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Welcome to the March issue of Veterinary Practice! In focus this month is dermatology. Anita Patel returns with her monthly column looking at the management of canine atopic dermatitis and Ewan Ferguson gives advice on how to fit a dermatology consult into general practice. Along with this, Vetruus report the findings from their recent survey on how practices charge for nurse clinics.

In the small animal section this month, we have an in-depth article about how to make tooth extractions easier, including a step-by-step guide on open extractions, illustrated by photos. Nationwide Laboratories give advice on how to get the best out of your surgical biopsies, and Marion McCullagh returns for her rare conditions mini-series discussing puppy strangles.

The Official Veterinarian section is back this month with an article looking at certification pitfalls in farm animal practice. In addition, Alasdair MacNab continues his mini-series on the importance of biosecurity in the veterinary industry.

Beth Reilly and Jon Reader of Synergy Farm Health provide an insight into their work to tackle lameness in the dairy industry in our large animal section, and Richard Gard reports on the 2019 British Mastitis Conference.

In the equine section this month, BEVA President Tim Mair explains the new system proposed by the association to tackle equine obesity. John Periam reports on the advantages of standing throat surgery.

Will Stirling gives you his top tips for making sure your practice website gives a good first impression. Qess Ali answers the question “Am I responsible for repairs to my practice before I sell it?” in the monthly legal column, and Adam Bernstein discusses dealing with HMRC penalties.

This issue also features our top tips for BSAVA Congress 2020 – an annual event that is set to be bigger and better than ever. With over 450 hours of CPD available for both vets and nurses in small animal practice, as well as non-clinical streams, BSAVA Congress boasts a programme not to be missed. I will be attending for the first time and I’m looking forward to everything the event has to offer. Make sure to come and say hi to the Veterinary Practice team on stand G44!

“Make sure to come and say hi to the Veterinary Practice team on stand G44”

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“It is very difficult to defend yourself against a balance of probabilities”
Improve International launches Manual of Clinical Small Animal Internal Medicine

Improve International has launched the first volume of the latest in its new textbook series – the Improve International Manual of Clinical Small Animal Internal Medicine.

Providing comprehensive information to support the diagnosis and treatment of commonly seen pathologies of dogs and cats, the new book covers topics including but not limited to haematology, immunology, diagnostic imaging, reproductive system disorders and gastrointestinal disorders, as well as hepatobiliary and exocrine pancreatic disorders. Each chapter has been authored by an internationally recognised expert in their field.

Improve, a global leader in veterinary CPD, launched its first textbook, the two-volume Improve International Manual of Small Animal Surgery in 2019. Its books support delegates studying for the company’s flagship Postgraduate Certificate training programmes as part of its blended learning approach but are also a useful reference source for other veterinary surgeons. Each chapter includes a self-assessment section with test questions and clinical cases.

One of the world’s leading veterinary training companies, Improve International was founded by a team of UK vets and has trained more than 20,000 veterinary professionals in 20 countries around the world. In the delivery of its programmes, it works closely with its assessment partner, the International School of Veterinary Postgraduate Studies (ISVPS), and with Harper Adams University, which provides the higher education body quality assurance.

The new books can be purchased from improveinternational.com/uk/books, 5mbooks.com or from booksellers worldwide. They are also available in Spanish with translations into additional languages planned

For further information, visit improveinternational.com or call 01793 759159

BEVA offers free membership to vet students

The British Equine Veterinary Association (BEVA) is offering free membership to veterinary students to help encourage more vets into equine practice. The initiative, launched this month, has been made possible by generous sponsorship from Baker McVeigh, CVS Group, IVC, Newmarket Equine Hospital, Rossdales, VetPartners and XLVets.

Currently fewer than one in ten veterinary students opt to go into equine practice. BEVA hopes that the new scheme will provide a broader base of students with an insight into the world of equine veterinary medicine and open more eyes to what’s great about being an equine vet.

Katie Roberts, the President of the Association of Veterinary Students, said: "This is a very exciting opportunity for students. Anecdotally, we know that some students can feel very daunted by equine practice, especially if they don’t come from a traditionally horsey background. Being able to become involved with BEVA at no cost means that they can get a true taste of the equine veterinary world in addition to their experiences on EMS, and I’m sure this will pique the interest of our members."

For further information about student membership of BEVA visit beva.org.uk/Join-BEVA/vet-student

Bayer Animal Health launches Neptra in the UK

For the first time, UK vets are now able to offer the only veterinarian-administered single-dose treatment for canine otitis externa (OE).

Neptra ear solution for dogs is the latest innovation from Bayer Animal Health – providing anti-inflammatory, anti-fungal and anti-bacterial activity – and the product is now available for veterinarians to prescribe in routine OE cases.

The UK launch follows a highly successful launch in the USA, under a different name, Claro. Claro is now the number one product for otitis externa in the country. Eliminating home treatments, Neptra’s launch will bring vets full control over treatment compliance and eliminate the uncertainty and stress of client administration.

Neptra is available now to order as one simple SKU via your regular wholesaler or speak to your Bayer veterinary business manager. A single, 1ml dose in each affected ear treats dogs of all breeds. To enquire about stocking Neptra please contact your local veterinary business manager

Practice support materials are also available via vetcentre.bayer.co.uk
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¹100% administration success by cat owners over 3 consecutive months.¹

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The RCVS has announced the candidates standing in the 2020 RCVS Council and Veterinary Nurses (VN) Council elections.

This is the first time that VN Council has held an election since 2017 – there was no 2018 election due to governance changes and there were too few candidates in 2019. A record 13 registered veterinary nurses have put themselves forward to compete for the two available places. For this year’s RCVS Council election, eight veterinary surgeons have put themselves forward to compete for the three available places.

Both the RCVS Council and VN Council elections are due to start in the week commencing Monday 16 March when the ballot papers and candidates’ details and manifestos will be posted and emailed to all members of both professions who are eligible to vote. The voting materials will be sent by Civica Election Services (formerly Electoral Reform Services) which is running the election on behalf of the RCVS and the emails will contain a unique security code for each member of the electorate as well as a link to a secure voting website. All votes, whether postal or online, must be cast by 5pm on Friday 24 April 2020.

As with previous years, the RCVS is also inviting members of both professions to get a better idea of why each candidate is standing by taking part in “Quiz the candidates” and submitting a question which will then be put directly to the candidates. Recordings will be published on the RCVS website and YouTube channel on the week the election commences.

Prior to the launch of the election the RCVS has uploaded each of the candidates’ biographies and election statements on to its website

The statements for RCVS Council candidates can be found at r cvs.org.uk/vetvote20 and those for VN Council candidates at r cvs.org.uk/vnvote20

The RCVS has published the results of its latest professions-wide surveys, conducted with veterinary surgeons and veterinary nurses last year.

All members of the respective professions were invited to take part in the surveys – including the non-practising and overseas-practising veterinary surgeon members – which asked a wide variety of questions on demographics, work status, type of work undertaken, type of organisation worked for, well-being, views on the professions, continuing professional development (CPD) and views on the RCVS. This is the seventh time such a survey has been undertaken for veterinary surgeons and the fifth time for veterinary nurses.

The response rate for the survey for veterinary surgeons was (including partial completes) 42.6 percent, while the response rate for veterinary nurses (also including partial completes) was 44.3 percent.

Many of the results and trends identified have fed into the College’s 2020–2024 Strategic Plan, which was recently approved by RCVS Council.

Lizzie Lockett, RCVS CEO, commented: “These surveys are an interesting and informative snapshot of where the professions are and how they are feeling at a particular moment in time, but they won’t be left on a shelf to gather dust as we will be using the data to inform many of our projects and initiatives. These surveys also help us to build an historical picture of the professions and spot long-term trends.

“The results of the surveys have already been incorporated into the five-year Strategic Plan and will continue to feed into our work over the next few years.

“I am glad to say that much of the College’s work has anticipated some of the issues raised by the respondents – for example, our recently approved Graduate Outcomes proposals, which seek to better prepare and support new vets into life in practice, and our first steps towards developing a more structured and rewarding career path for veterinary nurses with our new Certificates in Advanced Veterinary Nursing.

“There are some causes for concern in these results – for example, around veterinary nurse pay and retention, lack of work–life balance and retention of recent graduates – and, while not all of these are in the College’s remit or power to resolve, we will continue to work with our partners and stakeholders within the professions to better understand the identified issues and how we can contribute to the debate.”

The College has produced a series of infographics illustrating some of the key statistics, which can be found alongside the full reports of both surveys at www.rcvs.org.uk/publications
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The BVA has issued advice for worried dog owners following a spike in the number of acute gastroenteritis cases being reported in many parts of the country. Vets as well as owners have reported cases of dogs being struck by a vomiting bug, with symptoms including more frequent vomiting than is usually seen in canine gastroenteritis cases, accompanied in a few instances by diarrhoea, anorexia and lethargy.

A dedicated University of Liverpool veterinary surveillance database, called SAVSNET, had recorded 474 such reports since it went live on 30 January 2020. Most cases are confined to England and Wales, with one in Northern Ireland.

Researchers looking into the cases report that affected dogs usually make a full recovery following prompt veterinary care to treat the symptoms. However, a small number of deaths have been reported, but it is currently not clear if these are linked to the condition under investigation.

Responding to the reports, British Veterinary Association President Daniella Dos Santos said: “We are aware of a spike in cases of prolific vomiting in dogs being reported by vets in several parts of the country. While pet owners are understandably worried, the cases may be part of a normal increase in gastroenteritis that vets usually see during the colder months.

“Our advice to owners is to call their local vet for advice in the first instance if their dog shows any of these symptoms. If your dog is ill, we’d encourage minimising contact with other dogs in the vicinity until veterinary advice has been sought.

“BVA is also asking vets to report any cases and controls via a questionnaire on the Small Animal Veterinary Surveillance Network (SAVSNET) website, to help researchers build a clearer picture of the outbreak and to investigate if the spike is part of normal seasonal variation or if a specific virus or bacteria is in play.”

Professor Alan Radford, who is helping to coordinate the SAVSNET-University of Liverpool response, said: “Data from vets in practices suggests that gastroenteric disease is unusually increasing, starting from around November 2019. When we receive samples (faeces, vomit, saliva) from dogs that meet our case definition of five or more vomiting episodes in a 12-hour period, we will be looking to identify any evidence of an infectious cause.”

For the latest updates on the cases, and to complete case and control questionnaires, please visit liverpool.ac.uk/savsnet/dog_vomiting_potential_outbreak/
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BSAVA Congress 2020 programme announced

Dragons’ Den star Jenny Campbell has been announced as the keynote speaker for BSAVA Congress. The British entrepreneur, known predominantly for her role as a Dragon on BBC’s Dragons’ Den, is the flagship speaker for an exciting extended programme at this year’s congress, celebrating the event’s 30th year at Birmingham.

Striking the right work–life balance can be a struggle, especially for vets. As part of an increasing focus on well-being at congress, Jenny Campbell will be sharing her own thoughts on balancing a successful career with family commitments, as a key part of congress’s exciting and busy schedule on the Friday. Prior to becoming a Dragon, Jenny worked in banking for 30 years. She became CEO of cash machine company Hanco, bought out the business, turned it around and sold it for £50 million.

The expanded 2020 congress programme delivers 450 hours of top-quality CPD, via more than 100 globally recognised speakers, visionaries and experts. Designed, as always, to engage with the entire profession with something for everyone, highlights include more “open to all” streams, a new range of practical workshops, small group sessions, wet labs and nurse case reports.

BSAVA Congress Programme Committee Chair Sue Murphy said: “Our ethos with the 2020 programme is to deliver unrivalled education, designed to tackle the current needs of the profession, with topical, clinically relevant and evidence-based content. Each stream is devised by our committee of volunteer vets, nurses and practice managers, ensuring our entire programme is created by the profession, for the profession.”

The wide range of lectures cater for all levels of expertise from the new graduate to the advanced veterinary practitioner. As part of the special anniversary celebrations, a captivating historical stream on Saturday will take a dive into topics from the 1991 programme and draw comparisons with today’s modern approaches.

BSAVA Congress 2020 will also see an increased number of AVP streams, an infectious disease stream as well as a popular favourites stream, which will include endocrinology, critical care and trauma medicine, ophthalmology and cardiology.

Nurses have a brand-new stream on district nursing, and there’s a focus on compassion and well-being in the management streams. Different learning styles will be championed with engaging interactive streams, including gastrointestinal sessions on Thursday, anaesthesia on Saturday and the ever popular “What’s your diagnosis?” on Friday.

New wet labs have been introduced, with a chicken anatomy refresher focusing on linking this knowledge to clinical presentations and common procedures and a similar session for rabbit anatomy, along with a new dermatology practical and surgery of the small intestine.

The engaging exhibition will showcase innovation within the industry, an exciting schedule of social events will present unmissable networking opportunities and special yoga sessions and stress-relieving massage technique tutorials will keep delegates mindful of the importance of self-care.

To register for BSAVA Congress visit bsavaevents.com

For information on how to become a BSAVA member visit bsava.com/Membership/Member-categories

Professor Edward Hall announced as 2020 Bourgelat Award winner

Emeritus Professor Edward Hall has been announced as the winner of the prestigious Bourgelat Award. The award is presented by the BSAVA as the primary recognition for really outstanding international contributions to the field of small animal practice. It will be formally presented at BSAVA Congress on 2 to 5 April 2020.

The first RCVS Recognised Specialist in Small Animal Medicine (Gastroenterology), Professor Hall graduated from Cambridge University in 1979. He went on to take an internship and residency at the University of Pennsylvania. This was followed by a PhD at the Liverpool Vet School where he stayed on as a postgraduate researcher and lecturer in veterinary pathology. He went on to lecture at Bristol University Vet School, where he became Professor of Small Animal Medicine in 2004 and is currently a clinician with the university’s referral service Langford Vets.

Professor Hall is a regular speaker at veterinary conferences and training courses both at home and abroad and during his career has helped to train thousands of veterinary students and guided 25 more in their efforts to achieve Specialist status. He is one of the teachers on the BSAVA’s postgraduate certificate programme and he has recently finished co-editing the third edition of the BSAVA Manual of Canine and Feline Gastroenterology.

Professor Hall will deliver four lectures on topics in gastroenterology as part of the Bourgelat stream at BSAVA Congress 2020.
Practise essential techniques with our dedicated experts in one of the 450 sessions offered at Congress this year.

Including a brand new range of workshops, small group sessions and wetlabs.

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Our top picks for BSAVA Congress

Returning to Birmingham for the 30th year, what does BSAVA Congress 2020 have to offer?

BSAVA Congress is returning in April for its 63rd year, and is set to be bigger and better than ever. With over 450 hours of CPD available to choose from, delivered by over 100 internationally recognised speakers and experts, BSAVA Congress 2020 is sure to have content for every small animal veterinarian and veterinary nurse, no matter where your interests lie.

Taking place between 2 and 5 April 2020, this will be the last time the event is held in Birmingham before moving to Manchester next year. The programme has been especially curated by members of the veterinary community, designed to tackle the current needs of the profession with topical, clinically relevant and evidence-based content which is accessible by all – from new graduates to the most experienced members of the profession.

As well as lectures and practical sessions spread over 14 streams, delegates can also attend the exhibition hall to stay up to date on the latest products and services the exhibitors have to offer. This exhibition is free for all vets, nurses and practice staff, and includes access to the exhibition learning zone. This stream will take place on 2, 3 and 4 April and will feature content organised and delivered by different exhibitors at congress.

Keynote lecture and BSAVA awards

The keynote speaker at BSAVA Congress 2020 will be Dragons’ Den star Jenny Campbell. Being a successful entrepreneur, Jenny will be discussing how she balanced the demands of her career with her family commitments. This talk will be taking place on 3 April at 7pm.

Following this, the annual BSAVA Awards will be taking place, where the association recognises the outstanding contributions in the field of small animal veterinary medicine and surgery and honours recipients who have been nominated by their colleagues for their dedication to veterinary science.

On the morning of Friday 3 April, 2020 Bourgelat Award winner Ed Hall will be giving four talks on topics
in gastroenterology. First looking at canine gastroscopy and IBD, he will then explore the use and abuse of gastrointestinal drugs, and probiotics and faecal microbial transplants.

“Open to all” sessions
BSAVA Congress 2020 boasts more “open to all” streams than ever before. On Thursday, Friday and Saturday, there will be short talks throughout the day showcasing advances in the field of veterinary science, featuring clinical abstracts in various fields including anaesthesia, dermatology, infectious diseases and endocrinology, as well as non-clinical research too.

Thursday features streams on cardiology and orthopaedics for beginners, and a stream focusing on pain and rehabilitation. The RCVS will also be hosting a programme which covers topics such as the practice standards scheme and the Mind Matters initiative, as well as an RCVS VN Futures stream in the afternoon.

On the Friday, “open to all” sessions will include streams on neurology and infectious diseases, and a stream dedicated to continuous quality improvement hosted by RCVS Knowledge. Critical care, trauma medicine and anaesthesia will be “open to all” streams on the Saturday, as well as a stream looking back on the last 30 years of veterinary medicine, in alignment with this being the 30th year of the event in Birmingham.

