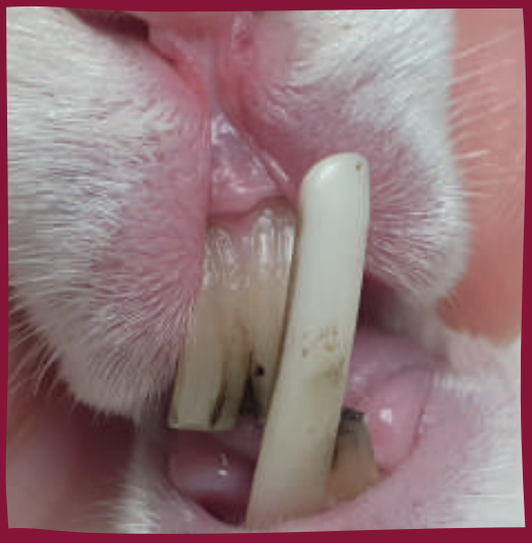
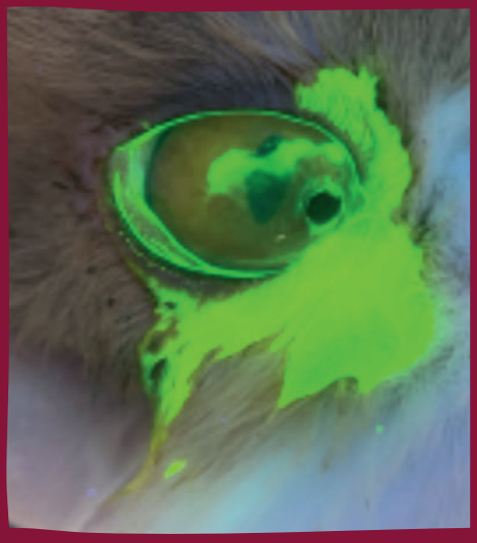
VETCT

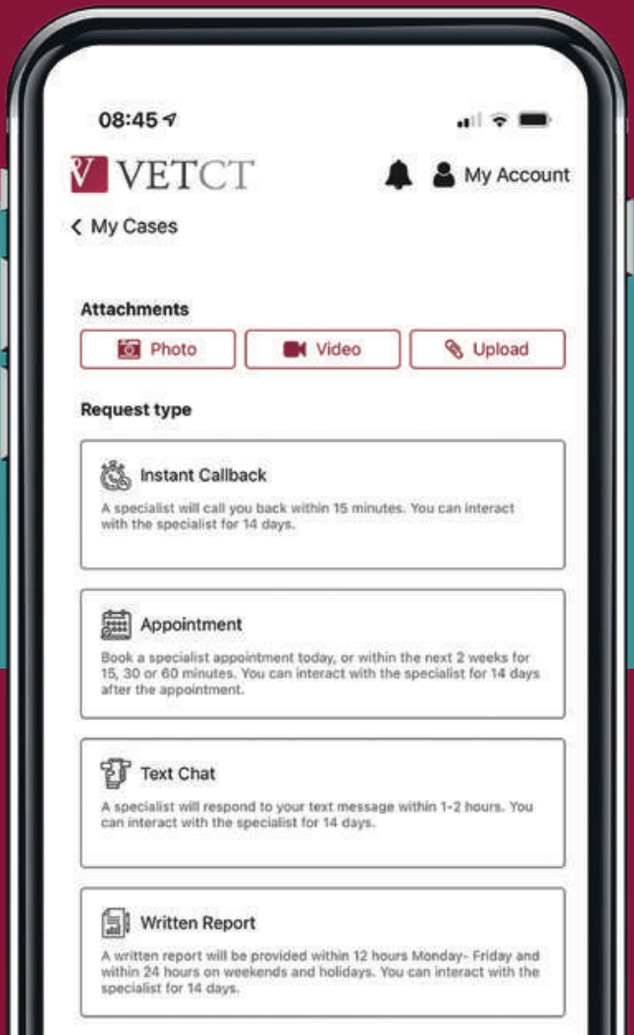
Teleradiology | Teleconsulting | Education





TELECONSULTING

Specialist advice and support whenever you need it.



DOWNLOAD THE CASE STUDY HERE!

SCAN ME

Internal Medicine

EXOTIC EPISTAXIS

INTERNAL MEDICINE

WITH DR MELLORA SHARMAN
AND DR KOSTAS PAPASOULIOTIS

Internal Medicine Case Study

Exotic Epistaxis

DOWNLOAD THE CASE STUDY HERE!

SCAN ME

CASE HISTORY

You have a 2yo FN Crossbreed dog, originally from Spain, presenting for sudden onset unilateral left-sided epistaxis. Your clinical history reveals the dog has been sneezing for some months and mild shifting lameness has been present over several weeks.

