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THE GUIDE
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WELL-BEING

Why can’t we just be KIND?

Everyone is talking about mental health problems among veterinary professionals. But it’s not just clients and tough cases and money problems. It’s us hurting each other, too.

By Cynthia Cohen, DVM

Almost daily, I open up a veterinary journal, Facebook page, or blog and read about the increasing suicide rate among veterinarians. It hasn’t always been like this. Ours used to be a profession likened to that of a pediatrician, and most of us were happy in our chosen field.

I don’t need to tell you about the profession’s high suicide rate—you read about it, too. You’ve seen it. Perhaps you’ve lost a coworker or friend. We all knew, in some way, Sophia Yin, DVM, MS—a successful, well-loved, well-respected veterinarian who gave so much of herself to her patients, clients, colleagues, and the profession-at-large. She died by suicide in 2014.

The pressures we face are real:
- Unreasonable expectations and demands from clients
- Huge student loans (I graduated 17 years ago and am still paying off my 30-year loan.)
- Comments from clients that we’re “only in it for the money”
- Our own perfectionism
- The daily pull of balancing home and work life

However, I chose to write this article to shine a light on how we treat each other. Veterinary medicine has become a sad documentary version of the comedy film Mean Girls, which shows the nastiness of high school society.

Turns out, it looks a lot like our workplace sometimes. Match this up with our own internal imposter syndrome—where we never feel good enough as graduates and, years later, maybe never feel fully confident in our role of veterinarian—and it’s no wonder we’re suffering silently.

Are we being kind to one another, vet to vet? Are we being kind to others at work: technicians, receptionists, other team members? My answer is, we’re not. In the midst of our profession’s mental health crisis, we’re making it worse by being unkind to one another.

‘I told him under no circumstances was he ever to throw me under the bus again...’

Here’s an example. For the better part of a year, I’d been silently experiencing a colleague passively putting down both me and my practice of veterinary medicine. During team meetings, he would counter my suggestions or opinions, not with alternative suggestions, but in ways that covertly conveyed that he thought my thinking was wrong. Weekly, he would say something to me that made me feel that he questioned my abilities as a veterinarian. I have a large following of clients who request me, and I love the clients and patients I work with. If clients give me positive feedback, why would I allow this colleague to get under my skin and make me feel like a lousy practitioner? Probably because almost 20 years after starting in the field, I still feel like an imposter.
One day, another veterinarian asked this colleague and me for our opinions on a radiograph of her patient. This colleague and I stood looking at the radiographs as the female veterinarian shared details about her case. He and I gave suggestions about our thoughts and the possibilities of what could be wrong with the patient. After my suggestion to look for “X,” the male colleague turned to me and said, “There’s no way it could be that!” That angered me. I quietly left the room to compose myself and think about how I needed to handle this. I decided I needed to use my anger to fuel a long-overdue conversation.

I called him into an exam room and closed the door. I told him that under no circumstances was he ever to throw me under the bus again or to treat me as if my way of thinking, my judgment, or my decisions were less than his. I let him know I was tired of him treating me like an idiot and suggesting that I don’t know what I’m doing. (Just so you know, this is not typical behavior for me. I’d never done anything like this before, but having experienced negativity and judgment from him for so long, I felt compelled to call him on it.)

He was shocked that I’d exploded at him and was quiet and apologetic. Not once did he deny or ask what I was talking about. He just stood there, eyes locked with mine, and apologized over and over. This man is not a bully. He’s actually got a good heart and a fun personality. People often say that no one can make you feel a particular way, no one can make you feel angry or sad or mad, that you make a decision to feel a certain way. I’m not sure I believe that anymore. I think the way people say things, the context in which they’re said, the tone of voice, and intention behind a comment have much to do with how the receiver receives it.

My bottom line here is that our profession is getting a lot of press on the pressures we face. Some of these pressures are intrinsic to the nature of our profession, and some are extrinsic. Being nice to one another, being supportive, listening, and caring are supposed to be what we’re here to do with our patients and clients. Why can’t we do that with each other?

**It’s not just me**

Recently, I had dinner with a former mentee in her third year of vet school. She had completed an externship and was telling me about her most recent experience with a particular practice owner. One of her biggest frustrations from that externship was witnessing how poorly that veterinarian talked about his associates. He was nasty in his judgment of their practice of medicine and of them as people. I was horrified to hear of her experience.

A veterinary receptionist shared with me that the reason she left her former hospital was that the majority of the staff were backstabbing and 2-faced. She worked there for 4 years and was treated terribly. She shared her concerns with her manager, who did nothing. Where she worked, the doctors thought they were better than the technicians, who thought they were better than the receptionists. I’m astounded she stayed as long as she did.