On Saturday afternoon there will also be a stream aimed at students with a series of “where do you start” talks. On Sunday, three streams will be open to all, two specialised ones on clinical pathology and dentistry, and one stream looking at topics beyond the clinics. This will include discussions surrounding perfectionism, resilience training and mentoring.

BSAVA AGM
All BSAVA members are welcome to join the BSAVA AGM in the Kingston theatre on Sunday 5 April from 10:45am. Following this, BSAVA President Sue Paterson will be hosting Cal Major of Paddle Against Plastic, for a conversation on their vision and their work to create a more sustainable future.

Veterinary surgeons
There is a comprehensive programme for veterinary surgeons across the four days of congress, covering topics ranging from common consults and challenges in imaging to specialist topics such as ophthalmology and dermatology. The content is especially curated to suit all levels of expertise. For example, the endocrine stream on Sunday 5 April has general content in the morning, but the stream features more advanced content in the afternoon. There are also three advanced veterinary practitioner (AVP) specific streams focusing on surgery, anaesthesia and diagnostic imaging.

Interactive sessions
An important feature of this year’s congress is the large amount of interactive sessions, indicated on the programme.
by a specific logo. On Thursday 2 April, interactive sessions focusing on GI disorders will be taking place throughout the day in hall 1. In addition to this, three interactive “orthopaedics for beginners” sessions will be taking place in the afternoon in hall 5, and short picture quizzes can be found in hall 8, on topics including among others neurology, laparoscopy and dentistry.

On the Friday, the popular “what’s your diagnosis” interactive stream returns, featuring sessions on various conditions such as the jaundiced dog, the dog with epistaxis, unusual patterns of oestrus and the rabbit with weight loss. There will also be interactive sessions on neurology on Friday, and anaesthesia on Saturday.

Nursing streams
Each day of congress there will be three lecture streams dedicated to small animal veterinary nursing. On 2 April, there will be streams dedicated to feline medicine, brachycephalic obstructive airway syndrome (BOAS) and advanced nursing focusing on analgesia, looking at new advances in canine and feline pain recognition and scoring and a review of medical cannabis among others. On 3 April, the three nursing streams will be focused on anaesthesia, canine medicine and nutrition separately.

On the Saturday, specialised streams on neurology, cardiology and surgical/theatre nursing will be taking place. The first will host talks ranging from nursing seizure patients and nursing considerations for the spinal patient to neurology trauma emergencies. The surgical nursing stream will focus on rehabilitation and discharge planning, as well as checklists and skin preps. The cardiology schedule is split into two halves: the morning will be more generalised content, whereas the afternoon will be directed at nurses with more advanced knowledge in cardiology.

On the last day of the event there will also be three nursing streams: emergency and critical care, looking into things such as coagulation tests and hypotension; district veterinary nursing, exploring the impact of this in the wider community and nursing at home; and behaviour, ethics and welfare, where there will be discussions about punishments of pets and considerations when treating pets of owners of no fixed abode.

Practical and small sessions
Besides the lectures and interactive sessions mentioned previously, there are other sessions in which you can get hands-on experience at BSAVA Congress 2020. These sessions are priced separately to BSAVA Congress tickets. Spaces are limited and filling up fast, with some sessions already sold out.

Wet labs will be held at Birmingham Medical School on the Thursday and Friday of congress. These will include sessions on the use of cytology in practice and on surgery of the small intestine. There will also be a session on surgical and anaesthetic considerations in chickens and a rabbit anatomy refresher.
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Practical sessions will be taking place at another venue, The Lodges, Austin Court, on the Thursday, Friday and Saturday. On the Thursday, there will be an introduction to root canal therapy in the morning and an introduction to composites in the afternoon. On the Friday, a session on flexible endoscopy will teach delegates to manipulate an endoscope to take biopsy samples, among other things. Finally, Saturday’s session will provide a practical introduction to internal fixation.

As well as these, a number of small group sessions will be taking place throughout BSAVA Congress 2020. Ranging from oncological imaging to reconstructive surgery and thyroid disease, there are plenty of topics to get involved with, no matter where your interests lie. There is also a nursing specific session on advanced ECG interpretation, and a session open to all on the highs and lows of medical cannabis.

Management
Non-clinical content is planned throughout congress. On the first day, the focus will be on compassion and well-being, with a stream on understanding empathy, organised in association with Blue Cross, focusing on understanding the pet owner, in particular in terms of end-of-life care, and a stream hosted by Vetlife focusing on the importance of caring for carers and building and supporting compassionate teams.

A leadership programme is organised by SPVS on Friday 3 April, exploring topics in sustainability in veterinary practice and the power to influence with communication strategy. The Veterinary Management Group (VMG) are hosting a stream on Saturday 4 April focusing on veterinary management, specifically topics such as managing staff turnover and the difference between leadership and management.

Social calendar
This year marks the last time BSAVA Congress will be held in Birmingham, and the social calendar is one not to be missed. On Friday 3 April, after the BSAVA Awards and keynote lecture, join your colleagues for the annual President’s reception for an evening of food and entertainment. Limited tickets are available to book so make sure to secure yours now.

The following day, join other delegates at the V20 party night from 7.30pm, which will include some whacky prizes at Bongo’s Bingo from 8pm, after which Satellite Down will be sure to get you on the dance floor with their wide repertoire of music. Following their set, if you’re still full of energy then grab some headphones and take part in the annual BSAVA Silent Disco.

For more information about BSAVA Congress 2020 and to book your tickets to congress, the practical sessions or the social events, visit bsavaevents.com
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24th - Canine Cruciate Disease
   - Patella Luxation
Helping clients cope with euthanasia

Euthanasia is a common but critical procedure. Robin Hargreaves, Vet Lead at Agria Pet Insurance, explains what he does to help owners deal with the end of their pet’s life

I’d like people to see euthanasia as I do. After over 30 years as a vet, I’ve seen animals die of everything, but nothing is as gentle or painless as being skilfully put to sleep.

When I got my puppy, I knew that I would, one day, put him to sleep. I knew I would not want to let him die and that it was my responsibility when the time came. This knowledge didn’t detract from our relationship; it was a blessing that I’d be able to help him fall asleep peacefully one day, when the time was right.

People will often say, “I couldn’t be a vet – putting all those animals to sleep must be so depressing”. Truthfully, it’s the opposite. I know that over my career I’ve alleviated more suffering with timely euthanasia than with any other procedures I’ve carried out combined. If we could help owners to switch their thinking to, “I hope I get the chance to choose the time to have my pet put to sleep”, and recognise that it’s a positive thing, that would help them to deal with it.

Time to mentally prepare is crucial. That’s how I had reconciled saying goodbye to my dog – I had known it was coming all his life.

Subconsciously many owners push the future loss of their pet to the back of their minds. This approach is the worst thing an owner can do as it leaves them no time to prepare. Should their pet come in one day critically ill, they may need to make a decision in a matter of minutes. For an owner to process this so quickly is impossible, significantly amplifying the immediate devastation and long-term grieving process.

In practice, we can help by talking openly and positively about euthanasia. The opportunities for these discussions are few, but look for them – whether an animal is a healthy three-year-old or a much older pet. This way, you can have a rational conversation about the positives of a planned and gentle passing to help the owner begin to see it as a kind and wonderful gift, when the time is right.

A pet must want to eat, be able to move around and recognise its surroundings and those around it. It’s helpful to discuss with the owner what their pet continues to take pleasure from. I feel that an animal must still be making choices, deciding on doing something just for fun and following it through.

Quality of life is essential; you need to be able to do things that you enjoy. Ask, “What has your pet done over the past few days purely for joy? Or has it been simply doing what it had to do next?” If they cannot identify anything their pet does just for fun, they will be taking nothing away from it except any pain or suffering.

So, if we accept that being put to sleep is preferable to any other manner of dying then it’s all about timing. Many owners will say that they would prefer their pet to die in their sleep. But do they really mean to die in “my” sleep, so they aren’t compelled to make a decision? It can be helpful to explain to owners that dying during the night doesn’t guarantee that it is peaceful.

Better than trying to measure suffering is to acknowledge we cannot quantify it, so it’s a huge decision to say they can tolerate it for another day or week, if there’s no compensatory pleasure. In other words, “Am I confident today is a day worth living?”

I believe there is comfort to be had in euthanasia. There is a transfer of suffering. The animal is in distress, while the owner will try to hold themselves together. Once the pet has been put to sleep, it looks peaceful, no longer suffering, yet the owner is often in bits, hit by a wall of grief. The animal had a terminal problem it was never going to defeat, but now it has been lifted onto the owner in the form of grief – which is something they can overcome, in time.

When an owner has lost a pet and feels dreadful, they can recognise that it’s because the animal doesn’t feel dreadful any more, and take comfort in that. Owners may face the choice: leave the pain with your pet, or lift it from them, and take the burden yourself.

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Parasite control in pets

Should we reconsider our parasite control strategies as they are harmful to the environment?

Andrew Prentis, BVSc, MRCVS, is a veterinary surgeon and a steering group member of Vet Sustain. Having retired from clinical practice, he campaigns for environmental protection, biodiversity and sustainability both in and around the veterinary profession.

Most of us are worried about the environment. In fact a recent BVA survey found that 89 percent of UK vets wanted to play a more active role in sustainability (BVA, 2019), but I suspect many of us struggle to see how we as individuals can take enough action to have a major impact on global CO₂ levels, rising temperatures, melting ice caps, plastic pollution and ecological collapse.

Well, here’s one area where we do have a huge opportunity to make a significant difference. Let me explain. Many non-domesticated species appear to be undergoing population collapse all around us. Put bluntly, the flies and bugs don’t get squashed on your windscreen these days, largely because they aren’t there any more.

Remember that 2017 article by Hallmann looking at insect populations in Germany? “More than 75 percent decline in total flying insect biomass over 27 years in protected areas” (Hallman et al., 2017).

Or how about the one in Nature in 2019 by Powney: “Widespread losses of pollinating insects in Britain” (Powney, 2019) or the Sussex Wildlife Trust’s “Insect declines and why they matter” (Goulson, 2019)?

Sanchez-Bayo and Wyckhuys (2019) stated that over 40 percent of insect species are threatened with extinction, with Lepidoptera, Hymenoptera and dung beetles (Coleoptera) being most affected. Four aquatic taxa are imperilled and have already lost a large proportion of species, and “habitat loss by conversion to intensive agriculture is the main driver of the declines. Agro-chemical pollutants, invasive species and climate change are additional causes”.

Imidacloprid, to members of the genus Apis (the honey bees), is one of the most toxic chemicals ever created as an insecticide, either killing them outright, changing the way they communicate and navigate or affecting their appetite. The Buglife report on neonicotinoid insecticide in British freshwaters (Buglife, 2017) states that “veterinary pour-ons and flea collars are implicated as the most likely source of pollution”. The article goes on to state that imidacloprid applied to pets can be washed off by rain, bathing or washing of bedding, which may result in the pollution of sewage, storm drains and water courses or direct pollution of a river, lake or pond if the animal is allowed to swim. In addition, some imidacloprid is likely to be excreted by the animals in urine and faeces after absorption through the skin.

Avermectins, also used as topical parasiticides, have similarly catastrophic effects on invertebrates and therefore everything else further up the food chain. As a consequence, insectivorous bird numbers have also taken a huge hit. UK populations of the grey partridge have declined 92 percent since 1967, nightingales by 93 percent, cuckoos by 77 percent and spotted flycatchers by 93 percent (Goulson, 2019).

According to NOAH, the UK veterinary medicines market is worth £725 million, of which half is now for pets. Parasite treatments account for 39.5 percent of the total (NOAH, 2019). So maybe as much as £140 million worth of parasite medication is being used in or on pets each year, with very little testing, but “the prophylactic use of broad-spectrum pesticides goes against the long-established principles of integrated pest management” (Goulson, 2013).

The conclusion is that “A serious reduction in pesticide usage and its substitution with more sustainable, ecologically-based practices, is urgently needed to slow or reverse current trends” (Sanchez-Bayo and Wyckhuys, 2019).

Section 6.1 of our Code of Professional Conduct states that...
“Veterinary surgeons must seek to ensure the protection of public health and animal health and welfare, and must consider the impact of their actions on the environment.”

And by happy coincidence, a recent RCVS survey found that vets are among the UK’s most trusted professionals (Loeb, 2020), ranking above doctors and dentists (although we lost out to opticians and pharmacists. Ouch). So, when we, as possibly the only working scientists that many of our clients have ever actually met, talk to them about the environment, there’s a very good chance that they’ll be listening to what we have to say.

This, then, is a call to action for us as veterinary surgeons:

1. Stop blanket parasite treatments for pets, especially for parasites that either aren’t there or don’t cause a problem if they are. Just this week there are adverts in the veterinary press for a product that “covers 22 parasites across cats and dogs”, but how many cases of *Eucoleus boehmi* have you seen in your career? And did you know that a single large dog dose of that product contains the LD50 of imidacloprid for 50 million bees? Indiscriminate treatment has consequences

2. Start risk assessing our patients – fairly straightforward for most UK parasites once you look at the numbers

3. Get into the habit of testing before treatment. If American clients all bring in faecal samples at their pet’s annual health check, why don’t the Brits? Because we don’t ask them to

4. Start doing regular faecal exams in our practice laboratories or pressure our commercial labs to do them for us more cheaply than such services are currently available direct to the public

5. Be well informed on the environmental profile of all the products we stock and ask the sales reps and technical advisors probing questions about their safety for our patients, the environment and the people who handle them, which includes us

6. Ask yourself “Would I willingly apply pesticides and other toxic chemicals to my children on a monthly basis?”

Steve Garland, entomologist and Chair of the Wildlife Trusts’ policy setting body for England said: “I really believe that the catastrophic decline of insects can be reversed by drastically reducing the use of chemicals in the environment and creating strong Nature Recovery Networks to give them space to live and thrive in safety.” (Goulson, 2019).

Maybe it’s time we don’t just listen to the scientists, but started acting like the ones we’re meant to be.
“Random” acts of kindness

Being kind to others can put a smile on someone else’s face and makes us happier in turn

M other Teresa once said that “we cannot do great things on this earth, only small things with great love”.

Whether you think she was deserving of sainthood or possessed by the devil in her later years, the fact remains that she was truly content, she lived to a fantastic age of 87, she felt deeply loved and she had a positive impact on thousands of individuals: things that many of us aspire to.

Contentment, feeling love and affecting people around us in a positive way is totally within our grasp. Just one way we can have a positive influence on people is through performing so-called random acts of kindness on a daily basis as our new normal.

We have the opportunity to show small acts of kindness every day in the simplest of ways:

- Letting someone cut in front of you in a traffic jam. And if they thank you, try thanking them for thanking you.
- Honestly, I’ve started to do that this last year and it feels great. The look of surprise on the other driver’s face is comical, but they drive on happier and so do you.
- Stopping to talk with an elderly neighbour, even though you are in a rush.
- Lending a helping hand to a co-worker who’s behind on their consults or ops list, even though this means that you will have to stay late at work.

Here’s a good one for Londoners. When you squeeze onto the packed tube with someone’s armpit resting neatly over your face, try, instead of feeling hatred towards your fellow commuters, to make yourself realise that they are actually just like you (stating the obvious). Maybe try to wish them well, happiness and peace; in your thoughts and not out loud. But when you scan the carriage and see the bowed heads of people frantically scanning their phones, avoiding eye contact and not enjoying their journey either, and you feel compassion and kindness towards them, it really can make for a more positive commute and a sense of acceptance and calm within.

Kindness is a trait in people which is often undervalued or seen as being “soft”. Some more cynical people see others who are driven by kindness as “enablers” or “suckers”. This reflects a belief system where success is only achieved through stepping on or ignoring others: a belief system which is rife in the veterinary world. I have yet to meet a truly content cynic.

Maybe we “soft suckers” are perpetuating this belief system by apologising for being a bit happy when we are advocating random acts of kindness towards fellow malodorous commuters instead of unapologetically promoting this behaviour as a route to true contentment.

In 2006, in a study of Japanese undergraduates, researchers Otake et al. found that happy people were kinder than people who were not happy. Which came first? The happiness or the kindness? Or is it a self-perpetuating cycle?

Their study also revealed that one’s sense of happiness increased by the simple act of counting the number of one’s acts of kindness. This is something to do at the end of the day just before sleep.

It’s like the very simple act of helping the little old lady to cross the street. You feel good about yourself and she feels heartfelt gratitude that someone cares and that she had a moment of connection with a kind person today. It’s a win-win situation. Changing our focus and looking around us, we will notice a multitude of opportunities for kindness.

From letting someone into the line of traffic and thanking them for thanking you (or at least not hating them for not thanking you), to allowing someone to get off the tube in front of you, to thanking the guy in Starbucks for making your coffee just how you like it, to dropping a thank-you note into the people downstairs who always accept your Amazon parcels for you. It takes no time or intelligence to suss out these opportunities. It provides a wholesome reward for releasing a burst of warm endorphins; the rewards are instant and last for as long as we decide. It’s a cheap and healthy high.

When you are kind to others, having that awareness then heightens the sense of your own good fortune. Also, random acts of kindness promote empathy and compassion; in turn, these lead to a sense of interconnectedness with others, which is vital for good mental well-being. Feeling connected brings us together rather than divides us. Kindness is potent in strengthening a sense of community and belonging. Interestingly, the simple witnessing of others being kind can release similar levels of serotonin that engaging in an act of kindness can produce.

