

King Edward Referrals News

Another year has flown by and the silly season is upon us. With it, your last news letter of the year. It has two main purposes— to THANK YOU very much for your support this year. Without you, this business couldn't function! I wanted to take a minute to highlight some of our commitments to you:

- ☺ We see our service **complimenting yours**, taking your internal medicine care to a new level. There are many things you can do that I can't, starting with all things ruminant.....
- ☺ All your clients are treated with the same compassion, courtesy, honesty and efficiency that Madiba would receive – even if you send us Robert Mugabe. The evidence: We regularly survey customer satisfaction to see how we can improve. We scored 10/10 with all bar one of the clients we could reach last month (she gave us an 8). We're very proud of this and I'm grateful to Sue and Anita without whom this would not be possible.
- ☺ Your professional image is of critical importance to us and that's why you will receive our total support at all times. You have my assurance that we will never make anything other than positive comments about your care.

The second purpose is to let you know what our opening times are over the festive season—see box below.

It remains for me to wish you all a relaxing and refreshing festive season doing all the things you'd really like to do.

Happy Christmas!

Malis

King Edward Referrals opening times during the Festive Season

Dec 18-21: normal working hours ie 8.30 am to 5 pm

Dec 24: 8.30 am - 2pm

Dec 27-28: normal working hours ie 8.30 am to 5 pm

Dec 31: normal working hours

**Summary:
open on work days, closed on weekends and public holidays**

We'll assist with genuine emergencies when

Index

Page 1: opening times

Page 2: case studies and announcements

Page 3: answers to case studies



Case study no 13: the snotty Dachsie

Biddy, a 9 year old Dachsie was referred by Dr Sharon Bower with a 4 month history of sneezing, antibiotic-responsive but recurrent bilateral purulent rhinitis, frequent reverse sneezing and two episodes of epistaxis. Exercise tolerance was decreased. On clinical examination, nasal airflow was decreased bilaterally but no nasal discharge was obvious. There was mild submandibular lymphadenopathy, the left tonsil was enlarged and there was some gingival resorption and tartar—most obvious around the maxillary canines. Pulmonary auscultation was unremarkable but there was a very localised Gr 2/6 left systolic high pitched mitral murmur. Sinus arrhythmia was obvious at lower HR and pulse fine. P 144-160, RR 24-30.



Biddy

Question 1: localise the problem in the cardio-respiratory system

Question 2: What are the most common DDs for this problem?

Question 3: How would you investigate this further?

Waste not....

Please consider donating elderly / recently **expired drugs** to one of the **welfare organizations** rather than just binning them. A call to your organization of choice will usually identify a way of getting the stuff to them

EC-SAVA AGM

Where: Port Elizabeth

Venue: TBA

When: 17 February

There will be a day's lectures including Tanya Schoeman on feline babesiosis

National SAVA congress 2013

Where: Port Elizabeth

Venue: New conference centre at the Boardwalk

Date: 19-22 August



Sassy

Case study no 14: the breathless Dachsie

Dr Gosia Ochabska referred Sassy, a 16 month old entire female Dachsie because she'd had progressive dyspnoea, exercise intolerance, reduced appetite and severe weight loss for 2 weeks. Similar signs had developed 4 months previously but had resolved after about 2 weeks while on treatment with doxycycline and steroids. The current episode had not responded to doxycycline / bronchodilators. Coughing was only rarely heard.

Clinical examination revealed the following abnormalities: Pulse 96, RR 180, BCS 1.5/5. Colour paler than expected with PCV but no obvious cyanosis. Severe Mm wasting and lethargy. Marked polypnoea with shallow respiratory excursions. Lung sounds surprisingly soft for the amount of respiratory compromise.

Question 1: Is this a right or left lateral? Why?