**Here’s my advice**

A friend of mine told me recently that in her day-to-day interactions with people—family, friends, coworkers—she asks herself, “Is what I’m going to say necessary, loving, kind, and productive? Is there a way I can say something constructive without being hurtful?” Yes, I realize that right there, I’ve lost some of you. I’m not naive enough to think that some of you aren’t reading this, saying to yourselves, “Come on, sometimes people need to hear the cold, hard, honest truth in a blunt way.” I get that. My reason for writing this article is to ask a hard question: “Are we being mean, nasty, cruel, judgmental, or impatient with our coworkers?” If you can answer yes, I applaud you for your honesty. If you answered no, I suggest you get a little more honest with yourself.

I would ask—no, beg—of you to do something different. Challenge yourself to stop being mean, negative, and competitive with your colleagues. Start showing you care about the people you work with. Be kind to them. We’re all facing the same frustrations with this profession—don’t add to someone else’s pain. Just don’t.

*Cynthia Cohen, DVM, works as an associate veterinarian in Massachusetts. She is also a nationally certified sign language interpreter.*
Abdominal radiography tips

Radiography is an integral diagnostic tool in companion animal practice. Here are brief guidelines for obtaining the most useful images of the abdomen in dogs and cats.

By Joseph Snock, DVM

Radiography can help evaluate the size, shape, and position of abdominal organs and is crucial to the diagnosis of a host of conditions involving the intestines, bladder, and other abdominal organs in companion animals. Acquisition of diagnostic images using the appropriate technique is crucial for accurate patient evaluation. Although a full discussion of the nuances of obtaining abdominal radiographs is beyond the scope of this article, following are tips for obtaining excellent images while promoting patient comfort.

Abdominal radiographic views

Although a single lateral and a single ventrodorsal (VD) projection will allow for diagnosis of many intra-abdominal conditions, it is highly recommended that both right and left lateral images are obtained in addition to a VD projection. Besides allowing for a broader evaluation of intra-abdominal contents, repositioning the patient to obtain the contralateral view allows for gas—an important contrast medium—to be redistributed for more thorough radiographic evaluation.
In most cases, a dorsoventral projection is not advised, especially as a replacement for the VD projection, because positioning for dorsoventral views can cause bunching of the abdominal contents, which can hinder appropriate evaluation and proper diagnosis. It is important to ensure that all abdominal contents are included in the fields of view. Failure to do so could lead to a misdiagnosis.

In most cases, a dorsoventral projection is not advised, especially as a replacement for the VD projection, because positioning for dorsoventral views can cause bunching of the abdominal contents.

Although many digital radiology systems allow for postcapture labeling of images, it is best to place markers into the images in real time as the radiographs are being obtained.

**Patient positioning**
Proper limb positioning will help ensure that the contents to be imaged are not obscured. Troughs and other cushions designed for use with imaging systems can be helpful to position patients properly and relieve discomfort during the image capturing process. This is particularly true for obtaining VD images, because positioning without a trough can place pressure on the spine, causing patient discomfort.

In most cases, all of the abdominal contents for review can be imaged with single VD, right lateral, and left lateral views. However, in some larger patients, obtaining additional films (eg, 2, right lateral images) may be necessary to fully image all of the abdominal contents. It is important to ensure that additional images are continuous with the images made prior and do not skip or miss any abdominal contents.

**Lateral projections**
With the patient in a lateral recumbent position, extend the thoracic limbs cranially and the pelvic limbs caudally. Take care when doing so not to promote patient discomfort or injury. Do not pull the pelvic limbs so caudally that they are almost parallel with the spine, because this could promote bunching of abdominal contents and potentially hinder evaluation.

To obtain a lateral projection, make sure the field of view extends about 1 inch cranial to the level of the diaphragm and about 1 inch caudal to the level of the coxofemoral joints. Dorsally collimate the field of view to just above the spinal column, so it is included in the field of view, and ventrally collimate the field of view to just outside the level of the body wall. In most cases, this should allow for all important abdominal contents to be included.

**Ventrodorsal projection**
The borders for VD abdominal radiographs are quite similar to those for lateral projections: Extend the cranial field of view about 1 inch cranial to the level of the diaphragm and the caudal border about 1 inch caudal to the coxofemoral joints. The lateral borders should be collimated so they are just beyond the level of the patient’s body wall on both sides, including them in the field of view.

When positioning the patient for a VD projection, do not pull the limbs perpendicular with the spine. This can increase abdominal tension, cause bunching of abdominal contents, and result in patient discomfort and possibly injury. Instead, rotate the thoracic and pelvic limbs laterally so they are not obscuring any abdominal contents, and provide only gentle retraction cranially and caudally for the thoracic and pelvic limbs, respectively.