References
Caseous lymphadenitis in sheep

Can vaccinating sheep reduce the occurrence of the infectious disease?

Caseous lymphadenitis (CLA) is an important clinical disease, found mainly in sheep. It can have a high economic impact on sheep production, as it can decrease the value and quality of the carcass or wool of the affected animal. The disease causes abscesses in the lymph nodes, which can rupture and release infectious pus. CLA is caused by the bacterium *Corynebacterium pseudotuberculosis*, which is highly contagious, and the presence of these lesions can contribute to the spread of the disease.

Imagine this scenario: a sheep breeder asks you how they could avoid this disease affecting their flock. They know that vaccines are available on the market, but wonder if they are effective. What evidence exists to indicate the efficacy of vaccines for reducing the occurrence of CLA?

The evidence

Ten studies were identified that assessed whether there is a decrease in the incidence of CLA in vaccinated sheep compared to unvaccinated sheep. In all of the critically appraised studies, animals were randomly allocated to experimental treatment groups, which were compared against a control group (where the animals were either given a placebo or no vaccination), providing a high degree of confidence.

One study compared a vaccinated group and a control group, where the bacterium *C. pseudotuberculosis* was introduced periodically. Vaccinated lambs had a 97 percent lower infection rate compared to unvaccinated lambs. In addition, vaccinated lambs that were infected with CLA had 96 percent fewer lung abscesses compared to unvaccinated infected lambs, and were, therefore, less likely to spread the disease. A different study compared vaccinated and unvaccinated animals, with one of the vaccinated groups receiving two doses of the vaccine. Vaccinated animals had fewer internal lesions and abscesses, especially those who received two doses. These findings were supported by two further studies, both of which found that vaccinated animals were at a lower risk of contracting the clinical disease compared to unvaccinated animals.

Some of the assessed studies also compared the efficacy of several different vaccines, in addition to comparing against a control group. One such study verified the effectiveness of several vaccines, including a combined vaccine formula, concluding that the toxoid phospholipase D vaccine alone was more efficient and provided the highest specific-cellular and humoral immunity, therefore making both treatments suitable for prevention and control of CLA.

Conclusion

In all assessed studies, it was found that animals vaccinated against CLA were less likely to acquire the disease when compared to unvaccinated animals. The evidence also demonstrates that vaccination for CLA is an effective measure for prophylaxis of the disease, since vaccinated animals were significantly less affected by the disease when compared to unvaccinated animals. All the studies were randomised, controlled trials.

Limitations of the findings include that not all the studies explained their methods of randomisation and that some studies did not clarify whether the control animals received a placebo vaccination or no vaccination. In addition, two of the studies did not describe whether the vaccine was administered intramuscularly or subcutaneously.

Despite these limitations, there is strong supporting evidence for the use of vaccination as an efficient prophylactic measure against caseous lymphadenitis for sheep flocks.

The full Knowledge Summary can be found at veterinaryevidence.org/index.php/ve/article/view/247
As discussed previously in part one of this series, the approach to fracture management is different in wild birds compared to companion birds. The goal must always be to release the patient as soon as possible with as minimal stress as possible. Fractures can be managed conservatively or surgically. If a fracture cannot be repaired and the patient cannot be released, then careful consideration must be made into whether it is ethical to allow the patient to survive.

Conservative management

In some simpler fractures, basic confinement and cage rest may be all that is indicated. Conservative fracture management requires less time, costs less and can be utilised by veterinarians with less experience. If used correctly, conservative management can result in less stress for the patient, as well as eliminating the risk of post-surgical complications. It is important to note, however, that poorer outcomes have been associated with the use of external coaptation without surgical repair (Ponder and Redig, 2016).

For simple, non-displaced fractures of the coracoid, clavicle or scapula, birds weighing less than 1 kg can be confined for 2.5 weeks in an enclosed area that they can move within but not flap their wings (Forbes, 2016). A retrospective study by Cracknell et al. (2018) showed that coracoid fractures managed in this way with no external coaptation resulted in a release rate of 75 percent of all birds and a 97 percent release rate of raptors alone. It is important to note that the Animal Welfare Act 2006 states that a bird must not be kept in an enclosure that does not allow for extension of the wings in all three dimensions; however, a short-term confinement is permitted when the bird is under the treatment of a veterinary surgeon.

If this is unacceptable, then in cases where minimal stabilisation of a thoracic limb fracture is required, the tips of the primaries can be taped together (Figure 1). This restricts the movement of the thoracic limbs without completely immobilising (Calvo Carrasco, 2019). A combination of cage rest and taping of the primaries can be useful in post-surgical cases, or in cases where the injured bone may already be stabilised, such as fractures where the ulna is fractured but the radius is intact (Forbes, 2016) or fractures of the minor metacarpal where the major metacarpal is intact.

External coaptation can be used for long-term management of fractures where the joints proximal and distal can be immobilised (Harasen, 2003). These techniques are never indicated for the humerus or femur. Figure-of-eight bandages are commonly used in practice to immobilise the distal wing (Figure 2), although several rules should be followed to ensure they do not cause iatrogenic trauma to the patient. Bandages should not be placed along the leading edge of the propatagium as pressure necrosis can occur (Forbes, 2016), which can be catastrophic for release. Figure-of-eight bandages should be changed approximately every three days to avoid contracture of the wing muscles.
and to identify any iatrogenic trauma that may have occurred from the bandage (Calvo Carrasco, 2019).

Aluminium foam-backed splints and Altmann’s tape splints can be used to immobilise the distal pelvic limb. Altmann’s tape splints are lightweight and useful in smaller birds weighing less than 300g to immobilise fractures of the tibiotarsus or tarsometatarsus (Ponder and Redig, 2016). A retrospective study by Wright et al. (2018) of birds weighing less than 200g with tibiotarsal fractures treated with tape splints resulted in a successful outcome in 97 percent of cases. In larger birds, aluminium foam-backed splints can be used to treat tibiotarsal fractures where surgery is not an option, as their malleable nature means they can be moulded to the shape required with ease (Calvo Carrasco, 2019). These splints can be secured in place using a cotton wool layer and a conforming bandage layer, ideally with external layers being changed every five to seven days to monitor for any iatrogenic damage from the bandage to the thin avian skin.

Fractures of the toes can be treated with a ball bandage, which keeps the digits in a semi-extended position (Calvo Carrasco, 2019). A ball of cotton wool is placed on the plantar aspect of the foot and the toes positioned around “grasping” the cotton wool. It is important to monitor the contralateral foot for any evidence of pododermatitis during the use of this technique.

**Surgical fracture repair**

In cases where conservative treatment is not feasible or appropriate then surgical repair can be performed. Fixation of long bone fractures is often carried out with hybrid type I external skeletal fixators (ESF). This technique utilises an intramedullary (IM) pin which exits the bone and is “tied in” to the ESF pins to stabilise the fracture in three dimensions (Figure 3). This technique is commonly used as the materials are lightweight, versatile and cost effective and it allows the patient to stand in a physiologically normal position (Calvo Carrasco, 2019). This technique is limited in that the IM pin needs to exit the long bone to allow it to attach to the ESF pins, and so cannot be used in bones where the joint space cannot be compromised, for example the tarsometatarsal joint of the pelvic limb. It has, however, been used with success in humeral, ulnar, metacarpal, femoral and tibiotarsal fractures and was associated with an 84 percent successful healing rate in wild raptors with tibiotarsal fractures (Bueno et al., 2015). Placing two ESF pins proximal and distal to the fracture has been reported to increase stiffness and safe load in torque and compression (Van Wettere et al., 2009), resulting in improved fracture reduction.

External skeletal fixators can also be used to varying degrees in avian long bones, as seen in Figures 4 and 5. Placement of the ESF pins depends on the location of the fracture, the length of the fractured bone and the pins available. IM pins can be used in some cases; however, these need to be chosen carefully as on their own they do not prevent rotational forces. They are often used in combination with an ESF, cerclage wire or external coaptation such as wing taping or figure-of-eight bandaging.

The use of bone plates is uncommon, due to their size compared to that of avian patients, the anatomy of avian bones, having generally thinner cortices compared to mammalian bones, and technical surgical skill required (Calvo Carrasco, 2019). Recent studies have shown that smaller plates can be used to successfully immobilise pectoral limb fractures in pigeons (Gull et al., 2012; Darrow et al., 2017); however, the use of bone plates is unlikely to be feasible when treating wild birds.

Amputation is not feasible for wild birds as it would prevent their release to the wild, which is always the main goal of treatment. In cases where fractures are catastrophic or fracture healing has failed, wild avian patients should be humanely euthanised. A number of fixation methods are available for wild birds suffering from fractures. Fracture evaluation should occur in a similar method to that of our companion species and a fixation method chosen based on the fracture biomechanics as well as the technical skills of the veterinary surgeon. Any wild bird ready for release following fracture repair should be thoroughly flight tested for readiness to return to the wild to ensure optimum ability to survive.

A full reference list is available on request.
Providing great customer care

The secret to great customer care? Embrace, engage and empathise with your clients, don’t judge

Shifting in human healthcare provision mean that it has become normal to utilise several sources and providers when it comes to meeting our own health information and care needs. We might google symptoms, see a nurse practitioner rather than a GP, source medications through Amazon or choose complementary medical practices. Multi-level service provision has become the norm.

Yet somehow this doesn’t seem to be OK when it comes to veterinary care. We see vet forums on social media swapping stories of “stupid” clients coming in with predetermined ideas about their pet’s prognosis or bringing their beloved dog in at 6.30pm on a Friday night when surely, they’ve had all week. “Hilarious” memes are shared, deriding the reactions and expectations of anxious pet and horse owners. But there’s no place for judgemental language and tone in a professional online forum, even if it is explained away as venting after a tough week. Because guess what, your client’s had a pretty tough week too. On top of the boiler breaking and their daughter’s school calling to say she is falling behind, the long work days and the lack of money left at the end of the month – on top of all this, the sore on the dog’s leg that seemed to be healing is now smelling strange and weeping. And it’s 6.30pm on a Friday night, but it’s OK because the local vet practice is open till 7pm and they’ll know what to do.

Great customer care starts when you put yourself in your client’s shoes. Understand that their lives are busy, and money may be tight, but that they almost always want what’s best for their pet. And if they’ve googled that first, then maybe they’ve done it because they’re trying to help you, and calm their worries, rather than undermining your professional competence? After all, we all google our symptoms too!

Embrace. Engage. Empathise

Growing numbers of academics are publishing research showing that we need to listen much more to our clients. To treat them as fellow humans with very real emotional concerns and issues, rather than as a barrier to getting home on time. In all honesty, if you work in a service industry it can’t be a surprise that you have to deal with people all day. People who pay your wages and recommend your practice to potential new clients. People who care about animals just as much as you do.

Two key PhD studies have proved the need to listen to clients and work collaboratively with them in order to ensure optimal patient outcomes: research by Alison Pyatt at Harper Adams University, and Louise Corah at the University of Nottingham. It might also help to know that providing warm and empathic customer care is actually good for you! The RVC’s Liz Armitage-Chan finds that vets with a more “challenge-focused” approach (whose priorities generally skew towards engaging with clients and understanding their context) enjoy stronger emotional health.

As vets we tend to look for patterns and explanations; numbers and science inform our decisions when it comes to formulating treatment pathways. But not everyone finds science compelling and speaking in textbook terminology can alienate many clients. Repeating the empirical evidence increasingly loudly is highly unlikely to persuade your client to change their mind, whereas couching your argument in terms of their pet’s unique lifestyle challenges and appreciating that with the best will in the world a lengthy course of hydrotherapy is simply unaffordable, so let’s look at other options, are far more likely to get you onto the same page. Labelling mums who may be genuinely concerned about the possible risks of vaccines as mad “antivaxxers” and throwing around facts and figures that prove they are wrong is more likely to make them wonder what there is to hide. Confirmation bias is a powerful thing, and it’s best left out of the consult room.

Pet and horse owners do know that you are far more qualified than Google to treat their much-loved family member – that’s why they’re standing in front of you at wine o’clock on Friday night. Trust me, they don’t want to be here any more than you do. So, if you can feel your hackles rising, please take a deep breath and imagine it’s your non-vetty partner or sibling standing there. Embrace the practicalities of their predicament. Engage them in what you can do to help and empathise with their desire to do what’s right for the animal, in the context of their busy life and existing priorities.

Showing clients empathy requires you to expose a degree of vulnerability, which quickly builds rapport and trust between you. Sympathy is actually a projection of our values onto others and implies some level of judgement – Mrs Smith hasn’t vaccinated her dog because she can’t afford it, and whilst you may smile and nod outwardly, you’re thinking that she shouldn’t have a dog if she can’t afford its care. An empath feels her pain in having to choose between paying the gas bill or booking an appointment for her healthy dog.

“Judging a person does not define who they are. It defines who you are” said Kristen Stewart. And she’s a Charlie’s Angel so she would know.
As an ophthalmologist, I rarely have to perform euthanasia for the animals that come to me – enucleations are the ocular equivalent! But on occasion we do encounter animals where saying goodbye, as we might put it, is the kindest thing.

One such case recently was a cat with a glaucomatous eye which came to see me through our RSPCA clinic at the vet school. The eye was blind and the cat was in pain so enucleation was the obvious answer. The owner had used a friend to get her pet to us in Cambridge but her friend wasn’t able to help her get the animal back after surgery so I popped her in the back of the car and took her the 10 miles back home. All seemed well, but histopathology showed that the increased pressure was caused by an intraocular tumour – an amelanotic melanoma.

I rang the owner and warned her that spread to other parts of the body may well happen but I was surprised how quickly the cat went downhill. A week later the owner rang me complaining that the cat was lethargic and falling over when she tried to walk. Again, getting in to see us was difficult so, having a student with me, I took a syringe’s worth of pentobarbitol and headed off.

It was clear when we got there that euthanasia was the way to go but the cat was so collapsed that intravenous injection was out of the question. I explained to the student and the owner that an injection into the kidney was a sensible alternative. The trouble was that the cat was also in renal failure with small knobbly kidneys – well, that’s my excuse, but remember I have told you I don’t do this sort of thing on a regular basis. I must have injected some barbiturate in the right place because the cat was rapidly anaesthetised.

However, as the student and I sat on the owner’s sofa with the cat between us on a towel and me crossing my fingers that she didn’t evacuate herself, she took a breath. More stroking, more chatting to the owner and her husband about the 12 years they had had the animal... and another breath. More stroking... 20 seconds... another breath. Surely 5mL of solution for an elderly emaciated cat would be enough, and it had to be – that was all I had brought with me. And so it went on for about half an hour until finally the end came. What a nightmare! What on earth would I do if miraculously she woke up again? She didn’t and all was well in the end.

Well, very well as it happened. “Thank you so much,” said the owner. “That was lovely. Whenever I’ve had an animal put to sleep at the vets there’s sometimes been a bit of a struggle with the injection and then, almost immediately, my dear pet is gone. Awake one moment, gone the next. I’ve always felt really guilty for killing them – even though I knew it was the right thing. But this was totally different – so calm and peaceful – thank you.”

How ironic that what to me was a bit of a disaster was just what the owner really appreciated.

And then – what to do with the body? I really wanted a post-mortem to see what was going on but often find that permission jolly difficult to ask for at such a tricky time. “Would you be able to take her for me please?” said the owner. “I haven’t a garden to bury her in. And could her body be useful in helping other animals?”

Of course, the answers to both questions were affirmative and so we learnt that the tumour was widespread in liver, kidneys and spine, explaining the signs we were seeing. A peaceful end for cat and owner, and I guess for me too.
Making tooth extractions easier

A logical approach and an awareness of dental anatomy and biomechanics will make dental extractions a lot easier.

It is clear that due to the inadequate teaching of veterinary dentistry in our universities (which is the subject of a separate future article) that many veterinary surgeons find dental extractions a significant challenge. Nothing can replace practical hands-on training on cadaver specimens. In the UK, we are lucky to have CPD organisations ethically sourcing specimens that can be used for postgraduate training. The aim of this article is to act as a theoretical supplement to this practical training.

Preparation

Having identified a tooth which requires extraction, the tooth needs to be cleaned. You may ask why a tooth that is to be extracted needs to be scaled, but the consequences of irretrievably dropping a lump of infected calculus deep into an alveolar socket are pretty clear. A non-healing sinus tract can be easily avoided by a few seconds with an ultrasonic scaler. Whilst we cannot make the mouth a sterile operating environment, a 2 percent chlorhexidine gluconate wash to the gingiva surrounding the planned extraction site will reduce the bacterial burden considerably.

What keeps teeth in place?

The junctional epithelium (JE) represents the soft tissue attachment of the tooth to the surrounding gingival tissues. The JE lies at the base of the gingival sulcus or pocket and is fairly unique in having two basal laminae. The external basal lamina lies adjacent to the gingival connective tissue; from this “normal” basal lamina mitotic divisions (with a high cell turnover of only four to six days) create new epithelial cells which are desquamated into the sulcus. The constant shedding of these cells helps remove surface bacteria, plaque and debris from the periodontal tissues. The JE’s other basal lamina (the internal basal lamina) lies adjacent to the tooth itself. The internal basal lamina is itself split into two layers: a lamina densa, which has organic fibril attachments onto the enamel or the cementum of the tooth, and the lamina lucida, which has hemi-desmosome binding onto the epithelial cells.