FINDINGS

- Mild generalised lymphadenopathy
- No evidence of gross haemorrhage or petechiation
- Mild lameness with some joint discomfort, but no palpable joint effusions
- Pyrexia 39.6 degrees

DIAGNOSTICS

• A general health blood profile reveals marginal thrombocytopenia at 109x10 9/L and marginal increase in globulins at 59 g/L.
• AFAST scan reveals splenomegaly.
• Buccal mucosal bleeding time is normal (less than 2 minutes)
• PT and PTT less than normal limits
• Angio Detect™ test is negative
• SNAP® 4DX® plus test is negative (Anaplasma, Ehrlichia, Dirofilaria and Borrelia spp.)

VETCT

WHAT DO YOU DO NOW? CONTACT VETCT!

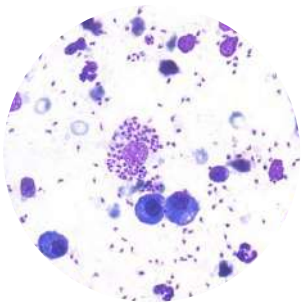
Internal Medicine Specialist, Mellora Sharman, is on hand to help! She guides you through the differential diagnoses and next steps. Mellora checks with one of VetCT's anaesthesia specialists to provide a protocol or intranasal medication to manage the epistaxis, using phenylephrine in preference to adrenaline. Mellora identifies the differentials, including generalised vasculitis (immune-mediated, infectious disease, i.e. Leishmaniasis), or non-specific inflammatory rhinitis, fungal rhinitis, or foreign body. Presence of lymphadenopathy, splenomegaly and shifting lameness increased the concern for something systemic rather than localised. Travel from Spain placed Leishmaniasis higher on the list of possibilities and Mellora advises testing prior to further diagnostic work-up.

WORKING WITH YOU STEP BY STEP

1

Results

A high serology result is obtained indicating exposure to Leishmania, and amastigotes are seen on cytology from FNA samples taken from the lymph nodes, indicating active infection.



2

Treatment Plan

Mellora agrees a treatment protocol with you - combination therapy including allopurinol and meglumine. Ongoing monitoring of renal parameters and proteinuria are recommended, together with repeated serology throughout the treatment plan across the next 6-12 months, as per LeishVet guidelines.

3

Outcome

Just over six weeks later a case review shows no further epistaxis and marked improvement in energy and general demeanour! Mellora and the team are on hand to advise on routine vaccination and further treatment in the case of recrudesence.

Create a New Patient Profile

Patient ID

17042021

Patient name

Perra Barker

Owner name

Rachel Smith

Date of birth

Aug 26, 2019

Species

Canine

Breed

Crossbreed

Gender

Female Neutered

Next

3. Review Details

Patient Details

Perra Barker Rachel Smith
17082021

Canine | Crossbreed | Female Neutered

Age
2 years 2 months

Case Details

Case ID

TELE-8581

Patient clinical history

- Rehomed from Spain one year previously
- Left sided intermittent epistaxis throughout the day
- Intermittent sneezing of several months duration
- Mild shifting lameness over several weeks

Physical exam:

- Mild generalised lymphadenopathy
- Temp 39.6 degrees
- Otherwise nad.

Clinical questions to be answered

- How do I stop the epistaxis?
- What are your differentials and further testing do you advise for the lameness and epistaxis?

Attachments

Photo | Video | Upload

Request type

Instant Callback

A specialist will call you back within 15 minutes. You can interact with the specialist for 14 days.

Appointment

Book a specialist appointment today, or within the next 2 weeks for 15, 30 or 60 minutes. You can interact with the specialist for 14 days after the appointment.

Text Chat

A specialist will respond to your text message within 1-2 hours. You can interact with the specialist for 14 days.

Written Report

A written report will be provided within 12 hours Monday- Friday and within 24 hours on weekends and holidays. You can interact with the specialist for 14 days.

Save | Previous | Next

Support

Perra Barker

Results:

Rachel Smith

- Biochemistry and CBC bloods: marginal thrombocytopenia (109x10^9/l), marginal hyperglobulinaemia (59 g/l)
- Ultrasound: AFAST scan – mild splenomegaly, no abdominal free fluid
- Buccal mucosal bleeding, PT and PTT within normal limits
- Angio Detect™ test - negative
- SNAP® 4DX® plus test - negative (Anaplasma, Ehrlichia, Dirofilaria and Borrelia spp.)

23 October 2021, 08:15

Perra Barker

Mellora Sharman

Hi Rachel,

Thanks for all the information on this case. First, here's some information for you on controlling the epistaxis. Having spoken to an anaesthetist - they advised that they typically use the equivalent of the IV dose in mg/kg for intranasal use of either phenylephrine over adrenaline given the highly vascular nature of the nasal mucosa. This would then be diluted. Their preference was for phenyephrine. I hope this helps you!