**Reducing patient stress**
The use of anxiolytics and/or chemical sedatives can help relieve patient anxiety and promote less patient resistance to imaging, ultimately allowing for more diagnostic films to be obtained. All medications and chemical methods for patient management should be made after thorough patient evaluation by a veterinarian and only on the order and guidance of a veterinarian because protocols will be specific to each patient. A discussion of medical management options, including their role, associated risks, and possible adverse effects, should be discussed with the client before use.

**Conclusion**
Obtaining accurate abdominal radiographs allows for the diagnosis of myriad medical conditions and improves the quality of patient care. All staff members working with patients should be familiar with imaging guidelines, such as those discussed here.

Joseph Snock, DVM, is an associate veterinarian at Mount Laurel Animal Hospital in Mount Laurel, New Jersey. He became a veterinarian to combine his love for his pets with his interest in science. Dr Snock is a member of the New Jersey Veterinary Medical Association and the American Veterinary Medical Association. His professional interests include emergency medicine and surgery.

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NOVEMBER 12-14, 2020
If drug-resistant pyoderma scares you, don’t panic. Plan.

Advice from a veterinary dermatologist for treating drug-resistant skin infections in your patients while protecting their owners and your staff from possible exposure.

By Karen Todd-Jenkins, VMD

Reports about methicillin-resistant Staphylococcus aureus (MRSA) and methicillin-resistant Staphylococcus pseudintermedius (MRSP) have been raising eyebrows and anxiety levels for years. Drug-resistant Staphylococcus infections aren’t just affecting dogs and cats. Horses, cattle, pigs, and even exotic species also get them. According to Alison Diesel, DVM, DACVD, clinical associate professor of dermatology at Texas A&M University College of Veterinary Medicine and Biological Sciences, these infections aren’t going away anytime soon. Results from research show they are on the rise.

Initial reports dealt with drug-resistant S aureus infections in humans. Yet Diesel warned, “We’ve been seeing an increasing number of these drug-resistant infections in our companion animals as well. These include methicillin-resistant S aureus, S pseudintermedius, Staphylococcus schleiferi, and other species.” During a session at the AVMA Virtual Convention in August, Diesel highlighted the need for clinicians to understand how to diagnose, manage, and help prevent these infections.

According to Diesel, there are several possible reasons for the rising number of cases, including more frequent culture testing and increased (or inappropriate)...
exposure to antibiotics. Diesel remarked that the strains of methicillin-resistant microbes being identified in humans are being detected in veterinary patients as well, so the increasing trend of MRSA in humans may be a factor in the rising numbers of veterinary cases of MRSP and MRSA.

The workup and initial treatment
Identifying drug-resistant pyoderma begins with the workup. However, Diesel cautioned that physical exam findings cannot tell a clinician whether an infection is drug-resistant. It is incorrect to assume that a more "virulent-looking" dermatitis is more likely to be caused by a drug-resistant pathogen, she said.

Staphylococcal bacteria are part of the normal skin and mucosal microflora in dogs, cats, and large animals. The most important skin pathogen in dogs is *S pseudintermedius*. However, other *Staphylococcus* species, such as coagulase-negative *S schleiferi* and *S aureus* (which is more traditionally a pathogen in humans), can also play a role in canine skin infections. Besides staphylococcal species, other microbes can have a role in canine and feline skin infections.

The diagnostic steps that focus on identifying the species of bacteria involved in the infection should not be dismissed. Papules, pustules, crusts, and epidermal collarettes are commonly featured in canine pyoderma. However, pustules are less common in cats. Papules and crusts may be identified in cats, but increased dander, exfoliative dermatitis, and scaling are more likely. Eosinophilic plaques and indolent ulcers can also be featured in feline pyoderma. Diesel reminded attendees that most veterinarians use glucocorticoids to treat eosinophilic plaques, granulomas, and indolent ulcers in cats, but these lesions may respond to antibiotics, too. "Consider treating with antimicrobials first, prior to reaching for those steroid medications," she advised.

In addition to selecting an appropriate antibiotic for pyoderma, the dose and duration of treatment can both have important implications for treatment success. For calculating an antibiotic dosage to treat skin infections, Diesel advised, "Go big or go home. If you aim for the higher end of the dose range, you reduce the risk of developing resistance down the line." This is important because some dogs that develop drug-resistant infections have previously received antibiotics near the low end of the dose range. Underdosing can increase the risk for developing a drug-resistant infection later.

Diesel also recommended treating superficial bacterial skin infections for 3 to 4 weeks initially. Deep bacterial pyoderma should be treated for a minimum of 6 to 8 weeks. "Ten to 14 days of antibiotics (for superficial pyoderma) is generally insufficient," she said. "You kill off the majority of the organisms, but some remain, so the infection comes right back."