Authors vary, but it is likely that the JE is responsible for 10 to 15 percent of the strength of the attachment of a tooth. There are many of us that will have recognised that attachment strength when extracting the last maxillary molar in dogs and a large flap of gingiva is created when the extracted tooth is pulled forwards.

Accordingly, taking a sharp scalpel (a 15c blade is my preferred option) and running it circumferentially around the tooth deep in the periodontal pocket to sever the JE (Figure 1) will reduce your workload in extracting the tooth considerably.

You may wish to consider using a circular or octagonal scalpel handle – it is surprising how this facilitates the operative ease compared to using a standard handle.

Periodontal ligament

We do this structure a disservice by thinking of it as THE periodontal ligament. The reality is that there are a number of different fibre groups running in different alignments, each providing resilience against various directional forces. The majority of the fibres run from the alveolar bone to the cementum; however, some run between teeth, some from the tooth to the gingiva or to the outer periosteum and others encircle the tooth pulling the periodontal pocket tightly closed. The fibres deeply embed into the alveolar bone and then into the cementum (indeed some of the cementum is formed from the fibre cells).

FIGURE (1) Severing the junctional epithelium using a sharp scalpel and running it circumferentially around the tooth deep in the periodontal pocket will ease the process of tooth extraction.
The role of the periodontal ligament is to act as a shock absorber during normal biting. Without this shock absorber (and the incorporated sensory nerve endings providing bite force feedback) any hard bite would result in either a tooth or an alveolar fracture. This shock absorber quality is important during extractions. If a tooth is simply "wagged" in the socket, the periodontal ligament simply performs its normal function and no damage is incurred. To extract the tooth, the periodontal ligament fibres must either be cut, or be so damaged and fatigued that they rupture.

In my practical classes, I encourage participants to choose a song that (however fast they sing it) will take 20 to 30 seconds to deliver. This can then act as a timer to ensure that forces are applied to the ligament for at least that timespan in order to weaken and break the periodontal ligament fibres. Songs have included the Romanian national anthem to a very politically incorrect modern version of "The Grand Old Duke of York."

As many that know me will testify, I am one of the least patient people you could meet. However, I know that rupturing the periodontal ligament is a time when I have to be patient. Steady force is applied to a tooth and that force is then maintained for 20 to 30 seconds. Force is then applied in a different direction and the process is repeated. Initially nothing seems to be happening – but as the fibres break down, suddenly significant movement is achieved and the tooth progresses towards luxation and extraction. Rushing this process is when tooth root fractures will occur; being patient will have the reward of a much faster overall procedure.

Different types of forces can be applied to teeth to strain the periodontal ligament, such as ramping (Figure 2), rotation (Figure 3) and fulcrum leverage (Figure 4).

**Elevators versus luxator-type instruments**

Elevators (Figure 5A) are the traditional instrument seen in veterinary practice. They are based on the Coupland bone chisel and typically have a 45-degree working angle at the working tip (Figure 5B). They are robust instruments and may have been lurking in the dental kit since the 1970s.

The profile of elevators means that they can’t enter the periodontal space without causing disruption of the alveolar...
Open extractions
A surgical gingival flap is used to ease access and visibility and to allow alveolar bone removal if required. Whilst much of the gingiva derives its blood supply from the underlying alveolar bone, care should be taken in flap design to preserve its vascularity.

STEP 1: Local antisepsis. Local tissues should be cleansed and the site radiographed.

STEP 2: Sever junctional epithelium.

STEP 3: Create flap release.

STEP 4: Elevate mucoperiosteal flap.

STEP 5: Remove some alveolar bone and amputate crown. Ideally using a slow handpiece and sterile Hartmann’s as an irrigation solution (but commonly a high-speed bur), a small portion of the buccal alveolar bone is removed to expose the furcation. Removing the crown not only makes “straight line” access to the root’s periodontal space possible, but also eases identifying the furcation of the palatal root.

STEP 6: Separate roots.

STEP 7: Luxate and elevate roots. Having extracted the roots, it is advisable to have a post-operative radiograph.

STEP 8: Curette sockets. Any infected granuloma tissue should be curetted out from the alveolar sockets. The alveolar margins should also be smoothed.

STEP 9: Replace flap and suture without tension. An absorbable suture material, ideally in an inverting suture pattern, is used to close the flap. It is essential that there is no tension or the flap will break down.

DENTISTRY

BOX (1) A step-by-step guide to open extractions
As the instruments are designed to enter the periodontal space, it is essential to have a full range of curvatures to match the different profiles of the roots that will be encountered.

Bone. However, once inserted they can be used to provide the forces required to fatigue the periodontal ligament.

Luxator-type instruments (Figure 6A) in comparison are made from softer steel, with a much finer working tip (Figure 6B). As such, they are more susceptible to damage and should not be used as elevators.

Their profile, however, means that the instrument can be inserted into the periodontal space. The instruments are inserted vertically and used to cut the periodontal fibres. Ideally the instrument is then withdrawn, rotated slightly and reinserted to cut a fresh section of fibres. Far less force is required when using these instruments.

The ideal sequence is severing the junctional epithelium, followed by the luxator cutting some of the periodontal fibres. The elevator is then inserted, and rotation and other forces used to fatigue, weaken and rupture the periodontal fibres. As more access into the periodontal space is gained, the luxator can be used again to cut further fibres, followed by further application of the elevator until tooth luxation.

As the instruments are designed to enter the periodontal space, it is essential to have a full range of curvatures to match the different profiles of the roots that will be encountered (Figure 7).

Open extractions
See step-by-step guide (Box 1).

Closed extractions
These are performed without creating a gingival flap. All sutures used should be without any tension, to avoid the almost inevitable breakdown of closing with tension.

Conclusion
Taking a logical approach to dental extractions, using the correct equipment (and keeping it sharp and well maintained), using controlled forces – with an awareness of dental anatomy and biomechanics – will make extractions a lot easier. Most importantly be patient – and sing your extraction song!

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Diagnosing puppy strangles

This rare condition has an autoimmune cause and usually affects one puppy in an otherwise healthy litter.

Puppy strangles, or juvenile cellulitis, is another rare condition and the focus of this month’s feature. It usually turns up in one puppy in an otherwise healthy litter. The puppy I saw was on a course of antibiotics and corticosteroids and at first glance appeared to have periorbital alopecia (Figure 1) which looked just like demodicosis, the “spectacles” of bare skin around the eyes. Otherwise he was lively and eating well. I continued his course of treatment and advised re-examination in two weeks.

The condition gets its name from the swollen submandibular lymph nodes which are the presenting sign of strangles in horses. Equine strangles is a primary bacterial syndrome which is caused by Streptococcus equi. It is highly infectious and highly prevalent.

Puppy strangles on the other hand is rare, usually affects one individual in a litter and has an autoimmune cause with a hereditary component. Pointers, Golden Retrievers, Dachshunds, Gordon Setters and Beagles are the breeds in which it is most likely to occur. Puppies are usually affected between three weeks and four months of age.

The first signs are swelling of the face (Figure 2A), chin (Figure 2B), eyelids, muzzle and lips with papules and then pustules developing in the first 24 to 48 hours. These become crusted and may bleed or discharge pus. The lesions are painful, the ears may discharge and the draining lymph nodes will be swollen and tender and may discharge serum or pus. Multiple joints can be affected with non-erosive arthritis and the puppy is depressed, pyrexic and anorexic. Sometimes there are nodular lesions on the back, or, as in the case that I saw, swollen eyelids which were followed by alopecia.

Skin scrapings for external parasites will be negative and any bacteria found will be secondary invaders. Impression smears will show a neutrophilic exudate which may include bacteria. Histopathology shows granulomas and pyogranulomas which can be discrete or conjoined. These are made up of cores of neutrophils surrounded by large epithelioid macrophages. The apocrine sweat glands and sebaceous glands may be obscured. In severe established cases, the hair follicles in the superficial dermis may be ruptured with suppurative changes in both dermis and underlying panniculus. In the referral situation, Andrew Jagoe has found that, very occasionally, puppy strangles shows up in a severe adult-onset version and sometimes it is missed in a diagnosis of deep fulminant pyoderma.

Treatment is primarily immune-suppressive doses of steroid, for example prednisolone at 2mg/kg per 24 hours or dexamethasone at 0.2mg/kg per 24 hours. This may need to be reinforced by antibacterials to control the secondary infection. Recovery is usually achieved in a few weeks, although more time is needed for hair regrowth which should be complete unless treatment has been delayed. If so, scarring and alopecia can be permanent.

The lesions of puppy strangles are highly characteristic in appearance and taken with the age of onset and the fact that most of the litter are unaffected give a strong index of suspicion. As Peter J Ihrke of the University of California said “The clinical presentation of some of these lesions comes very close to being pathognomonic. These clinical clues can be used to prioritise our index of suspicion when generating differential diagnoses and this allows us to take short cuts when considering the most appropriate clinical and laboratory diagnostic procedures” (Ihrke 2008).

Although puppy strangles shows up at the same time as the primary vaccination course is being given there appears to be no causal relationship and recovered dogs can have a normal pattern of vaccination through life without relapse of strangles.

Reference:
Biopsies should be fixed in 10 percent neutral buffered formalin (NBF). Maximum tissue thickness to allow optimal penetration of NBF is 10mm.

You can take multiple representative samples from different areas of the lesion, or for large samples, you can slice through the tissue using parallel slices which do not quite reach the bottom of the sample and fix in NBF ideally for 48 hours at your practice before wrapping in wet paper towel prior to packaging.

Margins can be inked, or tagged using different colours, lengths or numbers of sutures. Please do not use needles to mark margins.

Small/friable specimens, such as endoscopic samples, punch biopsies and needle core biopsies, are best placed in pre-soaked cell safe capsules. Pre-labelling the cassettes using an N2 pencil before immersion in NBF means that multiple cassettes can be placed in the same pot. Samples can be fixed free in NBF; however, although we endeavour to sieve these samples, inevitably some fragments can be left behind – particularly if they are placed in the same pot as larger biopsies. Submission on gauze or card can cause samples to rip when removing for processing. A single line drawn along the centre of skin punch biopsies in the direction of hair growth prior to biopsy can help with orientation.

Bone biopsies can be difficult to obtain and frustrating to interpret. This is because of the high risk of fracture during the biopsy procedure and, histologically, due to the presence of large quantities of reactive periosteum in most lesions, regardless of pathogenesis. A diagnosis of reactive hyperplasia is often of little clinical help. It is useful to take as large a sample as possible and/or to take multiple biopsies with some from the centre of the lesion. This is more likely to demonstrate the true lesion. Multiple biopsies reduce the risk of obtaining only haemorrhagic or necrotic tissue. Fixation in 10 percent NBF is adequate for routine diagnostic biopsies.

Eyes can be submitted whole in 10 percent NBF. There is no need to section the eye or inject the fixative as this causes significant artefactual damage.

Claws need to be softened and bones decalcified before processing. The digital site is naturally very restrictive, therefore any expansile mass will cause similar clinical signs: abnormal nail growth, swelling, pain, lameness and lysis of the bone. For this reason, amputation of one or more phalanges is the biopsy technique of choice. This includes inflammatory conditions of the nail bed, such as lupoid onychitis. Punch biopsy techniques have been described; however, these can be very difficult to orientate and can result clinically in permanent disfigurement of the claw. If possible, an affected dew claw can be sacrificed.
Managing canine atopic dermatitis

Canine atopic dermatitis is a common, relapsing and pruritic condition that often requires lifelong management.

In recent years, new therapies for canine atopic dermatitis have become available and at the same time, as more information on the pathomechanisms is published, the approaches to managing it are changing so to achieve the best outcomes.

Atopic dermatitis has complex pathomechanisms and multiple immunological pathways (Olivry et al., 2010; Bizikova et al., 2015; Olivry et al., 2015; Pucheu-Haston et al., 2015a; Pucheu-Haston et al., 2015b; Pucheu-Haston et al., 2015c; Santoro et al., 2015). Both innate and adaptive immune responses are responsible for the various lesions seen at different stages of the disease. The newer treatments like lokivetmab and oclacitinib are mainly targeted at IL-31, the cytokine associated with pruritus, whereas glucocorticoids and ciclosporin target a broader range of inflammatory mediators.

Depending on the severity of the clinical signs of atopic dermatitis, owner expectations and owner compliance, a mix of symptomatic treatment and/or proactive therapy (allergen avoidance, allergen-specific immunotherapy) for environment-associated allergic dermatitis may be implemented. From a clinical perspective these treatments are aimed at managing the pruritus and skin lesions and maintaining the epidermal barrier during the different stages of the disease.

Treatments can be divided into the "reactive phase", given to deal with acute (Figure 1) and chronic pruritus and inflammation (Figure 2); and the "proactive phase", used to maintain the skin lesion-free over the long term. Most dogs experience flare-ups, even when on proactive management, and so during this time reactive treatment is needed. The aim of the proactive treatments is to reduce the incidence of acute flare-ups by identifying and addressing flare factors.

Reactive treatment of acute flare-ups and chronic dermatitis in atopic dogs

The drugs of choice for acute flare-ups should be fast-acting, to rapidly reduce pruritus and inflammation, not just...
for the comfort of the patient, but also to prevent progression to chronic atopic dermatitis. Oclacitinib, lokivetmab and systemic and/or topical glucocorticoids are all useful, depending on whether the flare-up is localised or generalised. Antihistamines may also be included in this list. The evidence for their efficacy is patchy, but some owners do find them beneficial. Symptomatic treatments to manage chronic pruritus and dermatitis include oclacitinib, lokivetmab, glucocorticoids and ciclosporin.

Oclacitinib can rapidly reduce pruritus, in most cases within 12 hours of administration, thereby breaking the itch-scratch cycle in an acute flare-up. This rapid response helps prevent self-inflicted damage, subsequent infections and chronic changes in the skin. In dogs with seasonal atopic dermatitis, oclacitinib can be used to control the pruritus as needed.

An open study (Cosgrove et al., 2015) reported an improvement in quality of life with oclacitinib use, but more than 5 percent of dogs given oclacitinib had side-effects, mostly gastrointestinal upsets, urinary tract infections, otitis, pyoderma and development of skin masses. Bearing in mind that most dogs require lifelong management for atopic dermatitis, the possibility of these adverse effects should be discussed with the owners. Oclacitinib is contraindicated in dogs with immune suppression, hyperadrenocorticism, demodicosis and with progressive malignant neoplasia.

Lokivetmab is a caninised anti-canine monoclonal antibody. It has an extended duration of effect, acts within days and is repeated at four-weekly intervals as needed. In a blinded placebo-controlled study (Michels et al., 2016a), lokivetmab was shown to reduce pruritus, erythema and the severity of signs associated with atopic disease. It appears to be safe, with no reports of acute hypersensitivity reactions (Michels et al., 2016b) and the incidence of vomiting, diarrhoea, lethargy and anorexia were similar in both the lokivetmab- and placebo-treated groups.

Glucocorticoids, such as prednisolone, or methylprednisolone, given at 0.5mg/kg once or twice daily can rapidly reduce pruritus. They are highly effective drugs and short-term use (five to seven days) to break an itch-scratch cycle has no lasting adverse effects.

The topical glucocorticoid spray containing hydrocortisone aceponate can be effective in the management of flare-ups in atopic dogs. It is particularly useful for managing localised lesions. This use is supported by a study in which once-daily application of hydrocortisone aceponate to lesions in 21 dogs with atopic dermatitis, for 7 or 14 days, significantly improved lesions and pruritus (Nam et al., 2012). Topical gels/creams containing betamethasone are also useful in managing localised pruritus and/or surface pyoderma associated with atopic dermatitis.

Calcineurin inhibitors such as topical 0.1 percent tacrolimus have been reported (Marsella et al., 2004; Bensignor et al., 2005) to reduce the severity of localised lesions and, in
the author’s experience, it is particularly useful in localised lichenified areas that are not infected.

Ciclosporin administered orally, at 5mg/kg once daily until there is satisfactory control of clinical signs, which usually takes four to six weeks, is suited to some individuals. It is recommended that no dose adjustments should be made for at least the first four weeks. It can then be tapered every other day, or less often, depending on individual response. Using the measurement of serum levels of ciclosporin to regulate the dosage is not advised, as data correlating serum levels to clinical efficacy is lacking in dogs. Because of the slow onset of the response to ciclosporin, dogs with severe pruritus often require concurrent administration of prednisolone. It is reported that giving prednisolone at 1mg/kg with ciclosporin at 5mg/kg daily for 14 days resulted in a quicker improvement in skin lesions and reduction in pruritus when compared to those dogs given ciclosporin alone (Dip et al., 2013). Therefore, concurrent short-term use of a glucocorticoid with ciclosporin should be beneficial in severely affected dogs.

