visual tasks – canine and human visual needs are different. Dogs with generalised deficits in visual function lose confidence at night, are pondersome on steps and stairs, lose their owners on walks, lose confidence with other dogs, bump into objects, lose catching ability.
4. Age related cataracts have low complication rates and tend to be static to slowly progressive. All other cataract types are at a greater risk of progression and the development of complications.
5. Cataract complications include lens induced uveitis, vitreal degeneration, retinal detachment, lens instability, lens capsule fibrosis and glaucoma. All stages of cataract development are at risk of lens induced uveitis even if no overt clinical signs of uveitis are present and therefore topical anti-inflammatory medications are justified in all stages of cataract, but particularly as cataracts demonstrate progression.
6. Rapidly developing cataracts (days to weeks) are a surgical priority as there is a risk of lens capsule rupture.
7. 'Complete' diabetic stability is not essential in surgical patients.
8. Surgical success rates appear to reduce with the chronicity of the cataract and will depend on follow up times. Short term success is typically in the region of 90% with a median globe survival time of 2.9 years following surgery quoted.
9. The rate of globe-threatening complications is much lower in dogs undergoing phacoemulsification and intraocular lens implantation compared with dogs receiving topical medical treatment only, or dogs receiving no treatment.
10. Dry eye is bad for cataract patients – monitor STT values.
11. Cataract surgery discussions are nuanced and should ideally be undertaken by the ophthalmic surgeon following examination of the patient.

For advice, guidance or referral contact Brian at:

Vale Referrals
Ophthalmology
01453 547934
referrals@valevets.co.uk
www.valereferrals.co.uk

Canine chronic diarrhoea

Lisa Gardbaum BVetMed CertSAM MRCVS
RCVS recognized Advanced Veterinary Practitioner in Small Animal Medicine

Top tips for Chronic Diarrhoea

1. Rule out EPI and systemic, parasitic and infectious causes of diarrhoea.
2. 65% cases of chronic diarrhoea are food responsive so always carry out a food trial before considering biopsies especially in young dogs, large breeds.
3. Young dogs 4 years old often food responsive and very young dogs less than 2 years old are often antibiotic responsive and biopsies unlikely to be helpful for management of case.
4. If not respond after 2 weeks of food trial, try with antibiotic e.g. metronidazole for 7 – 10 days.
5. Check B12 and folate levels and supplement B12 by injection or orally
6. Consider biopsies if no response to food, anti-parasitic and antibiotic treatment.
7. If carrying out endoscopic biopsies ideally biopsy ileum as well as stomach and duodenum as to not miss a diagnosis of lymphoma
8. Surgical biopsies if suspect lymphoma and large mesenteric lymph nodes on ultrasound examination
9. If IBD diagnosed start treatment with prednisolone 2mg/kg daily for a minimum 2 weeks then start to taper by 20% for 4 – 6 months
10. Consider starting cyclosporine, chlorambucil or azathioprine if not tolerate or not respond to steroids.
11. If biopsy not an option can treat with prednisolone and chlorambucil to treat both IBD and small cell lymphoma.

For advice, guidance or referral contact Lisa or Federica at:

Bath Vet Referrals
Internal Medicine
contact@bathvetreferrals.co.uk
www.bathvetreferrals.co.uk
01225 832521

Lisa Gardbaum

Federica Manna

OMG, not another mast cell tumour!!

valereferrals

Stefano Zago DVM (Hons) MSc (Clin Onc) MRCVS
Clinical Oncologist

When to Refer:

- Large tumours
- Challenging or potentially more aggressive locations
- Tumours with clinically aggressive behaviour (fast growth, ulcerated, sick animal)
- Tumour staging before biopsy or removal
- High grade tumours following biopsy or removal
- Incompletely removed tumours
- Recurrent tumours
- Unresectable tumours
- Metastasised tumours
- Tumours necessitating neoadjuvant or adjuvant chemotherapy

For advice, guidance or referral contact Stefano at:

Vale Referrals
Oncology
01453 547934
referrals@valevets.co.uk
www.valereferrals.co.uk

Coping with pressure – a quick tour of canine glaucoma

David Nutbrown-Hughes BVSc CertVOphthal MRCVS
Veterinary Ophthalmologist

Top ten take home points:

- Always look at both eyes
- Always remember to test the menace and dazzle
- Take the intraocular pressure of any red painful eye – even the Schiotz tonometer is useful in determining whether an intraocular pressure is low, normal or high
- Always treat elevated intraocular pressure promptly and treat as emergency
- Always try and identify a cause for the glaucoma
- Be aware of breed predispositions for primary glaucoma
- Early referral for red eyes and any suspicion of glaucoma is advisable, the affected eye may not be salvageable, but the other eye is in danger too
- Be careful when measuring the intraocular pressure not to artificially elevate with restraint
- Be aware of pressure spiking – consider an intraocular pressure curve or repeated measurements

For advice, guidance or referral contact David at:

Rowe Referrals Eye Clinic
eyes@rowevetgroup.com
www.rowereferrals.co.uk
01454 521000