When to culture?
Bacterial culture and susceptibility testing can be costly, so it’s understandable that some pet owners and veterinarians delay this step. However, postponing it too long can lead to more serious problems in the future. Diesel recommended culture testing when empirical therapy doesn’t fix the problem. This includes patients presenting with lesions that don’t resolve, new lesions that appear during therapy, or lesions that recur after antibiotics are discontinued. Deep pyoderma should be cultured earlier in the process. The presence of nodules, draining tracts on the skin, and/or identifying rod-shaped bacteria on cytology are all good reasons for culture testing, Diesel said. “However, rods on a skin cytology tell me that I’m not dealing with a Staph infection,” she added. "Identifying what that organism is will help guide my treatment recommendations for that patient."

Ear infections warrant different considerations when it comes to culturing. Diesel cultures ears if a middle ear infection is suspected, in which case she obtains a culture sample from the tympanic bulla. In general, some veterinarians don’t culture pyoderma until 2, 3, or maybe even more different antibiotics have been tried, yet the infection is still unresolved. She noted that this sequential use of stronger and stronger antibiotics can lead to drug resistance. Instead, she urged attendees to culture earlier in the process. "If you put a dog on cephalixin, see the pet again in 3 weeks. If the infection is still unresolved, that’s the time to culture."

She also recommended culturing an intact pustule or nonruptured crust to obtain a good, representative sample. For deep infections, find an intact nodule and submit a small tissue/biopsy sample for culture testing.

Interpreting the laboratory’s culture report isn’t always straightforward, either. If the culture report identifies "coagulase-positive" *Staphylococcus*, that still doesn’t confirm whether the organism is *S aureus* or *S pseudintermedius*. In that case, Diesel suggested, before you decide what to do, call the lab to ask if they can identify the species further. Clinicians may also have to ask the lab to test separately for susceptibility to specific antimicrobials, as some antibiotics are not included in standard susceptibility panels.
What’s next?
You’ve cultured a pustule and received a laboratory report that confirms a methicillin-resistant infection, so what’s the next step? A methicillin-resistant microbe will be resistant to beta-lactam antibiotics, notably penicillins, cephalosporins, and carbapenems. Not only are veterinarians seeing methicillin-resistant infections, they are also seeing multidrug-resistant infections that are resistant to beta-lactam antibiotics and other drug classes like fluoroquinolones. Most of the “reliable” oral antibiotics veterinarians normally choose empirically for pyoderma won’t work for these infections.

Fortunately, topical therapies fill that void. Diesel noted that her practice relies much more on topical therapy for these resistant infections. “For superficial Staph bacterial folliculitis, you can treat them 100% with topical therapy,” she advised. Diesel recommended bathing the pet every 1 to 2 days, or at least 3 times per week. Leave-on sprays, conditioners, or mousses may extend the time between baths, due to their residual effects. (Some of these leave-on products can also be used in between baths.) Chlorhexidine, benzoyl peroxide, Tris-EDTA, and sodium hypochlorite are topical ingredients that may be effective. Mupirocin, silver sulfadiazine, and even some natural-ingredient preparations can also be options. Owner compliance may be an issue (especially with cats), so if the owner is unwilling or unable to bathe the pet, another option, such as wipes or sprays, should be considered.

Is it zoonotic?
According to Diesel, many studies have shown that MRSA is transmissible between humans and animals. She also cautioned attendees that “as veterinary professionals, our chance of being carriers for MRSA is about 4 times higher than in the general population. It’s even higher for large animal veterinarians.”

Currently, S pseudintermedius is not considered a pathogen in humans. Reports of human infections are rare and usually occur following bite wounds or in people who are immunocompromised. However, over the past couple of years there have been increasing reports of identification of this organism in people and consideration of S pseudintermedius as an “emerging human pathogen.” This may be related to improvements in molecular diagnostics in both human and veterinary laboratories. Coagulase-negative S schleiferi is also being investigated, but its zoonotic potential is still in question. This organism has been isolated from pustules in cases of canine dermatitis. Diesel cautioned that over 90% of coagulase-negative Staphylococcus species are methicillin-resistant or multidrug-resistant, so this is something to keep in mind when counseling clients and determining treatment for patients.

Prevention
Important preventive measures for veterinary professionals include using antimicrobials judiciously in patients and performing bacterial skin culture testing earlier instead of waiting, Diesel said. Additional recommendations for veterinary teams include the following:

• Practice good hand hygiene.
• Decontaminate surfaces such as exam tables and counters.
• Isolate contaminated patients, and wear appropriate personal protective equipment when handling them.