Gastrointestinal disturbances are the most common side-effects associated with ciclosporin in dogs. Other undesirable side-effects, such as reduced appetite, gingival hyperplasia, papillomatous skin lesions, muscle cramps, coat changes such as hirsuitism and erythematous pinnae, have been reported. Ciclosporin is contraindicated in dogs of less than six months of age, less than 2kg in weight and with a history of malignant disorders.

Proactive management to prevent the incidences of acute flares

Management of flare factors includes flea control and addressing any dietary triggers.

Allergen immunotherapy (AIT) is the only specific preventative therapy available for the management of atopic dermatitis. It is safe to use and can be used with other treatment modalities. It is beneficial in up to 75 percent of cases, but the time taken to show an improvement can be up to 10 months. A small percentage of dogs can be successfully managed on immunotherapy alone (Olivry et al., 2010).

AIT is made up, on a named patient basis, following intradermal and/or serological allergy testing. It is available as an injectable or oral therapy; both have been shown to be effective. The adverse effects are minimal, making it a safe way to ameliorate the clinical signs of atopic dermatitis. Over the years, administration using different protocols have been reported on (rush, traditional, low-dose and oro-mucosal), but realistically it should be individualised to the patient and the client. Many clients, for example, prefer to give the dogs four-weekly injections to once or twice daily oral drops. The frequency of treatment may also be modified to suit the individual response. There is a suggestion that an individual that has failed on injectable AIT may do better on the oro-mucosal formulation. AIT is usually recommended for life, as, at present, there is insufficient evidence to warrant stopping the treatment once an animal has been in remission for some years.

Serious adverse reactions such as anaphylaxis, urticaria and angioedema are extremely rare in animals treated with either the injectable or the oral forms. Transient facial pruritus and gastrointestinal upsets are associated with the oral form.

Skin and coat hygiene is important. Regular shampooing helps keep the skin surface clean by removing allergens and microbes and by hydrating the skin. Certain shampoos do have specific antipruritic effects, but even the simple act of bathing can reduce pruritus in some dogs. The choice of shampoo depends on the clinical findings, for example a chlorhexidine/miconazole shampoo is appropriate for bacterial and yeast infections, whereas oatmeal-based shampoos are indicated for managing pruritus. Some recent shampoo formulations contain synthetic antimicrobial peptides aimed at managing recurrent pyoderma.

Essential fatty acid supplements (EFAs) and specific diets that help maintain the epidermal barrier and immunity are also recommended as concurrent therapies for the management of atopic dermatitis. The general improvement in skin and coat condition helps maintain the epidermal barrier and can potentially reduce allergen penetration percutaneously and reduce microbial infections. EFAs may help some atopic dogs, but the results from studies vary and therefore one should not use them as a sole therapy for atopic dermatitis. Several EFA supplements and enriched diets for dogs are available in the UK.

Topical lipid formulations containing ceramides, cholesterol and EFAs may help some individuals in managing seborrhoea sicca, which can contribute to the pathogenesis of atopic dermatitis. A recently reported randomised controlled trial demonstrated the use of a topical spray containing plant-derived essential oils and fatty acids, and compounds with antimicrobial properties (manuka oil and N-acetyl cysteine), that resolved pyoderma in treated areas faster than in untreated areas (Bensignor et al., 2016).

In a recent study (Tamamoto-Mochizuki et al., 2019), lokivetmab administered at four-weekly intervals, as a proactive treatment, was reported to help one in four dogs. The study also reported increased intervals between flare-ups in dogs treated with lokivetmab.

Summary

To optimise the response to treatments, they need to be individualised depending on the chronicity of the disease, their potential adverse effects and the cost implications and taking into consideration the ability of the owner to implement them. For a successful long-term outcome, a combination of the various treatments should be adopted to maximise benefits and minimise adverse effects.

A full reference list is available on request.
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How can you fit a dermatology consultation into general practice?

Recognising and understanding the different demands of a dermatology consultation is key to learning to accommodate them.

3. The owner will be the principle carer
   Some procedures, such as bathing and ear cleaning, can be tedious and are probably among the most challenging things we ask an owner to do. To competently perform these procedures requires a thorough understanding of the goals and how to achieve them, and the motivation to do so. This comes through education, explanation and often demonstration, all of which will challenge the clinician’s communication skills. This, too, will take time.

Addressing the need for additional consultation time
   This can only be achieved through a limited number of strategies and which one best suits your practice will depend heavily on your appointment rotas, lay staff, client base, colleagues and a willingness to adopt some changes. The need for time can only be achieved in two ways – extending the consultation or restricting what you try to do within a shorter slot. The first strategy requires some reorganisation, whilst the second requires fewer changes but is probably harder to adapt to and achieve.

   For new cases, all strategies start with your reception staff. They almost certainly already collect the information needed but what is important is how it is utilised when booking the consultation. When booking in a dermatology case, what type of consultation are you going to offer and which clinician will see it?

   The following points should all be clearly made to the owner when booking the first appointment. Once all relevant expenses have been accounted for, running a consultation room in general practice costs in excess of £200 an hour. Such consultation time must be paid for and should not run as a loss leader.

Strategy 1 – extending the consultation

   1. All new dermatology cases are offered a double slot. This should be early enough in the day to allow the patient to be admitted for more detailed examination and sampling, freeing up more time for taking a detailed history. This in turn allows the clinician to identify the key issues that need to be addressed and have a clear “road map” for the process of investigation. If such appointments are made at the same time on allocated days, the clinician seeing the cases will know in advance that they are seeing a potentially complex case and will have the opportunity to read the history beforehand.
2. We all like some parts of clinical practice more than others so it makes sense to allocate dermatology cases to a clinician who enjoys them. This will result in many important benefits, the most important of which is continuity of care.

3. If the patient has been admitted, a discharge appointment is needed to clearly explain the results of any investigations and plan treatment and further work. It must be emphasised to the owner that dermatology cases often require a systematic step-by-step investigation and that if this is to succeed, it is essential that advice is followed closely and follow-up appointments are kept.

4. Follow-up appointments should always be made with the same clinician. These too can be extended if they are part of a reserved dermatology session or may be incorporated within the normal appointment slots.

There are several ways in which the above basic strategy can be expanded. Several slots could be allocated to dermatology forming a dedicated session once or twice a week for new cases and follow-ups. The strategy could be adopted for difficult or complex cases of any type or it could be held in reserve for cases being seen within the normal rota which are not responding well to management. In such cases, once attention has been drawn to the fact that little progress is being made, many owners will be appreciative of the special interest that their pet is being shown.

**Strategy 2 – reducing the content**

1. Most practices run 10- to 15-minute appointment slots and if this remains unchanged, dealing with dermatology cases becomes much more challenging. There will be little time to do more than briefly read the history, perform a cursory examination and ask a handful of questions so two factors become much more important. The first is the ability to admit the pet for further assessment – if this can be done, the physical examination can be delayed. The second is the ability to rapidly recognise and prioritise the key issues to address.

2. The goal for the first consultation will be to identify the differential list for the principle or underlying problem and ensure that the first step towards confirming a diagnosis is taken. If, for instance, there are clear signs of a superficial pyoderma, then the first step will be to eliminate this problem and then reassess the case. At each subsequent appointment, another issue can be addressed and eliminated until a definitive diagnosis is reached.

3. This step-by-step process is powerful and robust but it becomes essential that follow-up appointments are kept as planned. If appointments are missed, progress will be lost and secondary problems may relapse. This is the greatest challenge when adopting this strategy and success will depend on owner motivation and the clinician’s communication skills.

The clear advantage of this second approach is that it will fit seamlessly into most appointment systems and offers maximum flexibility to both clients and clinicians. However, maintaining continuity of case supervision may be more challenging and this would be a serious disadvantage if it was lost.

The benefits of case continuity cannot be overstated with respect to dermatology and ear cases. Such cases benefit from the development of a cooperative relationship between clinician and owner and this takes time to build. A clinician unfamiliar with the case cannot easily recognise whether there has been any improvement or deterioration and may have to repeat questions asked at previous consultations. They may have slightly different personal preferences regarding treatment and this can confuse owners. After several such changes, owners often become frustrated and as a result, less cooperative, compromising the chances of success.

The best outcomes will always be achieved by a motivated clinician assuming personal responsibility for each case, maintaining continuity of supervision and communication whilst remaining open to advice and assistance.
Should we be charging for nursing clinics?

A recent survey by the VNDG showed that many practices are seemingly giving away their nurses’ time for free.

The Veterinary Nursing Dermatology Group (VNDG) recently ran a survey investigating the way practices approach charging for nursing clinics. A significant number of nurses, 341, completed the survey and the results present a very interesting picture.

Utilising veterinary nurses

Ninety percent of practices offer nurse clinics, so we know the vast majority are offering them; however, only 40 percent of those practices charge for their nurse clinics, so more than half of practices are choosing to give their nurse consult time away for free. These practices, whilst not charging for nurse clinics, are, however, charging for nurse services, a high 83 percent of practices in total. But what are these services?

When asking about them in more detail the survey found: 97 percent charge for nail cutting, 90 percent for anal gland expression, 61 percent for blood taking and 51 percent for ear cleaning. So, the majority of practices do value and charge for their nurses’ time and skill, but only a minority charge for nurse "consulting" time.

Practices may have a policy for having the consult free and the services charged for, but the same practices will be charging for vet consult time, with services in addition. This suggests a missed opportunity to charge appropriately for nurse time and skill, which is clearly valued in other areas.

With much discussion in the industry as to the benefits of utilising nurses, by referring on to them work which the veterinary surgeon finds difficult to find time to do, the survey looked to identify if this is actually happening in practice. Encouragingly, 88 percent of practices do refer to their nurse clinics from veterinary consultations. This encouragement continues when looking at specialist consults, with a huge 97 percent of practices offering weight clinics, 94 percent puppy and kitten advice consults, 54 percent geriatric clinics, 48 percent diabetic clinics and 34 percent grooming clinics, suggesting nurses are indeed being utilised for specialist consults. Compared to just 26 percent of practices with vets offering any kind of specialist clinic, we see generally practices are already following the theory to a degree.

Of course, more practices could be offering nurse clinics so there is certainly room for growth, but from a business standpoint, the survey also revealed that even the practices doing so are not making the most of the opportunity. Of the practices offering weight clinics, 82 percent are doing so free of charge as they are 88 percent in the case of the puppy and kitten clinics. Perhaps unsurprising given the nature of those services? However, 80 percent of the diabetic clinics and 67 percent of the geriatric clinics are also being offered free of charge; this suggests a real undervaluing of nurses’ advice, and whilst 87 percent of the practices offering grooming clinics do charge, 70 percent are charging below £70.

So how much should we charge?

Of the 40 percent that charge for nurse consultations, the vast majority (59 percent) are charging only between £11 and £20 – so this seems to be the most popular rate. As it is, in fact, for every other nurse service or nurse consult which is being charged for by practices. Without fail this was the top answer every time the survey asked what was charged, regardless of the service. Is £11 to £20 the going rate for a nurse’s time? Based on an average nurse consultation being about 30 minutes, this gives an hourly rate of between £22 and £40 per hour, so not high given the skill of trained nurses and the facilities of the veterinary practice.

Still, whilst the value itself is up for debate, at least the charge in these instances is greater than charging nothing at all. It is still worth noting that the survey showed it can be greater: with 12 people responding saying their practice charges between £21 and £60 for their diabetic clinics, and five to say their practice charges between £81 and £100 for their geriatric clinics. Isolated cases though, which perhaps many would argue is not viable in all practices, but even if not charging at that level, it further highlights the question as to why in the vast majority of instances these nurse services are given away free of charge.

Conclusion, with a VNDG eye to dermatology

We at the VNDG know the real value of the nurse’s role in dermatology and are committed to increasing the number of practices offering nursing consults working alongside their vets in managing dermatology cases. More are doing so; however, the survey showed the numbers to still be very low at only 12 percent, in an area where we know nurses can improve patient outcomes and the owner’s experience and can assist their vets in really offering a much-enhanced client experience. As nurses’ involvement in dermatology cases increases, perhaps it will demonstrate the value of charging for nurse time in order to generate revenue otherwise missed.
# A look through the latest literature

## Antimicrobial activity of chlorhexidine and acetic acid/boric acid cleansing wipes

Rebecca Rafferty and others, University of Edinburgh

Antimicrobial wipes have become a popular option for use in controlling surface and superficial infections in dogs. However, there is a lack of controlled studies to assess their *in vitro* antimicrobial and *in vivo* residual activity. The authors tested commercial chlorhexidine- and acetic acid/boric acid-impregnated wipes against isolates of pathogenic bacteria from clinical cases. The chlorhexidine-based product was effective against both methicillin-resistant and susceptible *Staphylococcus pseudintermedius*, *Escherichia coli* and *Malassezia pachydermatis*. The acetic acid/boric acid impregnated wipes were found to be ineffective against those bacteria and neither product showed residual activity on hair. *BMC Veterinary Research, 15*, 382

## First identified cases of Alabama rot in the Irish Republic

Aimee Hope and others, University College, Dublin

Alabama rot, or canine cutaneous and renal glomerular vasculopathy, was first described in Greyhounds in the southern US in 1988 and has since been identified in various European countries. It causes erosive/ulcerative lesions affecting the distal limbs, ventrum, oral cavity and muzzle, followed by the emergence of acute kidney injury. The causative agent is still unknown. The authors describe the clinical findings in the first three confirmed cases in the Irish Republic. All three cases presented with azotaemia and were euthanised due to the poor prognosis. *Irish Veterinary Journal, 72*, 13

## Toxicity of human dermatological products for cats and dogs

Kathy Chu Tater and others, Veterinary Information Network, Davis, California

Many dermatological products available for human use are potentially toxic to other species. As well as chewing the product in its packaging, dogs may lick the material when applied to the owner’s skin or it may be absorbed transdermally. The authors examined the range of dermatological prescription products available in the US and assessed the risks to pet animals coming into contact with them. They found various products that can cause death or major illness in pet animals at low doses. Increased public awareness of these hazards, together with careful attention to safe home storage practices, can minimise the likelihood of exposure and toxicosis. *Veterinary Dermatology, 30*, 474-e140

## Effect of equine amniotic allografts on healing of full-thickness distal limb wounds

Alexander Fowler and others, North Carolina State University, Raleigh

Amniotic membranes have been investigated as natural scaffolding materials and sources of the extracellular matrix components and cytokines needed to heal large-scale skin wounds. The authors investigate the impact of a commercial acellular equine amniotic allograft on healing of experimental full-thickness distal limb wounds in horses. They found that the allograft resulted in increased granulation tissue production while maintaining appropriate wound healing. *Veterinary Surgery, 48*, 1416-1428

## Application of nail caps to minimise scratching injuries in pruritic cats

Elisa Maina and others, Veterinary Dermatology Service, Lovere, Italy

In cats with severe pruritus, physical restraint may be necessary to limit self-inflicted skin injuries. Elizabethan collars may provide a temporary cessation of scratching but such devices are often poorly tolerated. The authors investigate the use of soft vinyl nail caps fixed to the hind claws with cyanoacrylate glue to prevent scratching in 30 cats with head and neck pruritus. After 28 days the owners judged these caps to be comfortable in 90 per cent of cats and mildly uncomfortable in the others. The method appears therefore to be a valid and better tolerated alternative to collars in these cats. *Veterinary Dermatology, Online, December 23*
APHA Vet Gateway update

The Animal and Plant Health Agency would like to make official veterinarians aware of recent updates to the APHA Vet Gateway.

Export instructions
The Notifiable Disease Occurrence List (ET171) was updated on 12 December 2019 to reflect recent events and the small animal export instructions were updated in February 2020 to remove the Brexit pet travel documents.

Read the updated information on the APHA Vet Gateway: apha.defra.gov.uk/External_OV_Instructions/Export_instructions/Updates/index.htm

TB passive surveillance instructions
The passive surveillance instructions were reviewed and updated in January 2020. This includes updates to the general information about passive surveillance, clinical cases, slaughterhouse cases and knackers’ yards, as well as information about other mycobacteria.

Read the updated information on the APHA Vet Gateway: apha.defra.gov.uk/External_OV_Instructions/TB_Instructions/Updates/index.htm

Relaunch of the TB hub website
The TB hub website has been refreshed and APHA would like to encourage OVAs to become familiar with the relaunched website and promote this joint industry-government initiative to farmers.

Since it was launched in 2015, it has become the “go-to” place for British beef and dairy farmers to find practical advice and information on dealing with bovine TB on their farms. It covers a broad range of subjects, from biosecurity measures and TB testing, to understanding cattle trading rules. Alongside guidance on minimising the impact of TB on farms, there is also information on what farmers can do to reduce the risk of bovine TB getting into their herds, both from cattle movements and wildlife.

There are two key groups which the redesigned TB hub particularly aims to help: those who are currently dealing with a TB breakdown and those who want to protect their herd from TB.

The TB hub website can be found at tbhub.co.uk

Tuberculin testing revalidation process instructions
There have been changes made to the tuberculin testing revalidation process and OVAs are being urged to familiarise themselves with the new process.

Read the updated information on the APHA Vet Gateway: apha.defra.gov.uk/official-vets/training-and-authorisation/tt-revalidation-exempt.htm

OV briefings
29 JANUARY 2020
An update regarding equine movements as we now enter a transition period

The government’s Withdrawal Agreement Bill has now been agreed by Parliament and received Royal Assent, so we will now enter a transition period until 31 December 2020.