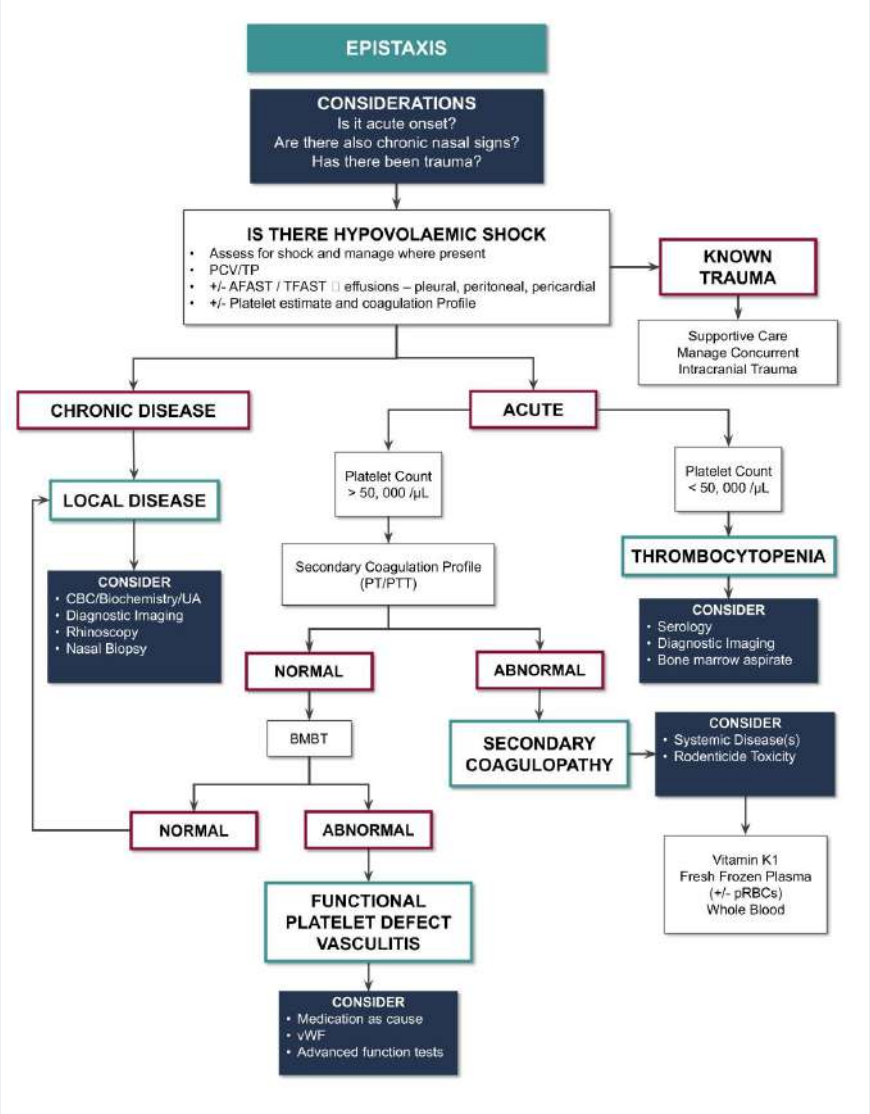
Mellora

23 October 2021, 08:24

Perra Barker

Mellora Sharman

Further advice about differentials and testing:



23 October 2021, 08:25

Perra Barker

Mellora Sharman

- Differentials include a generalised vasculitis (immune mediated, infectious disease - i.e. Leishmaniasis), or non-specific inflammatory rhinitis, fungal rhinitis. A FB rhinitis or reaction is possible, but seems less likely with the chronicity of sneezing and lack of current overt irritation. More advanced imaging of the head and rhinoscopy would be helpful to narrow down these differentials. The possible lymphadenopathy / splenomegaly and shifting lameness do make me concerned for something more systemic.
- The lameness could reflect inflammatory disease. Haemorrhage into joints seems less likely and would be more atypical in my mind where there is not an obvious primary or secondary coagulation disorder.
- The travel from Spain might place Leishmaniasis higher on the list of possibilities here - for which serology may indicate prior exposure or current infection. Identification of organisms on cytology samples from the LN or spleen would be more indicative of active / subclinical disease, and PCR could similarly be useful to detect organism DNA.
- The owner may wish to wait for these diagnostics before proceeding with more advanced imaging etc, although I would closely monitor the clinical situation to determine if this is appropriate - ongoing epistaxis that is not able to be controlled, or the need for transfusion would be good indicators for referral sooner rather than later when other diagnostics are returned.
- Other diagnostics / monitoring to consider would include BP assessment for possible hypertension, monitoring of the temperature and PCV ongoing in case of intermittent pyrexia, and worsening PCV.
- As the signs are vague and there is no obvious inflammatory Leukogram / stress Leukogram a basal cortisol may be a consideration - with stimulation testing recommended if baseline cortisol is < 55 nmol/L.
- A UPC might indicate proteinuria - this could be non-specific at this time, but may be an important consideration if there is borderline azotaemia (IRIS Stage 1 disease) or where Leishmaniasis is confirmed.
- Non-specific management for epistaxis would include intranasal adrenaline, ice-packs and consideration for sedation (buprenorphine / butorphanol). Medetomidine might also be a consideration that might help with peripheral vasoconstriction and therefore help reduce the risk of re-bleeding.
- As above - more definitive diagnostics would include advanced imaging of the head and rhinoscopy. Abdominal ultrasound might also be worthwhile extending in this case for further assessment of cavitary lymphadenopathy, splenomegaly +/- sampling.