It is also important to educate clients so they understand the zoonotic potential. For pets receiving antibiotic therapy, Diesel advised sharing the following recommendations with clients:

• Minimize pet contact with young and immunocompromised people.
• Practice good hand hygiene.
• Administer the full antibiotic prescription.
• Wear gloves when administering topical therapies.
• Keep draining wounds covered.
• Discourage the pet from licking faces.
• Don’t allow the infected pet to sleep on the bed.
• Discourage sharing towels and linens with pets.
• Postpone social events/activities for the pet.

The role drug-resistant microbes play in veterinary medicine is an ongoing area of investigation. Diesel referred attendees to the consensus guidelines from the World Association for Veterinary Dermatology for more information about diagnostic testing, patient management, and preventive measures.

Karen Todd-Jenkins, VMD, a University of Pennsylvania School of Veterinary Medicine graduate, is a medical writer and has remained in clinical practice for over 20 years. She is a member of the American Medical Writers Association and One Health Initiative.

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Degenerative myelopathy (DM) is a canine genetic disease that occurs later in life and causes relentlessly progressive degeneration of the spinal cord, with no definitive treatment in sight. Of all the treatments and supplements anecdotally promoted for use, to date only physical therapy and rehabilitation have been shown scientifically to slow disease progression and maintain quality of life for longer than in untreated dogs. Even so, the condition continues to progress over 6 to 12 months, despite rehabilitation therapy.

In a new study out of New England,1 outcomes of patients with DM treated with 1 of 2 photobiomodulation therapy (PBMT; previously called low-level laser therapy) protocols were compared.

Degenerative myelopathy: Does laser therapy offer new hope?

A new study examines the use of photobiomodulation therapy to prolong survival for dogs with a progressive, fatal disease that currently has no definitive treatment.

By Rebecca A. Packer, DVM, MS, DACVIM (Neurology/Neurosurgery)
Study design
This nonblinded, retrospective study described clinical outcomes of dogs referred to a specialty physical rehabilitation facility between 2003 and 2012 for treatment of DM. Definitive or presumptive diagnosis was made using one or more of the following tests: DNA testing for the SOD1 mutation, magnetic resonance imaging of the thoracolumbar spine, or postmortem histopathologic evaluation.

Twenty dogs met the inclusion criteria and were sorted into 2 groups based on the PBMT protocol used in their treatment:

- **Protocol A** (n = 6) was 904 nm wavelength, 0.5 W, 0.5 w/cm², 8 J/cm², covering a treatment area of 650 to 1000 cm² in a point-to-point grid pattern consisting of 20 points. Treatment for protocol A lasted 5 minutes 20 seconds.

- **Protocol B** (n = 14) was 980 nm wavelength, 6 to 12 W, 1.2 to 2.4 w/cm², 14 to 21 J/cm², covering the same treatment area (650–1000 cm²) in a continuously moving grid pattern covering the entire area at a rate of 1 to 3 inches per second. Treatment for protocol B lasted 25 minutes to 26 minutes 15 seconds.

In addition, all dogs also had twice-weekly in-clinic rehabilitation therapy, including range of motion, stretching, standing/proprioceptive exercises, stabilization and core exercises, walking obstacles, and underwater treadmill walking. Home exercise protocols were also prescribed for all dogs.

Results and discussion
Survival time from the start of treatment to the time of euthanasia was significantly longer for dogs in protocol B than in protocol A (27.05 and 6.83 months, respectively). Given the variability in owner decisions regarding euthanasia, the time to non-ambulatory paraparesis may be a more reliable indicator of treatment outcome. The mean time from the start of treatment to the time of non-ambulatory paraparesis was also significantly longer for dogs receiving protocol B compared with protocol A (20.61 vs 4.26 months, respectively).

There are several considerations when interpreting these results. Median survival and median time to non-ambulatory status were not reported by the authors, but may be a more reliable outcome measure, as the median values are less influenced by outliers than are mean values; however, the outcomes using PBMT in protocol B nevertheless remain promising. The outcomes from protocol A were similar to those of prior studies; however, outcomes reported with protocol B surpassed those reported in a prior study evaluating intensive physical rehabilitation in dogs with DM, in which mean survival was 8.5 months in the intensive rehabilitation group, 4.3 months in the moderate rehabilitation group, and 1.8 months in the untreated control group.

Further studies are needed to confirm these results, particularly where eventual histopathologic evaluation can provide a definitive diagnosis for all enrolled cases. Given the presumptive nature of antemortem diagnosis, despite positive DNA test results, the findings in this study should be interpreted cautiously. This is particularly true as protocol B patients had a mean duration of clinical signs of 11.15 months prior to enrollment. This surpasses the typical outcome of untreated patients and could indicate that a subset of patients in that group did not actually have DM. Additionally, 2 authors on this paper are employed by the company that manufactures the PBMT device, and participated in data collection and analysis.