During the transition period, you should continue to move equines in the same way as you do now (using all the current processes and systems in place) until the end of 2020 – there are no immediate changes to the process.

The arrangements after that date will depend on the outcome of our negotiations with the EU which will take place in the interim.

All of the relevant guidance will be available on gov.uk and the government will continue to engage with the public at regular intervals to keep you informed of what they need to know and the actions that they will need to take.

30 JANUARY 2020
An update regarding pet travel as we now enter a transition period

The government’s Withdrawal Agreement Bill has now been agreed by Parliament and received Royal Assent, so the UK will leave the European Union on 31 January 2020 and then enter a transition period until 31 December 2020.

During the transition period, pet owners will be able to continue to travel with their pets in the same way as they do now (using a pet passport) until the end of 2020, as there are no immediate changes to the process.

The arrangements after that date will depend on the outcome of our negotiations with the EU which will take place in the interim.

All of the relevant guidance will be available on gov.uk and the government will continue to engage with the public at regular intervals to keep you informed of what they need to know and the actions that they will need to take.
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Certification pitfalls in farm animal practice

It’s important to understand when a task is one of certification and to be aware of common mistakes to avoid.

Certification is an important part of farm animal practice and a regular feature of the day job for most practitioners. International trade in animals and animal products is reliant on veterinary certification and whatever shape our relationship with the EU and the rest of the world takes over the next few years, we can be fairly certain there will be more, not less, veterinary certification.

Farm animal practitioners are familiar with the importance of veterinary certification and that they are required under the RCVS Code of Professional Conduct to certify facts and opinions honestly and with due care, in accordance with the Principles of Certification. This level of awareness is reflected in the relatively low levels (seven cases in the last five years) of farm-related civil claims for compensation handled by the VDS, when compared to the number of veterinary certificates issued every year.

If you are questioning what you are doing, there is a good chance you shouldn’t be doing it.

It is always easier to take the care required when the task is obviously one of certification. If the document requiring veterinary input and a signature is clearly labelled (eg export health certificate), then practitioners are already alerted to the need to be on their guard. More problems arise for the unwary when the assignment is less recognisable as certification and the RCVS’s chapter 21 on certification in the supporting guidance to the Code of Professional Conduct is particularly helpful in this respect.

While it may not be top of every busy practitioner’s reading list, if, like the author, readers struggle to keep the 10 (Yes, 10 now, not 12?) Principles of Certification at your fingertips, then the guidance is worth a regular dip into. Perhaps as important as the 10 Principles is the help on what constitutes a certificate and how to approach tasks which aren’t immediately apparent as certification.

A certificate is defined as “a written statement made with authority”; in this case the authority coming from the veterinary professional status (eg MRCVS, FRCVS or Official Veterinarian (OV)).

Some common examples of veterinary certificates in farm animal practice are:

- Forms requiring a veterinary signature, such as for health scheme accreditation
- Declarations such as fitness to travel
- On-farm emergency slaughter
- Insurance claims
- Witness statements: these might be attesting to facts with the practitioner’s knowledge such as recording clinical findings ("witness of fact"), or giving opinion on a case or set of facts ("expert opinion"). More detailed guidance is given in chapter 22 of the RCVS supporting guidance
- Self-certification documents, such as declaring compliance with CPD requirements at the annual RCVS renewal
- OV certification
  - Export
  - TB testing. Remember that signing off the test is certifying it has been performed according to the correct protocol
  - Other statutory testing (eg anthrax, brucellosis, sheep scab)

Most problems arise through simple human fallibility such as transcription errors (dates, ear tag numbers, product codes etc) but mistakes with performing the wrong tests or reporting results inaccurately are also frequent causes of incorrect certification. Even simple errors are likely to result in stressful, time-consuming complaints as well as having the potential for some eye-wateringly large claims for compensation. While the hope of eliminating all human error might be a step too far, there is still much that can be done to mitigate the risks of claims and complaints by being well prepared and allowing time to give the necessary care and attention.

Nick Perkins, BVSc, CertCHP, MRCVS, qualified in 1989 and spent 25 years in clinical practice in the South West before joining the Veterinary Defence Society as a Claims Consultant. Nick’s work involves both farm and companion animal claims.
Export health certification requests in farm animal practice are often made at short notice but may be complex and require a significant amount of preparation. Exporters often exert considerable pressure on OVs to complete tasks quickly, or even cut corners, because of deadlines or financial pressures, but it is imperative to resist and instead, to allow the necessary time to prepare well in advance, as well as to double check each stage carefully as it is completed. Remember that the first request to export a particular type of animal or product will always take much longer than on repeat occasions when familiarity with the task will help. If there is not time to complete the certification properly, then do not be afraid to refuse or refer to someone else with the relevant experience.

It is equally important to ensure the correct facilities are made available to perform necessary checks, such as physically inspecting consignments. Some exporters will make arrangements purely for their own ease, or even deliberately difficult for the OV, so it is always worth thinking ahead. The corner of a dark field at 3am is not going to be a suitable place to inspect 500 sheep to ensure they are fit for export!

Beyond the difficulties of export health certification, farm practitioners frequently find themselves in the unenviable situation of making decisions on fitness to travel, eligibility for on-farm slaughter, or whether post-mortem findings fit the criteria of a client’s insurance policy; all of which have the potential to put the benevolent practitioner in direct conflict with their client’s financial interests.

Unfortunately, while simple errors can only lead, at worst, to a civil claim for compensation, a lack of care over certification, or worse still, false certification to assist a client, opens up the more worrying prospect of a conduct complaint to the RCVS.

Navigating the minefield of possible certification pitfalls is far from straightforward in farm animal practice but following a few basic principles will help to avoid major trouble.

- Recognise a certificate and take the appropriate care
- Don’t rush, even if you are put under pressure
- If needed, step back and think
- Check with the relevant authority (eg APHA for OV certification)
- Ask a colleague (or the VDS)
- Take the time required to be fully prepared
- Ensure good communication. If you are unsure what is required, seek clarification and make certain you are properly understood
- Follow the RCVS guidance and seek their clarification if required

Perhaps most importantly, if you are questioning what you are doing, there is a good chance you shouldn’t be doing it, so stop and take the time to find out.

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Do vets understand biosecurity?

It is becoming increasingly clear that as a profession we need to be more attentive to biosecurity

ALASDAIR MACNAB
Alasdair Macnab, BVMS, MRCVS, Cert BIP OVS, owns a consultancy, AJM Agri Ltd, which does advisory work for farmers and crofters and advises businesses on biosecurity. He is the local branch chair for the National Farmers Union for Scotland and sits in the NFUS Legal and Technical Committee.

In my first article in the December/January 2019/20 issue, I questioned the standards and attitudes to biosecurity in the veterinary profession and provided some examples. I highlighted the indirect language being used to control disease, how the profession’s biosecurity standards are viewed by others and how easy it is to spread disease. What evidence is there to back my assertions?

This article will show a number of examples of poor biosecurity and lack of awareness of the potentials for disease spread or control. Reflection on how the medical profession are reacting to the current coronavirus outbreak is enlightening and should provide us with a warning which we must heed.

Challenge 1 – blood sampling protocols
In the last article, I described a young vet who was about to reuse a needle while doing my annual cattle health scheme test. At an assessment I carried out for two vets, one was blood sampling while the other was TB testing. I noticed that there were 12 blood samples and four used needles in the container. I challenged this finding to be regaled with the “fact” that if you withdraw the needle before the tube is full, the vacuum will “clean” the inside of the needle. I explained the folly of this concept.

How have these two vets, graduated from different veterinary schools, both come to their respective opinions? What were they taught at university? If biosecurity was taught, why was the lesson not learned? Who is auditing this aspect of their professional work? Have they picked this up from colleagues in the profession? Anecdotal evidence from laboratories suggests this is not an uncommon practice. Why is it so?

Challenge 2 – hygiene and cleanliness
How clean is the vehicle you take to farms? Would you eat your dinner off the inside? If not, why not? Given the minimal amount of fomite it takes to transmit disease and potentially the transfer of antibiotic and anthelmintic resistance, are you placing your farm clients at risk?

Figure 1 shows the inside of a car. Consider the picture before reading further. What are the issues? There are five issues here. First is the unacceptable state of the container the boots are kept in. Second, apart from being too small, it is beside a towel and a roll of paper towels. Third, there is the latch on a box lying in the boot’s container. Fourth is the new measuring jug, unused, the new FAM30 container and new buckets. Lastly, we also need to be aware that this scenario could also be a pointer that someone is not coping and needs some help.

Figure 2 shows the state of PPE which a vet arrived at an assessment with, heavily contaminated with faeces. How has this, in the light of our professional training and knowledge, become acceptable and why do our colleagues not appear to pick up on this?

Challenge 3 – are you letting your colleagues down?
Figure 3 shows the state of a carrier for TB equipment. The outside is covered with some fairly fresh and some dry faeces. This indicates that the container was brought back to the surgery on more than one occasion, put back in storage and left for someone else to clean.

What does this say about that vet’s attitude to their job, their colleagues, their place of work and their profession and its role in society? Why would any farmer allow this onto their farm? Would a farmer challenge this? Why shouldn’t they challenge it? It is not acceptable.

Challenge 4 – how do you clean a bucket?
Figure 4 shows a very tidy and clean boot with the exception of, again, the boot container. The vet concerned was challenged about the contamination on the outside of the container. The response was “how are you supposed to clean it?”

Challenge 5 – antibiotic storage and handling
On an assessment, I witnessed a bottle of antibiotic on a wall and two syringes. The vet being assessed was challenged as to why, an hour into the assessment, he hadn’t noticed it nor challenged the farmer about it. As a young vet, he was very reluctant to speak out about it. Why are young graduates unwilling to speak out about issues that are clearly wrong and part of a growing threat to humanity? How do we engender a change in approach? Where would this vet stand in the situation where this is a “big” client of the practice? Would partners and senior managers support that vet? If not, I would like to know why not.

There was a picture of a medicine storage cabinet in a veterinary magazine a few months ago. It had faeces on the outside of bottles, on the shelves and on cardboard outers. It was included in the article as an example of a medicine cabinet. What message does this send to colleagues, farmers and stockmen when this is considered a good example?
Challenge 6 – the fitting dog, are you prepared?
You are faced with a dog with a history of mild aggression for a few days and now taking fits. On exploring its history, you discover it came into the country about two months ago from an unknown source. What is your differential diagnosis? Do you consider rabies? Well, you should. What do you do next? Good question!

You should contact APHA and report suspicion of rabies. You will be asked to isolate the dog. How many of you are aware of how to isolate a rabies suspect? How many of you have a practice protocol for isolating a rabies suspect or any other infectious disease? What disinfectant do you use? What are the health and safety implications for the practice staff? How do you handle that dog?

Challenge 7 – personal biosecurity
We all use stethoscopes every day. We are all used to seeing pictures of vets and vet nurses with stethoscopes hanging round their necks. This is the image we portray. Is it right? The stethoscope is in contact with all manner of animals with all manner of infections, with variations in antibiotic resistance, yet we just launch it round our neck when we have finished using it. Then we go home to our families, some with young children and when hugging them, place them in contact with the same area of our neck as the stethoscope. Sensible?

Consider MRSA and multidrug-resistant Pseudomonas aeruginosa. It is common in dogs and humans. Do you handle animals with these infections without disinfecting equipment, tables, keyboards or hands between animals? My mother recalls when taking us children to the doctor that when you entered the consulting room the doctors were always making the point that you could see them finish washing and drying their hands before examining you. Do you see that with doctors today? Do you as vets do that? If not, why not?

Challenge 8 – are we really playing our part in society?
The above challenges are a small sample of many issues I could quote in support of the contention that vets do not really understand biosecurity. Society faces challenges from disease and antibiotic and anthelmintic resistance. There are many issues associated with these challenges and as a profession closely working on them it is beholden on us to use and demonstrate clearly the use of all the armoury we have. Biosecurity, whatever that really means, needs to be at the forefront of it.

I believe there needs to be a very comprehensive rethink of what we are teaching students, what our “biosecurity” standards ought to be, what our stance is on our relationship with colleagues with regard to this, our relationship with the society and industries we deal with and how we can improve the understanding and implementation of “biosecurity”. Perhaps a return to old fashioned cleanliness and hygiene might not be out of order.

Challenge 9 – can it be done?
I leave you with a picture of the back of a vet’s vehicle which is absolutely immaculate (Figure 5). Is there any reason why the whole profession cannot meet a reasonable standard of hygiene and cleanliness such as this?
A t the BCVA Conference in October 2019, renowned lameness experts Nick Bell, Justin Birch, Sara Pedersen and Neil Wills debated the topic “Despite extensive scientific knowledge, cattle vets are still failing lame cows”. It was a thought-provoking debate, with the side proposing the motion pointing out that despite our efforts, lameness prevalence is still 30 percent (Randall et al., 2019), and that lame cows are not being treated as soon as possible. However, a key point made by those opposing the motion is that huge steps have been made in regards to lameness in the UK over the past 20 years. The National Association of Cattle Foot Trimmers (NACFT) was founded in 2000, DairyCo Mobility Score introduced in 2008 and the Register of Mobility Scorers (RoMS) founded in 2017 to name a few. The industry certainly has been reacting to the need for lameness interventions. Stressed by all was the need for a team approach to tackling lameness: enthusiasm is key.

There was a lot of food for thought following this debate including suggestions from the audience that a National Lameness Programme should be introduced, similar to BVD and Johne’s. It was noted that lameness levels are variable across farms in the UK and proposals were made that a more achievable target of reducing percentage of lameness on farms individually, rather than a countrywide target, would be a sensible first step. Who would provide funding for such a scheme was not discussed – the elephant in the room. From analysing mobility scores in 2019 from Synergy Farm Health Ltd, the average lameness prevalence (AHDB Mobility Scoring system, score 2 and 3) was 11 percent with a total of 50,949 cows being scored. This undoubtedly is a skewed data set, resulting in a lower percentage than national average, as mobility scores are only conducted on farms that are actively preventing lameness or forced by milk buyers to mobility score. Ultimately, all vets, farmers and milk buyers should be aiming for the same goal of reducing lameness, subsequently increasing cattle well-being on-farm.

The difficulties surrounding the detection and perception of lameness were discussed. Perhaps a move to using techniques such as motivational interviewing is required to broach the topic on farms where they don’t perceive there to be an issue. An argument raised at the BCVA debate was that no progress has been made over the past 10 years, as lameness prevalence is still at 30 percent (Randall et al., 2019) 10 years on from the study by Barker et al. (2010), which showed 37 percent lameness prevalence. One counter argument raised was that lameness has potentially improved, but the industry’s detection of lesions overall has improved and that we are now detecting less severe lesions such as sole bruising which previously may have gone unrecorded. The levels of lameness, however, are still unacceptable and action is needed.

Another point of discussion from the audience was what to do with those chronic score 3’s that “hang around” on-farm? Some milk buyers have instigated policies for score 3 cows in an effort to tackle the issue. For some, if a score 3 is present on-farm at two consecutive mobility scores, they must be culled. However, some milk buyers have a more lenient policy, whereby the farm is required to have a written action plan for each individual score 3 animal, following an independently conducted RoMS mobility score. These policies prevent an individual animal from suffering long term, but perhaps doesn’t prompt preventative measures on-farm to prevent that score 3 from occurring in the first place. Milk buyers certainly have a very important role to play with regards to lameness prevention, as well as treatment, and it is an opening for vets to broach the topic of lameness.

The phrase “Buy British, buy local” is often used, but who governs the animal health and well-being on these farms if they are supplying straight to a farm shop, and skipping out the “middle man” of the milk buyers. Should vets be taking on this responsibility and benchmarking their farms against one another in regards to lameness? It’s a lovely idea, but some level of lameness awareness is required by the farm to have conducted a mobility score, to be able to benchmark.

Synergy Farm Health Ltd has been benchmarking dairy farms based on their antimicrobial usage in herd health.

Tackling lameness in the dairy industry

Do we need to revisit our strategy for controlling lameness in dairy cattle?

BETH REILLY
Beth Reilly, BVetMed, PGDipVP, MRCVS, graduated from RVC in 2017 and completed the Cambridge Junior Clinical Training Scholarship in Production Animals. She joined Synergy Farm Health in July 2018, completing her Postgraduate Diploma in Veterinary Clinical Practice at RVC in 2019.

JON READER
Jon Reader, BVSc, DCHP, MRDVS, graduated from Bristol in 1997 and is a director at Synergy Farm Health. He was awarded the Diploma in Cattle Health and Production in 2010 and is an RCVS Recognised Specialist in Cattle Health and Production.
plans for a few years now and these have been very well received by clients – giving some the nudge they required to make a necessary change. Is an annual mobility score before renewing a dairy herd health plan too much to ask? How else can we as vets accurately and appropriately discuss the lameness issues on-farm? An initial mobility score and subsequent benchmarking of the lameness prevalence is perhaps a good starting point to start tackling lameness in a proactive fashion and to identify problem herds and subsequently the problem cows.