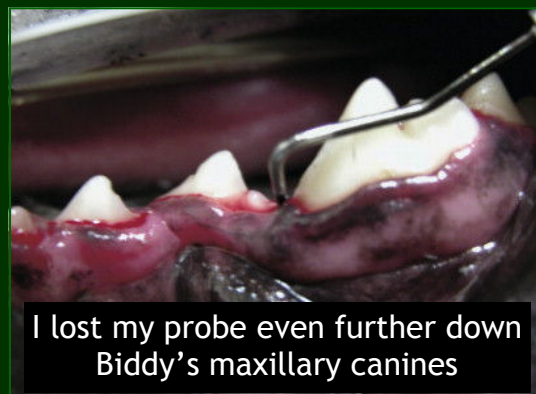
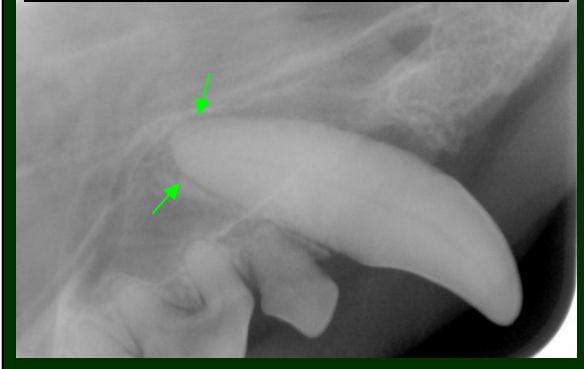
Question 2: Does this patient have cardiac disease / lung disease?

Question 3: How would you investigate this case further? Are there potential risks?

Answers on the next page



Post extractions, Biddy is snot free



Case 13's Answers (the snotty one)

Answer 1: The nose and/or nasopharynx (last because of the reverse sneezing)

Answer 2: Common causes for chronic rhinitis include nasal foreign bodies, fungal infections, nasal tumours, dental disease and lymphoplasmacytic rhinitis. When considering dental disease, many people assume this will only cause rhinitis when there is an oro-nasal fistula or obvious tooth root abscess. Recent studies have proved that dental disease associated with relatively mild radiographic changes like the one here can cause lymphoplasmacytic rhinitis. This is also well described in humans.

Answer 3: Imaging with intra-oral films or nasal CT. If you superimpose the mandible over the nose you'll miss significant pathology. While the patient is anaesthetized, check the TEETH. If you're losing your periodontal probe next to a tooth this is significant!! Nasal swabs have a high prevalence of false positive and false negatives when used to try and identify fungal infections. DON'T waste money on them. Culture from a biopsy. Just please check the dog can clot first. Biopsies may be collected blind if nasal disease is generalized, but if it is focal, it does really help to guide the biopsy with an endoscope. If you're going to biopsy remember to measure for and avoid the cribriform plate. Transnasal brain biopsies are not usually helpful.



Case 14's Answers (the breathless one)

Answer 1 (revision for folks who attended recent clinical rounds): Right lateral—because the cardiac apex looks pointy and is not lifted from the sternum, the cd v cava appears to arise out of and not cross over the crus of the diaphragm, the crura are parallel to each other and gastric air is in the fundus not the pylorus

Answer 2: Pulmonary disease. There is a generalized unstructured interstitial pattern throughout the lungs (on VD too). The left atrium (red arrow) is not enlarged. For cardiac disease to cause a cough / breathlessness, the left atrium must be enlarged. Think about it.

Answer 3: DDs for this pattern are allergic or parasitic airway disease, chronic fibrosis (paraquat poisoning, chronic bronchitis or idiopathic), fungal infection, pneumocystis (classified sometimes as a fungus and sometimes as a protozoan), toxoplasmosis. Usually I would GA the patient for endoscopy and BAL for cytology and culture. Here, we did a TTA under sedation instead (because she was so compromised). As there were no eosinophils on cytology we submitted TTA fluid for pneumocystis PCR. She was positive. Sometimes, you need a lung biopsy to make the diagnosis. People have also made it on lung aspirate but this technique risks causing a tension pneumothorax (And death). As you know, Dachshies and CKCS are at high risk of infection with this ubiquitous but usually feeble organism because they have an underlying immunodeficiency.