Clinical impact
This study reports promising results as to the potential benefit of PBMT in slowing the progression of canine DM. Independent, third-party studies evaluating patients in which definitive diagnosis is eventually acquired are needed to confirm these outcomes.

Rebecca Packer, DVM, MS, DACVIM (Neurology/Neurosurgery), is an associate professor at Colorado State University College of Veterinary Medicine and Biomedical Sciences in Fort Collins She is active in clinical and didactic training of veterinary students and residents and has developed a comparative neuro-oncology research program at Colorado State University.

REFERENCES
A long-time veterinary architect shares some important lessons she has learned about veterinary hospital design over the course of her career.

By Erica Tricarico, Senior Editor
In 20 years of working with veterinarians, Heather Lewis, AIA, NCARB, AAA, a principal at Animal Arts in Boulder, Colorado, has had a lot of architectural success stories, but she’s the first to admit that she’s made just about every mistake that you can make in veterinary architecture along the way.

“I call them the architectural Darwin awards,” Lewis said at the recent Fetch® dvm360 virtual conference, where she offered advice about 3 vital aspects of hospital design and planning.

Right-sizing your project
Planning the appropriate size of your hospital is key. “The rule of doubling square footage is very useful for determining the right size of a project,” Lewis said. “If you are in a 2000–sq ft lease space, you simply will have underbuilt if you move to a 3000–sq ft building. You will almost certainly outgrow it immediately,” she said.

Once you have determined the appropriate square footage for your new hospital, think about the number of exam rooms you’ll need, Lewis said. “This is the building block—and the first question I ask the veterinarians I work with,” Knowing the number of exam rooms that you’d like at your practice will help the architect determine the overall size of your hospital.

The standard number of exam rooms for a practice is 2 to 3 per doctor, but that seems to be changing, Lewis said. “What we’re seeing now is a trend toward the larger end of that scale and slightly exceeding that number for Fear Free practices,” she said. “In a Fear Free practice, you are moving patients and clients to those exam rooms really quickly.” More exam rooms may also be needed in practices that leverage their technicians well.

The next critical component in right-sizing your hospital is getting the floor plan right. “I see so many oversized floor plans from designers who are not familiar with veterinary medicine,” said Lewis. “Spend your efforts on the floor planning, using skilled professionals, and taking as much time as required to get it done properly.”

Coordinating equipment purchase, delivery, and installation
This may seem like a small point, Lewis said, but the reality is that many projects fall short in this area. Equipment must be able to fit down the hall and through doorways, counter space must be deep enough and high enough to hold the required equipment, and the correct outlet types must be installed.

When it comes to equipment coordination, it’s best to focus on the larger items first, because those need more detail coordination, Lewis advised. Understand that equipment representatives such as Patterson, Midmark, and Henry Schein do not help you coordinate many aspects of equipment.

Find out what is included with your architect’s services. Once you know what they are not doing, you’ll have a better idea of what you need to coordinate on your own. Much of the following is often left to the practice owner to coordinate:

- Animal housing. “This has improved, as the major vendors now represent various housing brands, but if you want to mix and match brands, then it gets difficult,” Lewis said.
- Furniture
- IT requirements
- Major medical equipment (eg, computed tomography and magnetic resonance imaging machines, radiology and rehabilitation equipment)

Controlling costs
Out-of-control costs top the list of calamities on any build or renovation project, even more so during the COVID-19 pandemic. “This is especially important in our current market, where we’re dealing with really big challenges related to COVID-19,” she said.

Because of several pandemic-related issues, no one really knows how much construction will cost right now, so it’s best to choose your contractor and bring them on during the design phase, Lewis said. Benefits here include early cost feedback, proactive value engineering, and valuable input on your architectural drawings.

Construction is not easy, so it’s helpful to start with positive feelings for the whole team. When searching for the right contractor, here are a few things to look for:

- A company/contractor who does commercial construction
- A company/contractor who does similar work to what your project will require
- A company that has good references, is financially healthy, and is bondable
- A contractor who is interested in your project and enjoyable to work with
- A contractor who tells you the truth, not just what you want to hear

The take-home
“Veterinary projects take a lot of planning. I can say from 2 decades of working on these projects that the veterinarians who take the planning seriously almost universally succeed,” said Lewis. “Right-size your project, get your costs under control with help from the right professionals, and studiously plan your equipment. If you remember these 3 tips, you will avoid the most common problems.”