The Cattle Lameness Academy (CLA) (Figure 1), part of Synergy Farm Health Ltd, has a strong ethos around the team approach to lameness and provides mobility scoring (Figure 2), foot trimming services (Figure 3) and veterinary care all under one roof (Figure 4). A key aim of the CLA is communication within the team regarding lameness on each farm.

As a result of demand from farmers for training material on lameness the CLA is developing multiple educational training videos as part of a series called “Mobility Matters” which has been supported by Care4Cattle, a Bayer Animal Health initiative (Figure 5). These videos will be broken down into modules for farmers to easily navigate between topics, and they will be freely available to watch online via the CLA website. We hope that these videos might prove useful for vets as well as for getting farmers to see and interact with their vets in regards to lameness on their farm. Referring back to the BCVA debate title “Despite extensive scientific knowledge, cattle vets are still failing lame cows” it is pertinent to say that vets certainly are not failing lame cows and are making steps forwards.

The CLA is holding its third Cattle Lameness Academy Seminar on 25 March 2020 at Dillington House, Ilminster. The focus will be on cattle welfare in relation to lameness in the dairy industry, as well as foot care in practice and how a team can approach lameness control. We hope that the seminar provides some much-needed answers and ideas for how the dairy industry can tackle lameness on-farm following the thought-provoking lameness debate at BCVA. A new initiative, Healthy Feet Programme lite (HFPlite) will be discussed by Owen Atkinson, one of the architects of the new scheme, at this seminar.

How is your veterinary practice contributing to tackling lameness? Do you have AHDB trained Mobility Mentors in your practice that are trained in delivering the Healthy Feet programme? The authors hope this article provides food for thought and summarises some of the possible approaches to tackling lameness we should be undertaking as vets in 2020.

Tackling lameness in the dairy industry

FIGURE (1) The Cattle Lameness Academy vet tech team 2019 (2) Mobility scoring is done by a RoMS approved Cattle Lameness Academy vet tech (3) Cattle Lameness Academy vet techs also do foot trimming

FIGURE (4) Cattle Lameness Academy’s team approach to lameness provides mobility scoring, foot trimming services and veterinary care all under one roof for farmers (5) Cattle Lameness Academy’s education lameness videos, “Mobility Matters”, are supported by Care4Cattle and will be released in spring 2020

References and further reading
Considerations when tackling mastitis in cows

Vets were urged to consider how best to develop a structured approach to mastitis with clients

**RICHARD GARD**  
*LARGE ANIMAL CORRESPONDENT*

Following a 16-year apprenticeship with Beecham, Richard established a project management and development consultancy and writes regular contributions for the veterinary press.

The 31st British Mastitis Conference attracted some 25 veterinary surgeons from practice, who shared their knowledge and awareness with industry and academia. The event is organised by The Dairy Group, the British Cattle Veterinary Association, Quality Milk Management Services Ltd and the University of Nottingham. One of the features of this event is the high quality of poster presentations from the UK and overseas and four of the authors are invited to present their work as part of the main timetable of events. The speakers and poster presenters gather for general discussion in the centre of the hall and delegates have time during lunch to translate what is offered into their own practical requirements. Each year more detailed and original information becomes available and the British Mastitis Conference provides the opportunity to gather the latest ideas in an informal setting. The contact details for authors and speakers are within the proceedings so that follow-up is available and encouraged. Copies of the proceedings are available from The Dairy Group. The event is sponsored by Vetoquinol, Boehringer Ingelheim, Hipra, MSD, Milkrite, Zoetis and Ambic. Colin Mason, SRUC Veterinary Services, discussed the importance of *Mycoplasma bovis* as a mastitis vector. A common clinical sign is that cases do not respond well to treatment. The organism does not have a cell wall so β-lactam antibiotics are ineffective, neither does it synthesise folic acid so sulphonamides are ineffective. The organism is susceptible to antibiotics that interfere with protein or DNA synthesis including tetracyclines, macrolides, lincosamides, florfenicol and fluoroquinolones. The need for accurate diagnosis is evident if high priority critically important antibiotics are to be selected. Sensitivity testing cannot easily be carried out in diagnostic laboratories or veterinary practices. Minimum inhibitory concentration testing is available and the cost justifiable. The speaker highlighted that increasing antibiotic resistance has been indicated. Clinical cases are sporadic but one 350-cow herd with a history of low cell count and low incidence of clinical mastitis had cows with swollen fetlocks and joints, an increase in clinical mastitis and raised cell count. Some cows had leg problems, some mastitis and some both. Twenty-six cows were treated for arthritis with NSAIDs, oxytetracycline and tylosin, with variable results, and four were culled. A compulsory control programme is operating in New Zealand with 201 confirmed properties (Biosec New Zealand). Bulk tank PCR and serology testing offer options for assessing herd status but more than 30 percent of cows in a herd need to be infected for the bulk sample to show positive. There are no vaccines licensed in the UK. Biosecurity of the herd is paramount, with strict controls and quarantine of purchased animals and suspect clinical cases. The milking order of cows from low to high risk should be implemented and hygiene in the milking parlour, with control of fomite spread, is essential. As well as cow-to-cow contact and spread of the organism via the milking machine and directly by handling teats and udders, there is a risk from a shared airspace and transmission nasally. Pasteurisation of milk is effective and it is essential that waste milk from treated animals is not fed to calves.

Ian Ohnstad of The Dairy Group presented a practical awareness of the effective use of the milking machine that can be utilised without involving complicated and expensive equipment. For veterinary surgeons in practice a copy of the paper as reference would be worthwhile. Ian concluded that “it is not sufficient to consider the operation of the milking system based on physical tests without the interaction of the milker and the cows”. It is important to be aware that an evaluation of the milking system, without taking account of the animals and the operator, is likely to lead to a system being described as satisfactory when this is far from the case. The following aspects may prove useful for veterinary investigation.
The presence of palpable mouthpiece rings on more than 20 percent of teats indicates problems with vacuum levels in the liner mouthpiece chamber, with incomplete collapse of the liner around the teat end. There is an association between circulatory impairment and new infection rates. No more than 5 percent of cows should exhibit liner slippage. If an increase is noted then it is important to establish whether it is due to individual cows with poor udder confirmation or a general problem throughout the herd. Once the milking unit is attached the automatic cluster removal (ACR) cord should be fully extended and the milking unit hanging squarely below the udder, with even weight distribution on all four teats. Experience shows that over 10 percent of clusters are poorly presented to the cow. Problems with ACR settings and unit positioning can leave milk in the udder. When hand stripped after milking a quarter should yield less than 100mL of milk.

It was established that cleanliness of the milking environment and the operator is important for the production of high-quality milk. Examination of areas in contact with hands, such as keypads, can highlight hygiene issues. Agitated cows in the collecting yard release adrenaline that can interfere with milk let-down and prolong milking. Calm cows do not generally defecate and if more than 5 percent of cows defecate during milking, change is indicated to allow cows to enter and leave the milking facility in a calm manner. Teats should be clean and dry prior to unit attachment and it can be informative to wipe teats with a moist white towel post-preparation. Dirty cows are three to four times more likely to have higher infection levels. Scoring teat condition on a regular basis includes teat end hyperkeratosis, teat oedema and congestion, teat colour and the presence of palpable teat base rings. A teat condition portfolio chart is available from the National Mastitis Council. Less than 20 percent of teats should have rough or very rough teat ends.

James Breen, University of Nottingham, and Austin Russell, Church Farm Cirencester, discussed the implementation of the AHDB Mastitis Control Plan. Applying the AHDB Dairy Mastitis Pattern Analysis Tool, the herd mastitis pattern was one of environmental infections of dry period origin with lactating period origin infections associated with periods at pasture. Changes on-farm included a review of drying off technique, the availability of loafing and feed space, improving ventilation and managing the aspiration to move away from loose yards to housing dry cows in cubicles. Over two years, the dry period new infection rate has decreased from 21.6 percent to 11.4 percent and the incidence of clinical mastitis from 64 to 47 cases per 100 cows per year. A start has been made to manage antimicrobial use with a reduction from eight to six defined daily doses. The authors of the comprehensive paper conclude that the structured approach to mastitis control provides a platform for future progress. In discussion it was pointed out that no quick fixes were anticipated and that part of the role of the advisor is to manage the expectations of the farmer.

The best poster was voted on by the delegates and awarded to Derek Armstrong on behalf of a technical group involving AHDB, University of Nottingham and QMMS Ltd, outlining the QuarterPRO initiative. The farm team is encouraged to sit down with the farm vet and advisors, once a quarter, to review what has been happening with mastitis on the farm. The Mastitis Pattern Analysis Tool is available to predict the most important udder health issues on-farm in the next quarter. The PRO in the title is to “Predict” the mastitis activity, to “React” and decide what changes to make and who will make them and to “Optimise” udder health on the farm. The aim is for continuous improvement. Implementing QuarterPRO will meet the new requirements of the Red Tractor Dairy Standards.
Tackling equine obesity

We need to change our approach to addressing obesity in our equine patients

Obesity in horses is an escalating problem, especially in leisure and show horses. In view of the clear association with laminitis, the management of obesity is now a high priority in equine practice and veterinary surgeons can play a pivotal role in tackling the complex issues surrounding obesity and the factors that contribute to it. However, the causes and solutions to the obesity problem are complicated.

Obesity is the excess accumulation of body fat; it develops because of abnormal biological regulation of energy balance, and can have multiple complications. As a result, some human medics, as well as some vets, believe that obesity should be considered to be a disease.

The Oxford Dictionary defines disease as “a disorder of structure or function... especially one that produces specific symptoms... and is not simply a direct result of physical injury”.

Human obesity, in which excess body fat has accumulated to such an extent that health may be adversely affected, meets that definition, and the World Health Organization has considered it a disease since 1936. However, this conclusion is controversial. The American Medical Association also classifies obesity in people as a disease, but the NHS does not.

Likewise, in the veterinary world, there are differences of opinion regarding the classification of obesity as a disease. The BSAVA considers obesity to be a disease, stating that “in companion animals, obesity has a significant adverse effect on health and welfare including associations with various additional and often concurrent conditions or diseases, reduced life expectancy, functional impairment and poor quality of life”. On the other hand, the BVA has decided that obesity is not a disease, stating that “while obesity can result from disease and often causes secondary disease processes, formally classifying it as a disease could have unintended negative consequences”.

Regardless of whether obesity itself is a disease or not, it is clear that obesity in horses can be associated with potentially devastating consequences, such as laminitis. As a result, the veterinary profession, including both vets and vet nurses, needs to educate and provide guidance to horse owners about the importance of achieving and maintaining an appropriate body weight in their animals, and how to feed and manage them accordingly.

However, this is easier said than done. Educational programmes are limited in their effectiveness; awareness of an issue is not enough to change people’s behaviour. Campaigns that rely on raising awareness alone often fail to achieve significant change, and this has been observed in the past with both human and veterinary promotions aimed at educating people about obesity.

Behaviour change science is a discipline focused on understanding what makes people tick, using this to develop interventions that change people’s habits, attitudes and behaviours towards a desired goal. In public health, behaviour-based tools have been effectively used to prevent disease and improve people’s health.

BEVA has recently launched a pilot project that takes a behaviour change science approach, based on advice from the Behaviour Insights Team. The objective is to motivate horse owners to look at their own horse’s body condition, and where appropriate to provide advice about what they can do to address any obesity problem. The scheme uses a traffic light colour system of vaccination reminder stickers that vets can place on the front of passports at the time of vaccination. The stickers are designed not only to remind owners as to when the next vaccination is due, but also to inform them about the horse’s body condition. A green sticker indicates a healthy body condition, whereas amber indicates moderate obesity requiring changes to the diet, exercise, management and rugging or clipping. A red sticker indicates that the horse is seriously obese which requires immediate action to reduce the risk of life-threatening complications.

The main objective of these stickers is to initiate a conversation with owners about their horse’s weight/body condition. The stickers have colour-specific QR codes that owners can use to find additional information and advice via their smartphone. Nine equine veterinary practices are currently trialling the scheme, which will run for six months. After this time the success of the scheme will be assessed in terms of what proportion of owners used the QR codes to visit the advice pages, and how effective the vets involved believe that the scheme has been in addressing the problem. If it proves to be a valuable tool in the battle against equine obesity, then it can be rolled out across the country.
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Standing throat surgery
Performing the tie back on the standing patient allows better anatomical recognition and visualisation

The Sussex Equine Hospital situated in Ashington, West Sussex has featured in Veterinary Practice magazine several times. “We try to encourage new vets with experience in specialist fields that offer new surgical inroads for our clients,” said Ed Lyall, MRCVS, one of the directors. Currently there are 26 equine vets based at the practice covering East and West Sussex into Kent, Surrey and Hampshire. The ambulatory vets have specific areas to cover, ensuring client continuity. Surgery plays an important part back at the hospital with dedicated surgical areas. Veterinary Practice magazine was there to meet Luis Rubio-Martinez who hails from Spain and is an RCVS, American and European Specialist in Equine Surgery with special interest in standing throat surgery. Luis is also board-certified by the American College of Veterinary Sports Medicine and Rehabilitation (equine).

First – a little about Luis’s background. He graduated from the University of Zaragoza in Spain. Following this he travelled a great deal gaining experience in Hannover (Germany), Mexico and Argentina and practised in private practice in Spain before going to the University of Madrid where he completed his PhD. More travels took Luis to the University of Guelph in Canada in 2005 where he trained as an equine surgeon to 2008. Luis then stayed as a faculty member in equine surgery at the University of Guelph. This was followed by faculty positions at the University of Pretoria (South Africa) for three years when among Thoroughbreds, sports horses, endurance and pleasure horses, he had the privilege of working on some more exotic animals such as elephants, antelopes and rhinos. In 2013, Luis moved to the University of Liverpool where he was senior lecturer in equine orthopaedics and surgery until November 2017 when he came to the Sussex Equine Hospital in Ashington.

“It seems a lot of travel, but I felt it was an ideal way to gain experience and see how veterinary medicine was performed in different parts of the world,” Luis said.

Luis felt very excited to join a practice that was investing so much into its future and of those who worked there, and that is what appealed to him to come down to Sussex Equine Hospital. The directors likewise wanted a team that showed interest in the future of the practice especially in the development of new equine surgical procedures; so, it was an ideal move for him.

“The bulk of my work is hospital related and I am a member of the surgical team. I go out from time to time, but that is to offer patient aftercare support if required. I am also involved in lameness investigations and advanced imaging including nuclear scintigraphy, MRI and the development of the new standing CT at the hospital.”

Luis covers all aspects of equine surgery and has a special interest in upper wind surgery, having treated sports horses and racehorses around the world. One of the procedures is “standing throat surgery” which is a relatively new procedure that we will be discussing in this feature.

Procedures
Over the last few years, surgery of the upper airway in horses has evolved rapidly. The surgery “tie back” has been performed for many years on horses with recurrent laryngeal nerve paralysis. However, it was only in 2015 when the tie back was first reported being performed on the standing horse. At Sussex Equine Hospital they perform tie backs on the standing patient as default, unless in the seldom encountered excitable patients, in which the procedure under general anaesthesia is more suitable. Performing the tie back on the standing patient allows better anatomical recognition and visualisation, which facilitates the completion of the procedure with a more controlled assessment of the degree of arytenoid abduction achieved.

To illustrate this, Luis shared details and pictures of a case that underwent standing tie back by the team at the Sussex Equine Hospital.

A six-year-old Warmblood gelding was presented to the hospital for loud audible inspiratory noise and marked exercise intolerance and fatigue after just a few furlongs trotting. Exercise endoscopy of his upper airway revealed that the horse suffered from left-sided grade 4 (total paralysis) recurrent laryngeal neuropathy and marked bilateral vocal fold collapse (Figure 1). Ultrasound examination of the larynx showed marked atrophy of the left dorsal and lateral cricoarytenoid muscles but also a dysplastic larynx with the left thyroid blade extending more dorsally than the muscular process of the arytenoid cartilage, which was also misshapen (Figure 2). The treatment of choice for these animals is usually arytenoidectomy (removal of the abnormal left arytenoid cartilage) as these abnormal arytenes are often not suitable for tie back. “However, this time we decided to assess whether the less invasive approach of a tie back would be suitable on this horse,” said Luis.

The horse underwent standing throat surgery by Luis and his team at Sussex Equine Hospital, including laser ventriculocorpectomy and left-sided tie back (Figure 3). “During the procedure it was noted that the muscular process was quite underdeveloped and was very difficult to reach.
However, we managed to place two prosthetic sutures tying the left arytenoid cartilage back to the cricoid cartilage.* The surgeons felt very satisfied with the procedure and the horse recovered very well from surgery.

Five months after surgery, the horse had returned to ridden activity with a much-improved exercise capacity and no noise production. Repeat overground endoscopy was performed at the time and revealed the larynx was stable in an open or abducted position (Figure 4). The owner was very satisfied with the result.

Tie back has been the treatment of choice for many roaring horses for decades. This surgery fixes the larynx of the horse in an open state improving the airflow. Although this is an appropriate treatment for many horses, laryngeal reinnervation or nerve grafting is a superior treatment. This technique involves transposition of healthy nerves (most commonly first and second cervical and/or spinal accessory nerves) that are implanted into the dorsal cricoarytenoid muscle responsible for opening the airway. After reinnervation this affected muscle can regain its functionality with roaring horses having a good chance to recover their ability to open the airway.