23 October 2021, 08:27

Perra Barker

Rachel Smith

Updated results:

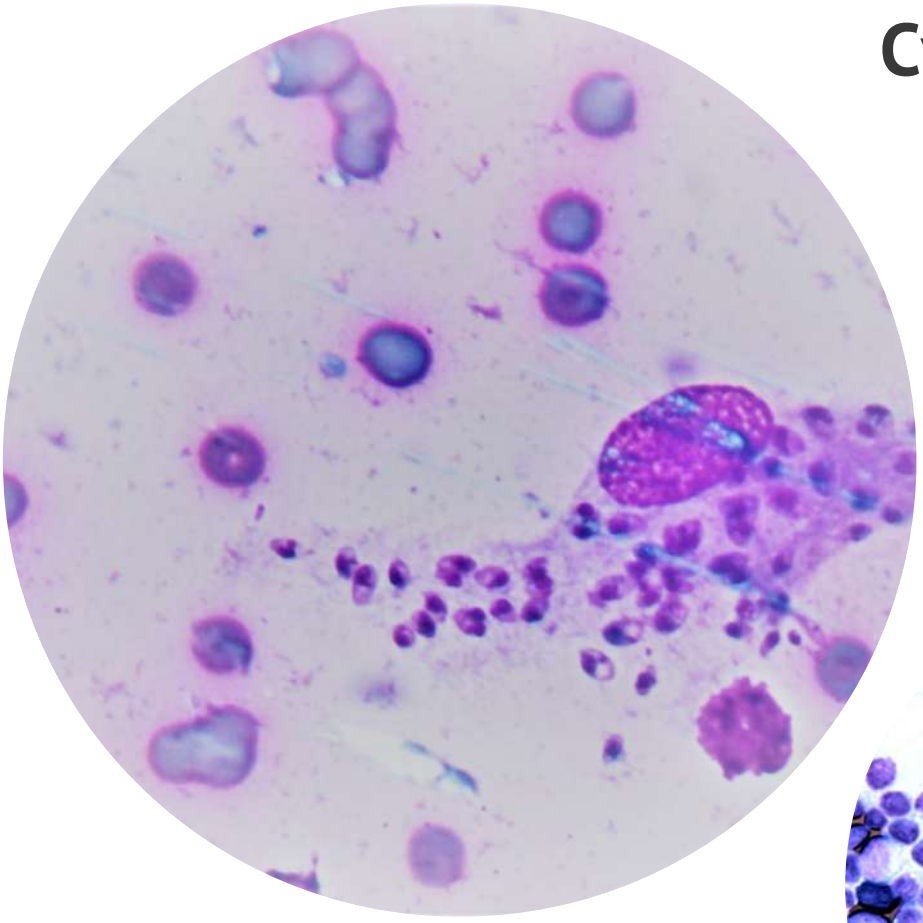
- Leishmania serology - strongly positive with a titre of > 1:1000
- Cytology of the LN - amastigotes seen
- PCR was suggested by the pathologists to check for Leishmania DNA.

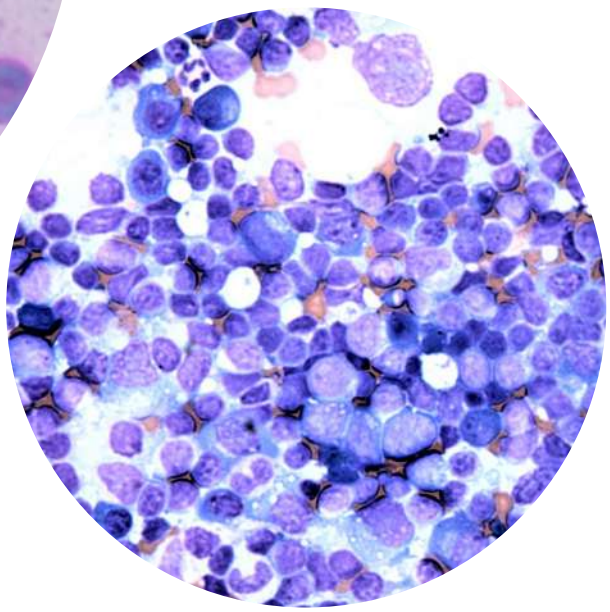
How do we treat the Leishmania?