One of the primary hurdles veterinarians face when adopting telemedicine in their practice is that virtual care traditionally has been free. At the inaugural Veterinary Virtual Care Summit in August, Cherice Roth, DVM, vice president of veterinary operations at ask.vet, Beth Fritzler, DVM, CVPM, managing partner at Cascade Heights Veterinary Center in Seattle, Washington, and Aaron Smiley, DVM, chief of staff at 2 Indiana veterinary hospitals, talked about the economics of incorporating telemedicine into veterinary practice, and how to profit from this service.

The hurdles
When it comes to telemedicine, the hurdles do not appear to stem from pet owners, the panel noted. Clients are appreciative of the service because they perceive value in virtual care and are willing to pay for it. The resistance, they said, comes from the veterinary side.

Shifting the mindset
It is not easy to change the mindset of veterinarians and staff to start charging for something that typically has been offered for free. The first step is to remember that your knowledge has value and that you deserve to be compensated for sharing that knowledge, Roth told summit attendees.

It also helps to make the process more structured. Instead of informal callbacks or text-message responses, tell the client that you agree that the pet’s issue needs to be addressed and that you can give them your full attention during a virtual appointment. Because the conversation has transitioned to a formal (albeit virtual) appointment, the owner sees greater value in it. It also provides a template for staff to explain the telehealth process and fees to owners.

Fritzler reminded attendees that human patients typically cannot talk to their physicians so easily. Instead, they typically receive a callback from a nurse, or set up a recheck appointment if they need to speak to the doctor. “We can easily expect the same in veterinary medicine,” she said.

Clinical and social confidence
Another hurdle facing veterinary teams is a lack of clinical and social confidence. We have spent years learning to become proficient clinicians, Roth said, and pet owners are paying for our knowledge and experience, not just a 10-minute chat. In other words, we need to believe that our words have power and value.

To practice telemedicine, veterinarians and staff must make time in an already busy schedule to learn new technological skills, and so should be compensated for this time. Further, incorporating virtual visits into the normal daytime schedule results in less nonbillable time spent after hours returning phone calls to pet owners. When these calls are incorporated into virtual visits during normal appointment hours, the practice is not losing money.

Financial benefits
Neither Roth nor Fritzler has experienced lower average transaction rates for virtual visits compared with in-person visits. Roth did note that owner compliance and willingness to pursue additional diagnostics are often higher when the visit is virtual, a fact that she attributes to the virtual visit allowing more
time for education and discussion about why certain diagnostic tests are important. When recommended during a virtual appointment, owners can bring their pet in for a technician visit to complete diagnostic testing. If the virtual visit requires an in-person evaluation, then the client is credited the amount of the virtual visit and the appointment is converted.

Fritzler noted that virtual visits tend to be quicker than in-person visits because there is no need to put the pet in a room or to clean the room after the appointment. The increased number of visits per hour offsets any potential decrease in revenue per transaction. For this reason, daily revenue per doctor may be better than average transaction per doctor.

Finally, because virtual visits lower the barrier to receiving care for some new pets, they may help bring in new clients. For example, an owner who is really reluctant to bring their pet into the clinic may start with a virtual visit and establish a relationship with the veterinarian. Subsequently, when they do need in-person care, they continue the relationship.

How to charge for virtual visits
Smiley mentioned 3 options for charging for virtual visits: subscription services, per appointment, or per unit time. All 3 veterinarians on the panel charge per appointment, and their fee is the same whether a visit is in person or virtual. That said, Roth noted that many younger clients seem to prefer subscription-based services, so that may be a pricing model to consider.

The panel agreed that triage services should remain free. It should be clearly stated that while triage can be provided at no charge, if the owner would like to talk to a doctor or if the pet requires medical expertise, a virtual appointment will be required and charged for. In addition, to offset the time spent sending text updates about patients, Fritzler adds a nominal fee for all hospitalized pets or those undergoing procedures. This allows doctors and staff to be compensated for their time without specifically billing for providing updates to owners.

Charging for virtual visits appears to be straightforward, but what happens when a virtual visit needs to be converted to an in-person visit? Smiley learned this lesson the hard way. Initially, when he recommended that a virtual visit convert to an in-person visit, he would waive the fee for the virtual appointment and instead charge the in-person visit fee. However, when a subset of patients recovered and no longer needed an in-person visit, that revenue was lost. Instead, he now charges for all virtual visits, but if an in-person visit is also required with a doctor (versus a technician appointment for diagnostic tests), he credits the cost of the virtual visit during the in-person visit. Costs are the same for virtual and in-person visits, but the timing of the charge is different.