Fabrice Rossignol from Equine Clinique Grosbois (France) is a world-leading equine surgeon who was fundamental in the development of the laryngeal reinnervation technique. “The Sussex Equine Hospital is privileged to work closely with Fabrice Rossignol, who has helped us develop and offer top-quality service including these advanced procedures.” Fabrice has visited the hospital several times and in collaboration with him eight laryngeal reinnervations have been performed in the last year. All of these but one were performed on the standing horse. The recovery of those horses has been excellent, and they have all gone back to or carried on with their training and athletic career (Figure 5).

**Conclusion**

As you can see from the above featured case histories, standing surgery and new procedures are now taking over from the conventional tie back under general anaesthesia. The nerve graft procedure is now becoming a preferred procedure for many sport horses and selected racehorses.

How does Luis see his future? He loves what he does and where he now works and has moved to Chichester with his wife, Eva Rioja, who is a board specialist in veterinary anaesthesia and works in a practice based in Havant in Hampshire. Both Eva and Luis look after their two children, aged five and three. It works out well for them both. “I really enjoy the equine hospital; we make a great team and help each other. The directors are very supportive too,” added Luis.

Rob van Pelt, MRCVS, a senior partner in the practice said, “Avoiding the need for general anaesthetic is a good thing for the safety of both the horse and the personnel involved. With advances in veterinary surgery and the use of local anaesthetics we are doing more surgery standing. Sometimes it is better as the anatomy is in a more natural position. With some procedures this means that there are less complications.”

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* Figure 1: This snapshot endoscopic image of the larynx during ridden exercise shows left-sided grade 4 (total paralysis) recurrent laryngeal neuropathy and marked bilateral vocal fold collapse.

** Figure 2: Upon ultrasound examination of the larynx, the difference between right and left sides was apparent, with marked muscle atrophy of the lateral cricoarytenoid muscle and abnormally elongated left thyroid blade covering the misshapen, underdeveloped left muscular process of the arytenoid cartilage.

** Figure 3: The Sussex Equine Hospital team regularly performs standing tie back surgery.

** Figure 4: Five-month post-operative repeat endoscopic image of the larynx during ridden exercise showed very good abduction of both arytenoid cartilages. A comparison of the preoperative (A) and 8-month post-operative (B) endoscopic images of the larynx of a 5-year-old horse suffering from left-sided recurrent nerve paralysis highlights the excellent degree of abduction on the repeat endoscopy, showing the regained muscle functionality of the larynx in this horse.

** Figure 5A & 5B: The recovery of those horses has been excellent, and they have all gone back to or carried on with their training and athletic career.
Dealing with HMRC penalties

The HMRC has regimes in place that are backed by penalties for those who do not comply with their obligations

Taxes are an evil necessity, and whether the taxpayer is a person or a business, penalties are imposed for a number of reasons – simply missing a deadline by a day, or for situations where taxpayers have deliberately sought to evade tax due, are classic causes.

While HMRC issues penalties for good reason, it also appears that in January 2019, a technical glitch at HMRC meant that some taxpayers received inaccurate payment reminders that led to the wrong amounts of tax being paid and a fine being levied as a result.

It's worth pointing out that UK tax law is complex and is growing. In 1997, tax law stood at 5,000 pages, by 2009 it was 11,520 pages, but by 2016, it had grown to around 21,000 pages. With some 10 million words, it's 12.5 times the number in the Bible and 12 times that in the complete works of Shakespeare. In comparison, Hong Kong's tax law is 150,000 words over just 276 pages.

How HMRC works

It makes sense to understand how HMRC works, when penalties can be levied and what should be done if a penalty is received.

The first point to note is that the rules apply to numerous taxes including income tax, corporation tax, VAT, PAYE, national insurance contributions, capital gains tax and others. The rules also allow for different penalties according to the tax. VAT, for example, allows for a “wrongdoing penalty” where someone issues an invoice that includes VAT that they are not entitled to charge, for instance.

The problem for most is that their excuses just don’t carry any water. HMRC regularly publishes the most popular excuses it receives which, in January 2019, included “my mother-in-law is a witch and put a curse on me”, “I’m too short to reach the post box”, “my first maid left, my second maid stole from me, and my third maid was very slow to learn” and “my boiler had broken and my fingers were too cold to type”.

Planning to fail

Tax compliance failures are generally quite easy to list and as far as HMRC is concerned, include late filing of tax returns, failure to submit a tax return, late payment of tax, failure to notify HMRC of a tax liability (such as a tax assessment that is too low, a new source of income or a business that should be VAT registered but isn’t) and a failure to provide information and documents.

Of course, the actual penalty will depend on how convincing an excuse is and whether the taxpayer can show that “reasonable care” had been taken in complying with their obligations. This will be an uphill task for a penalty-hit taxpayer.

Errors relating to a tax return

If errors arise with a tax return, HMRC will decide whether to impose a penalty but they tend to follow on automatically precisely because the error was made. However, the penalty will be graded according to the degree of blame that lies with the taxpayer. HMRC uses three categories: “careless” – which may involve a maximum penalty of 30 percent of the missing tax; “deliberate but not concealed” – which can mean a maximum penalty of 70 percent, or “deliberate and concealed” – which can lead to a penalty of 100 percent of the missing tax or more if the error is a serious matter, say fraud or offshore tax matters.

Penalties can be suspended by HMRC, in total or in part, for up to two years. This doesn’t happen often and isn’t offered; a taxpayer has to request it.

Where deliberate errors have been found, penalties cannot be suspended. What happens next depends on whether the error was disclosed by the taxpayer to HMRC and whether the disclosure was “prompted” (by, say, a visit) or “unprompted” (the taxpayer’s own accord). Naturally, “unprompted” may lead to leniency.

Most people recognise their obligations and do their best to comply. In circumstances when they have taken reasonable care and have a reasonable excuse, HMRC often don’t impose penalties. But if a penalty is levied it’ll be up to the taxpayer to prove that a reasonable excuse for the failure existed.

It’s interesting to note that reasonable care and reasonable excuse are not defined by HMRC. This means the interpretation by a tax officer will be very subjective and no doubt will differ from that of the taxpayer.

Of course, there will be times when circumstances beyond a taxpayer’s control cause an event that leads to a penalty. Again, demonstrating a reasonable excuse for the
failure may lead to the penalty being waived in relation to late payment of tax, late filing of tax returns, a failure to notify liability or a failure to comply with an HMRC information notice.

**Reasonable or not?**

So, what is a reasonable excuse? Guidance from HMRC allows for a number of these, including a taxpayer’s close relative or domestic partner passing away around the time they should have filed their return or paid tax; a serious illness where the taxpayer or a close relative falls seriously ill around the time the tax should have been paid; unforeseen events which can include delays due to industrial action or returns; or payments being lost in the post.

As to what might not, or will very rarely, be considered a reasonable excuse, HMRC says these include a deliberate failure to submit a tax return on time as this act is controlled by the taxpayer; insufficient funds – but not if the shortage could not have been reasonably foreseen by the taxpayer, or the lack of funds is down to something outside of their control or reliance on someone else unless it can be shown that the taxpayer took reasonable care to avoid the compliance failure – hiring a professional accountant as opposed to a family friend for example.

It is also worth noting that HMRC has the power, in certain circumstances, to provide a special reduction to a penalty where it can be removed entirely. These situations are considered on a case-by-case basis, and HMRC offers no real definition of what constitutes special circumstances.

Another option open to HMRC is to “stay” a penalty; this effectively delays enforcement of a penalty. But in exchange, the taxpayer will probably have to agree some form of compromise with HMRC.

**The tax tribunal**

Just because HMRC has levied a penalty doesn’t mean that a taxpayer must accept it. The system allows taxpayers a right to appeal a penalty to the tax tribunal, an independent body which will consider the arguments of both sides – objectively.

It’s at this point that a taxpayer will have the opportunity to show that they took reasonable care and can show a reasonable excuse or special circumstances. But considering that there are no real definitions of these terms, this won’t be easy.

**The harsh reality**

Quite simply, any taxpayer who is handed a penalty levied by HMRC will face a steep uphill climb to prove that they had a reasonable excuse when the failure occurred. However, even if HMRC finds against the taxpayer, they have the right to challenge the decision at a tribunal.
Am I responsible for repairs to my veterinary practice before I sell it?

Between landlord and tenants, it is not always clear who is responsible for repairs

An area which is often overlooked, but can become very costly when you come to sell your business, is property repair. There is a misconception among many practice owners that the landlord is responsible for maintenance and repair so long as the tenant continues to pay rent. The purpose of this article is to clarify any misconceptions and provide an informative insight into the expectation of buyers when it comes to repair.

The first place to look when trying to assess your repairing obligations is the lease under which you occupy your properties, in particular the repairing clause. The two main types of lease which practice owners have are either a full repairing and insuring lease or a repairing and insuring lease subject to a photographic schedule of condition.

Full repairing and insuring lease

This type of lease is known as an FRI lease and is favoured by many landlords. The burden of repair, namely the maintenance of the property including its structure, interior and exterior, will all be the sole responsibility of the tenant throughout the term. At the end of the term the property must be returned to its original condition by the tenant including the removal of any alterations and in good and substantial repair and condition, even if this means returning the property in a better state of repair than it was in when you took on the property.

In the context of a sale the purchaser will commonly require either an amount to be held back in respect of dilapidations (amount required to put property into good and substantial repair and condition from the completion monies) or repairs to be undertaken before the sale is finalised, as the purchaser would potentially be required to carry out repairs required as a result of changes caused by the seller.

Lease qualified by a photographic schedule of condition

This form of lease is popular with tenants. The tenant would have a surveyor inspect and photograph the interior and exterior of the property and have them produce a written and photographic schedule which would be annexed to the completed lease. The repair clause in the lease would then be qualified, meaning that the tenant would want to keep the property in good repair and condition but would not need to put it in a better state of repair and condition than evidenced in the schedule.

The schedule serves as a visual reference point in the event of a dispute between the parties in the future. The purchaser who would be taking an assignment of this type of lease would undertake a survey of their own and use the schedule as a reference point to determine what sum should be held back from completion monies or what works should be undertaken before completion.

One thing for the sellers to bear in mind is that although a photographic schedule of condition does not oblige the tenant to improve the property at the end of the term, it does not put any obligations on the landlord to improve it either. If there are items of disrepair it would be to the detriment of the owner who is trying to run or sell their business if these repairs were not carried out.

Schedule of dilapidations

At the end of the term the landlord may instruct a surveyor to prepare what is known as a schedule of dilapidations which estimates the costs involved in putting the property into the condition required by a lease.

The landlord may accept a sum of money in lieu of the repairs being undertaken; however, it is not unusual for such costs to be unrealistic.

Therefore, it would be advisable for the seller to always have an independent survey carried out to verify the sums demanded by the landlord and if required to negotiate with the landlord’s surveyor.

Conclusion

The key things to take away from this article are to keep on top of repair works and to fully appreciate the significance of your repairing covenant under the lease. This will result in a smoother and quicker process if you ever decided to sell your practice.
Top tips for your practice website

Your website is an important tool to get your message to pet owners so it’s important that it gives a good first impression

The internet is full of websites – in fact, at last count there were nearly 2 billion of them. That’s a truly vast number, but how many of those billions of websites are even worth looking at? When it comes to your own practice website, it’s important to know what makes a good website in the first place and how to ensure that you’ve created your site to be the best possible representation of your practice brand.

To start with, some basic features of a quality website are:

- Clean, modern design
- Easy to navigate
- Fast loading speed
- Well branded with your logo and colours
- ... and that it motivates the visitor to do business with you

Keep it simple

To ensure that your practice has a great website, start with a design that has a simple user-interface, meaning that visitors can easily find what they are looking for. The fact is that most visitors to your website will be people looking for your phone number and address, so information such as opening hours, driving directions and contact details should be extremely easy for visitors to find.

People want a quick solution to their problem. Make it easy for them and they will reward you with their custom.

Avoid clutter

People are turned off by too much text and visual clutter, so it’s important to keep your homepage simple; resist the urge to cram everything in. If you feel you really must tell people more detail about what you offer, then use the menu section to link to separate pages with extra content.

Another tip to hook new visitors in right away is to ensure that you grab their attention by placing your brand message front and centre. Give your landing page a large title heading, using no more than one or two sentences to communicate your brand values or define how you solve a clear or unique problem for your practice customers.

Communicate your brand

Whilst undertaking the design phase of your website, use the opportunity to ensure that you create a design that embodies your brand identity, focusing on such things as a memorable or unique colour scheme, photography and modern fonts to bring across your brand voice.

At the same time, whilst you might think that your expensive operation theatre toys are really exciting, your customers probably either don’t agree or don’t want to know about things that sound painful or expensive – so don’t feel you need to display, or talk about, lots and lots of technical and medical things (unless you’re a referral clinic).

Instead, rather than talking about yourself, talk clearly and concisely about what problems you will fix for your customers and their pets.

Appearance is everything

The other part of the branding message that you can directly influence is the quality of images that you use for your website. Professional photos immediately define the brand identity you are trying to convey. The veterinary business is a people business and people want to see and feel that they can rely upon the team that they are entrusting their beloved family member to.

Your photos should feature smiling staff fussing over animals in clean, brightly lit rooms. Convey an image of warmth and friendliness that customers can immediately feel upon opening your website; in the blink of an eye they can decide if they like you or not, so ensure first impressions count.

Build trust

Client testimonials are another guaranteed way to build trust in potential customers. If you can, display them front and centre on the homepage for all your site visitors to see. You can also encourage people to give you testimonials by adding a review system to your website or using a plugin that displays your Google or Facebook reviews.

As a vet, showing that your team is up to date with all the latest web design standards and technologies builds trust. Your entire website is a visual representation of your brand and your business – if customers see a slick, professionally designed modern website, by inference they will also judge your veterinary practice to be slick, professional and modern and therefore a business to be trusted with the care of their pets.

MARKETING

WILL STIRLING

Will Stirling is a freelance marketing consultant who has worked in small animal practice marketing for over a decade, consulting on marketing strategy. He now spends his time helping independent veterinary clinics to grow and thrive.
The RCVS Disciplinary Committee (DC) is considering lowering the standard of proof needed to convict a vet of misconduct. It currently stands that the committee must have something proved to a criminal court standard "so as to be sure". They are considering reducing the burden of proof for your accuser to just "the balance of probabilities". A past president of the BVA has also been quoted as saying she would support "moving away from the criminal standard" of proof. I don’t know about you, dear reader, but if someone is going to take away my career (and therefore my house and means of supporting my family) then, well, to be frank, they need "to be sure", not just think well, you know what, on balance, they might have done it. And then have your life ruined on that basis.

I am indebted to Richard Stephenson, ex-RCVS council and DC member, for corresponding with me about this subject and giving me further information.

One reason the RCVS has given is that moving to a "balance of probabilities" standard of proof would increase public trust in the profession. But as the RCVS has recently published a survey that showed a 94 percent trust level in vets this hardly seems a valid argument. Especially as this is higher than some professions whose regulators do use this standard, such as accountants and GPs. One thing that sets us apart from other professions is that our patients, who we have a primary responsibility to do the right thing for, are not going to be the ones making the complaint. And their interests may, and often do, vary from their owners’. GPs have seen a big increase in disciplinary cases, and subsequent appeals, after their regulator made this change in proof. There has also been shown to be a negative impact on patient safety in human healthcare by changing the standard of proof, no doubt from increased defensive medical practice.

For vets, a DC case costs overall around £50,000. An increase in cases following such a change will hugely increase costs and therefore RCVS expenses and fees. Besides that, very few cases that are not upheld against a vet are due to the evidence or proof not being found to be sure. The RCVS seem to be looking for a problem that is not there.

In tandem with this, the RCVS has discussed bringing in a wider range of sanctions against vets for disciplinary matters. This in itself is not a bad thing; at the moment there is not much other than being struck off and a reprimand. In the eyes of the public, a reprimand from the RCVS would not seem much of a punishment, but for a practising vet it would be devastating, as would the ordeal of the disciplinary process. So, it is not right to couple the two together; you cannot be found to be probably guilty for anything – the DC must be sure. The balance of probabilities is not a sliding scale, where you need to be more sure for a more serious case than for a less serious one.

The effect of a disciplinary case has been well studied in health workers, with approximately a quarter developing physical symptoms and more than a quarter being signed off work for a month or more. For vets with little or no paid sick leave, this poses a real problem – either keep working or lose your income.

We can also quote Lady Hale, she of the famous spider brooch who delivered the verdict on the prorogation of parliament, that in respect of civil proceedings where a sanction on the respondent may be the outcome “there are some proceedings, though civil in form, whose nature is such that it is appropriate to apply the criminal standard of proof”.

After floating this idea, the RCVS president wrote, in January 2020, that the RCVS has no “imminent plans” to make this change. It is under review by the college and will have an impact on vets if implicated. If it happens and we follow what happened to human healthcare workers we will see more cases going through the disciplinary process. We will face our livelihoods being stripped from us on the basis of what probably happened. Not what the DC can be sure happened. It is very difficult to defend yourself against a balance of probabilities. I would urge all of you reading this to contact the RCVS and make your concerns known.
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