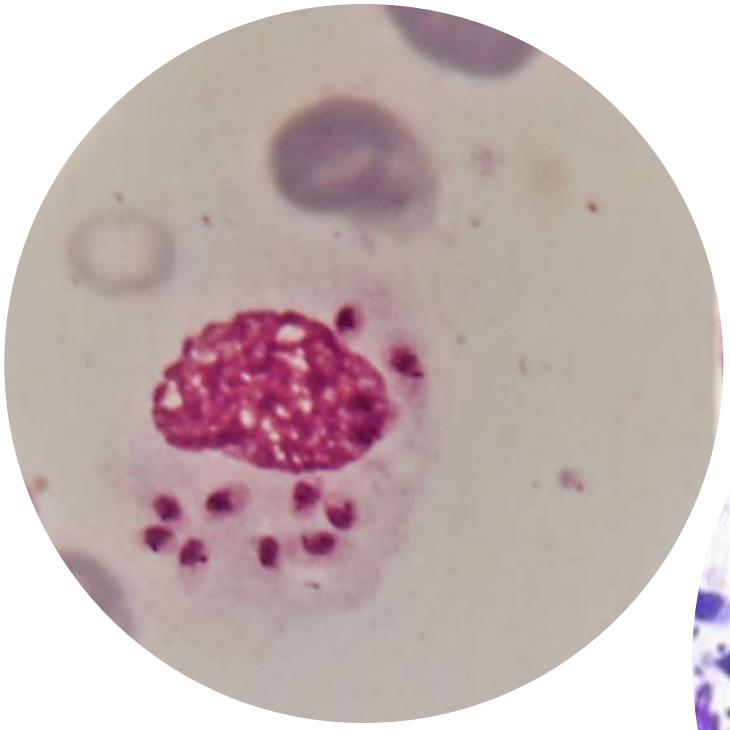
23 October 2021, 08:30

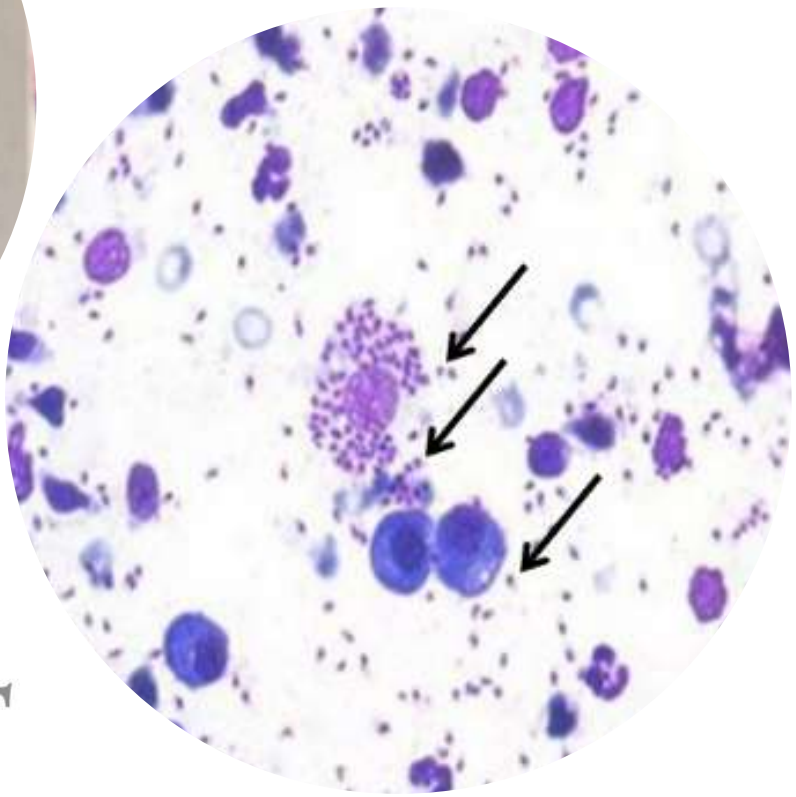
VetCT
Thanks for your message, a specialist will be in touch shortly
23 October 2021, 08:28

Cytology Findings









VETCT

Perra Barker

Case Summary | Results | Consult Chat

Mellora Sharman

Hi Rachel,

I generally follow the LeishVet Guidelines (http://www.leishvet.org/fact-sheet/), and having worked with many Spanish vets previously, my treatment protocol for management of these cases is combined **allopurinol** + **meglumine** therapy.