Acute disc disease

Jon Shippam BVSc CertSAS MRCVS
Orthopaedic surgeon – Bath Veterinary Referrals

Top Tips

Acute disc disease:

1. Main indication for surgery: non-ambulatory (less common: severe ongoing pain)
2. Deep pain should be assessed if non-ambulatory (firmly pinch digit, then forceps if no reaction - but don't make a noise)
3. Deep pain positive only if reactions from the head (looks round, growls/cries in pain, looks restless - withdrawal reflex is not confirmation of deep pain)
4. If deep pain is lost, prognosis is poor without surgery, fair if surgery within 48 hours: so refer promptly
5. If painful, or painful with proprioceptive deficits/ataxia - strict cage rest and analgesia to minimise risk of deterioration (4-6 weeks)

For advice, guidance or referral contact Jon at:

Bath Vet Referrals
contact@bathvetreferrals.co.uk
www.bathvetreferrals.co.uk
01225 832521

Medial patellar luxation

Edward Corfield BVSc CertAVP MRCVS
Assistant Referral Surgeon - Bath Veterinary Referrals

Top Tips

1. Perform a thorough conscious and anaesthetised examination of entire limb.

2. Prompt referral is advised for heavier patients or those with more frequent symptoms.

3. Be sure to check for concurrent cranial cruciate ligament rupture

4. Consider early referral in growing puppies with more severe signs due to potential for worsening of condition

5. Remember most cases are due to limb malalignment therefore consider referral for CT assessment for a better outcome.

For advice, guidance or referral contact Ted at:

Bath Vet Referrals
contact@bathvetreferrals.co.uk
www.bathvetreferrals.co.uk
01225 832521

Assessment and treatment of laryngeal paralysis

valereferrals

Richard Artingstall MA VetMB Cert SAS MBA MRCVS
RCVS Advanced Practitioner in Small Animal Surgery
Referrals Director at Vale Referrals

Top Tips

1. Diagnosis is always based on clinical signs, signalment and history.
2. Don't rush into general anaesthesia to make a diagnosis.
3. Laryngeal paralysis is part of a more global polyneuropathy – GOLPP.
4. Take a thorough history – change of bark? Regurgitation?
5. Don't be tempted to 'have a look' at the larynx if you're not planning to do the surgery yourself – dogs can die on recovery.
6. If you do assess the larynx be aware of paradoxical movement.
7. If the dog is under general anaesthesia always take a chest x-ray - aspiration pneumonia and mega oesophagus are contraindication to surgery.

For advice, guidance or referral contact Richard at:

Vale Referrals
Small Animal Surgery
01453 547934
referrals@valevets.co.uk
www.valereferrals.co.uk

Diagnosis Lactate: Why bother?

Anna Ellams BVMS CertAVP MRCVS
Internal Medicine Clinician - Bath Veterinary Referrals

Top Tips

1. Get a hand-held lactate meter

2. Run it as part of your emergency database in anything admitted that is collapsed / very sick

3. Use it on your joint taps / free fluid taps to increase your suspicion of sepsis / malignancy prior to getting culture / cytology results back

4. Use it to help stratify patient's illness to assist in allocation of resources (your time/ owner's money) and decision-making re need for referral

5. If you're struggling to get it within normal limits after 12-24 hours of goal-directed therapy or in a suspected situation of Type B hyperlactataemia, phone for advice or refer

For advice, guidance or referral contact Anna at:

Bath Vet Referrals
contact@bathvetreferrals.co.uk
www.bathvetreferrals.co.uk
01225 832521

When a derm case gets under your skin Think referral

Peri Lau-Gillard DrMedVet CertVD DipECVD MRCVS
RCVS and European Specialist in Veterinary Dermatology

Notes

For advice, guidance or referral contact Peri at:

Rowe Vet Referrals or Vale Referrals

Rowe
01454 275000
referrals@rowevetgroup.com
www.rowevetgroup.com

Vale
01453 547934
referrals@valevets.co.uk
www.valereferrals.co.uk

The exploratory laparotomy: Common pitfalls and how to avoid them

Elisa J. Best BVSc Cert SAS MRCVS
RCVS Advanced Practitioner in Small Animal Surgery

Having a plan:

Not biting off more than you can chew:

Complete exploration of the abdomen:

Avoiding 'Nothing Found':

For advice, guidance or referral contact Elisa at:

Rowe Referrals
elisabest@rowevetgroup.com
www.rowereferrals.co.uk
01454 521000

Notes

IVC REFERRALS 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.

Referral Contact

Bath
Rosemary Lodge, Bath BA2 5RL
T: 01225 832521 ext 3
E: contact@bathvetreferrals.co.uk
W: www.bathvetreferrals.co.uk

Rowe
Bradley Stoke, Bristol BS32 9DT
T: 01454 521000
E: referrals@rowevetgroup.com
W: www.referrals@rowevetgroup.com

Vale
The Animal Hospital, Dursley, GL11 6AJ
T: 01453 547934
E: referrals@valevets.co.uk
W: www.valereferrals.co.uk