Meglumine requires a **special import license**, and this can take a couple of weeks, so I typically **start allopurinol pending arrival**. I also recommend importing at least the **6 week course** of therapy, even if 4 weeks is given ultimately.

Further staging and monitoring of renal parameters and for proteinuria is recommended - as per the **LeishVet Guidelines**. Repeated serology down the track will also help, but may take time to drop - so again the Leishvet Guidelines are helpful to direct your serologic monitoring as well.

Best Wishes,
Mellora

23 October 2021, 08:50

Perra Barker

Rachel Smith

Hi Mellora. Perra has been doing very well since being diagnosed with Leishmaniasis while being treated with allopurinol + meglumine.

She has been bright and happy - marked improvement in behaviour, no further epistaxis, resolution of lymphadenopathy, and eating well. The owner is very pleased.

Haematology, biochemistry and urine tests are normal.

Mellora Sharman

Thanks for the update Rachel, it's fantastic to hear Perra is doing so well. Let me know if you or the owner has any further questions!

Rachel Smith

Hi Mellora. I have some further questions, please see:
- Costs may limit diagnostics regularly - is dipstick ok, or would UPC be preferred?
- Can we vaccinate and provide parasite prophylaxis?

Perra Barker

Mellora Sharman

Thanks for the great update for us on Perra - it's great to hear things are going really well! Below is a little summary of our chat for you and answers to your questions.

History

- Doing really well since being diagnosed with Leishmaniasis has been treated with allopurinol + miltefosine with the latter finishing a 28-day course of therapy relatively recently
- Has been bright and happy - marked improvement in behaviour, no nose bleeds, eating well, owner very pleased.
- Haematology and biochemistry normal
- Owner brought in urine sample - performed stick, with trace protein with USG 1.043 - UPC not performed previously - but previously dipstick showed 2+ protein with USG 1.050.

29 October 2021, 08:50

Perra Barker

Case Summary | Results | Consult Chat

Mellora Sharman

Questions

- Costs may limit diagnostics regularly - is dipstick ok, or would UPC be preferred?
- Can we vaccinate and provide parasite prophylaxis?

Discussion

- Ideally a **UPC would be great** - it may be that we can perform one this time and if it is normal, it might mean that we do not have to monitor it as regularly and only from time to time or via **dipstick** largely to try and save SOME funds.
- I have no concerns with providing **parasite prophylaxis** in this patient - it would be ideal to limit the possibility of concurrent disease being acquired I agree!
- If we have previously had core vaccines as an adult, immunity is likely still available from these and a booster only may be needed - other vaccines such as KC, or lepto may require recommencement of a primary and booster where there has been a significant lapse depending upon the manufacturer's recommendation. **I see no reason why these can't be given** as there is no indication of immune compromise as such as she is well - if there is a risk for acquiring these diseases, then a vaccination is likely to be preferred, albeit could be delayed a little longer if risk was lower.

I hope this helped, and of course let us know if you have any further comments or questions!

Best Wishes,
Mellora

29 October 2021, 08:50

DOWNLOAD THE CASE STUDY HERE!

SCAN ME

INCISOR ISSUE

RABBIT DENTISTRY

WITH DR. COPPER AITKEN-PALMER

Rabbit Dentistry

Rabbit Dentistry Case Study

Incisor Issues

Contact us today at info@vet-ct.com

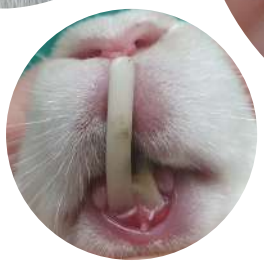
DOWNLOAD THE CASE STUDY HERE!

SCAN ME

CASE HISTORY

A 2yo FE Dutch rabbit with a 3-month history of incisor malocclusion presents struggling to eat. On clinical examination, both lower incisors are abnormal with overgrowth of the right lower incisor and the left lower incisor appears necrotic.

You want to know if you should extract the incisors and what further steps you should take to ensure this rabbit has the best possible outcome.



WHAT DO YOU DO NOW? CONTACT VETCT!

Copper Aitken-Palmer, Specialist in Zoo, Wildlife and Exotic Animal Medicine, is on hand to help! Copper summarises the issues facing this rabbit, then advises on diagnostics and management.

"Typically, this type of malocclusion is caused by maxillofacial trauma as a juvenile but can also be congenital in dwarf breeds. Often the incisors are not the only affected teeth. The rabbit will likely require lifelong recurrent dental trimming and veterinary attention.

The right lower incisor is growing abnormally and appears to be affecting the growth of the left lower and both upper incisors. The upper incisors are splayed laterally. When there is malocclusion affecting normal tooth growth from the gumline, the pressure on these continuously growing teeth will result in elongation of the roots (reserve crown). The abnormal roots can then cause abscessation, pain, inflammation of surrounding soft tissues, and trauma to neighbouring teeth."

VETCT

PTO for part 2!

Rabbit Dentistry Case Study

Incisor Issues

Contact us today at info@vet-ct.com

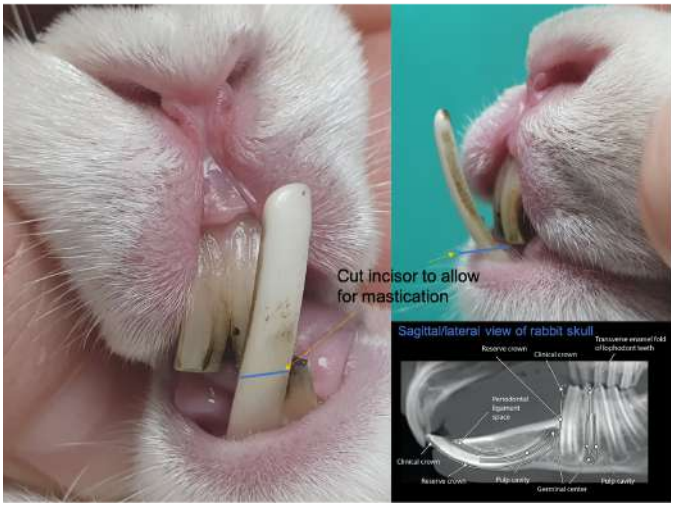
DOWNLOAD THE CASE STUDY HERE!

SCAN ME

MANAGEMENT

Incisor extraction is not an easy procedure in rabbits. Lower incisor extraction has fewer complications than upper incisor extraction, but extraction is a last resort. This rabbit could probably be managed with routine periodic dental trimming, but she may have lifelong health challenges related to dental disease. Extensive dental disease impacts an animal's welfare and is a common reason for euthanasia among rabbits.

For this rabbit, it will be important to address the dental abnormalities in stages as below.



WORKING WITH YOU STEP BY STEP

1. **Ensure adequate nutrition since the rabbit is not eating well**
   The priority is ensuring this rabbit can consume adequate nutrition. Nutritional support should include a high-fibre slurry daily while she is not able to eat her food normally. This will also make her a better anaesthesia candidate for dental trimming and evaluation.

2. **Address incisor malocclusion**
   Next, address the incisor malocclusion with a full dental exam and imaging under general anaesthesia. Ideally any abnormal teeth should be trimmed to allow for improved mastication. Use a dental drill while protecting neighbouring soft tissue structures. I've included annotations to your photos to help guide the trimming of the incisor.

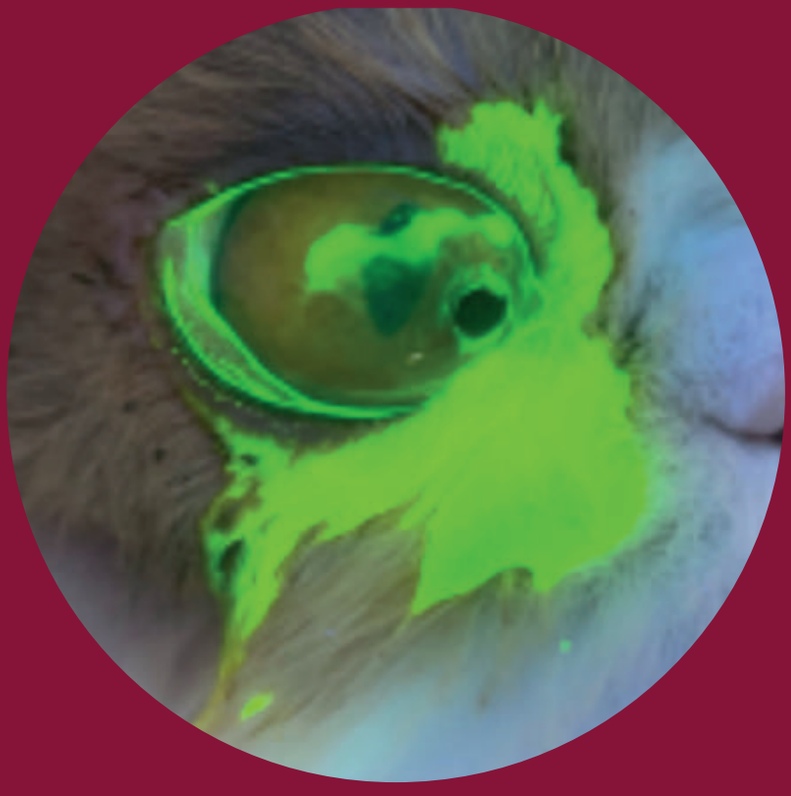
3. **Evaluate for and address cheek teeth malocclusion**

4. **Diagnostic imaging**
   Diagnostic imaging should also be performed to evaluate the severity of the disease and plan for long term management. Skull CT is a more powerful diagnostic tool in rabbits, but skull radiographs provide some essential information.

5. **Plan for long term care (e.g. frequent dental trimming/adjustments or extractions).**

DOWNLOAD THE CASE STUDY HERE!

SCAN ME



AN EYE FOR AN EYE

OPHTHALMOLOGY

WITH DR. MARIAN MATAS

Ophthalmology

Ophthalmology Case Study

An eye for an eye

Contact us today at info@vet-ct.com

DOWNLOAD THE CASE STUDY HERE!

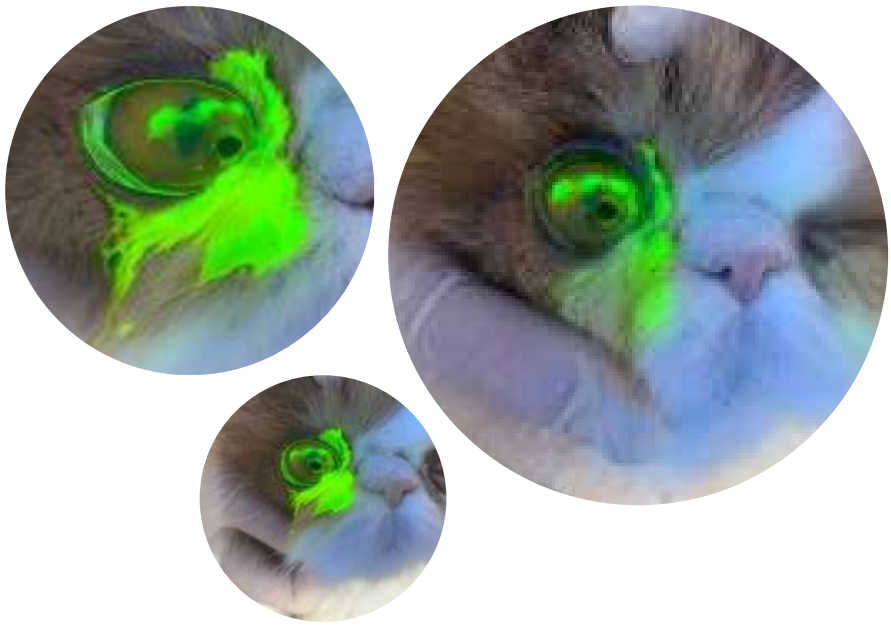
SCAN ME

CASE HISTORY

A 2y 8m MN Persian cat presents 3 months prior with a 5x3mm corneal ulcer. You treat with one week of topical chloramphenicol.

At recheck the ulcer and region of fluorescein uptake was reducing in size and almost fully resolved.

The patient then re-presented several weeks later, quiet and withdrawn.



WHAT DO YOU DO NOW? CONTACT VETCT!

After repeating the examination, you take photographs to send to VetCT for an ophthalmologist to review.

The case history and images are reviewed by Dr. Marian Matas, a diploma holder in ophthalmology, who confirms the presence of a corneal sequestrum. These can be commonly missed as a cause of non- healing corneal ulcers.

Following Marian's advice, the patient was referred locally for surgical treatment. VetCT passed the images and case discussion to the referral hospital prior to the appointment.

VETCT

PTO for part 2!

Ophthalmology Case Study

An eye for an eye

Contact us today at info@vet-ct.com

DOWNLOAD THE CASE STUDY HERE!

SCAN ME

WORKING WITH YOU STEP BY STEP

1

Why causes a corneal sequestrum?

"Great question, but unfortunately we do not know for certain! We suspect that any corneal injury in cats can cause the development of a corneal sequestrum, especially if the injury leads to chronic corneal ulceration. Persians are over-represented and this is probably because their shallow orbit, prominent globe and relatively reduced blink predisposes the cornea to ulceration. A sequestrum forms when part of the exposed corneal stroma becomes necrotic and subsequently pigments, leading to the characteristic 'black spot' which is diagnostic for a corneal sequestrum. Corneal sequestra are usually painful and, although in some cases they may slough naturally, this process can take months and may lead to complications including severe keratitis, corneal rupture, and chronic discomfort. Surgical options (keratectomy with or without grafting) are often the treatment of choice and, if possible, a consultation with a veterinary ophthalmologist is advisable to discuss possible treatment options."

2

The owner wants to know what the prognosis is?

"The prognosis for corneal sequestrum is good, with published surgical success rates >80%. The referral centre will discuss this with you during your appointment. In the uncommon event of sequestrum recurrence then a second surgery might be required. In the longer term, and in predisposed cats, regular use of eye lubricants may be advised in order to lubricate and protect the corneal surface and reduce the risk of recurrence."

VETCT