Roth noted that one of the biggest hurdles for adopting and charging for telemedicine remains state-specific veterinary practice acts, and whether a veterinarian-client-patient relationship can be established solely by virtual means. The other hurdle, as Smiley reiterated, is for veterinarians to believe in our sense of worth and remember that clients are willing to pay for our expertise. We must remember that we have value.
Let’s undo the twist: diagnosing and treating splenic torsion in dogs

Sometimes, splenectomies are straightforward and predictable. Other times, not so much. A veterinary surgeon shares tips for getting better outcomes in splenic torsion cases.

By Sarah Mouton Dowdy

The serious nature of spleen removal surgery is often overlooked. Perhaps the fact that dogs can function well without the organ is partly to blame. Or maybe, as posited by Harry W. Boothe, DVM, MS, DACVS, professor emeritus of soft-tissue surgery at Auburn University College of Veterinary Medicine, it’s because for many years it wasn’t unusual for veterinary schools to use the procedure in junior surgical laboratory settings as an exercise in knot-tying and ligation placement.

Years of experience have taught Boothe to see the surgery a little differently. He says that while splenectomies are often straightforward and predictable, he has been a part of many surgeries that haven’t fit that neat and tidy mold—both peri- and postoperatively.

“There are a lot of things we don’t understand about the spleen,” Boothe explained during a session at the Fetch dvm360 virtual conference in August, “not the least of which is the cause of cardiac arrhythmias being associated with splenic masses, splenic enlargement, and splenectomies.”

A lean and mean review of the spleen

Boothe began with a quick refresher on splenic anatomy. The spleen, he said, is suspended by the greater omentum and attached to the greater curvature of the stomach by the gastrosplenic ligament. The splenic artery arises from the celiac artery, which is the first branch of the abdominal aorta, and divides into multiple smaller hilar branches before entering the spleen.

“In addition to supplying the spleen, the splenic artery supplies the left pancreatic limb,” Boothe said. That pancreatic limb that lies caudal and parallel to the stomach is a lot closer than I think we often realize—or at least the blood supply is. And I think part of my concern with some of the minimal ligation techniques is

Ultrasonography is the best imaging tool for diagnosing splenic torsion for.

Close-up surgical image. Note the proximity of the left pancreatic limb to the twisted pedicle.
that, particularly with splenic hilar disease, we could be a lot closer to embarrassing blood supply to the left pancreatic limb than we realize.”

Boothe added that it is important to remember that although the splenic veins parallel the splenic artery, they enter the portal vein, not the caudal vena cava. “We can use them to access the portal venous system and to evaluate portal venous pressures,” he explained.

**Plot twist: diagnosing splenic torsion**

There are several reasons for removing a patient’s spleen, including lesions and trauma. Boothe focused first on splenic torsion, explaining that the condition occurs when the spleen rotates around its vascular pedicle, resulting in venous obstruction and subsequent splenomegaly. True to the textbooks, Boothe has seen splenic torsion consistently in large- and giant-breed dogs with deep-chested conformations. “In my experience, it’s usually an isolated event, meaning it’s not necessarily associated with trauma or other situations.”

But, he said, “we always look for splenic torsion in association with gastric-dilatation volvulus.”

Boothe explained that there are 2 possible presentations for dogs with splenic torsion: acute and chronic. Abdominal pain and collapse are common acute presentations, while vomiting, anorexia, intermittent abdominal pain, abdominal distension, polyuria, and polydipsia characterize chronic cases. “I can recall a case with chronic presentation that did very poorly following splenectomy,” said Boothe. “I think time is somewhat of the essence in dealing with presumed or documented splenic torsion.”

With regard to laboratory results, Boothe said hemoglobinuria may be noted on urinalysis in chronically presenting patients and that hematologic findings often include anemia, thrombocytopenia, and leukocytosis.

While abdominal radiography and ultrasonography are often part of getting to a diagnosis, Boothe said he could probably argue that you can’t definitively diagnose splenic torsion based on radiographs alone. Abdominal ultrasound, however, particularly with Doppler flow capabilities, is an excellent diagnostic tool in splenic torsion cases. “Findings often include generalized splenomegaly, evidence of splenic infarction, a twisted splenic pedicle, and absence of blood flow through the splenic vessels on Doppler evaluation,” Boothe explained. Still, he said, it’s not uncommon for the definitive diagnosis to be made at the surgery table through exploratory laparotomy.

**How to unwind: treating splenic torsion**

Complete spleen removal is the treatment of choice for dogs with splenic torsion. Boothe said if you can perform surgery in a timely fashion, you will typically just see splenic engorgement with a twisted pedicle once your patient reaches the operating table. “But if it’s been more of a chronic situation with a delay in getting to surgery,” he continued, “there may be evidence of venous thrombosis and the possibility of necrosis.” Necrosis tends to correspond with worse outcomes, he said.

Because Boothe knows that the patient’s splenic tissue may be friable, making simple attempts at exteriorization potentially insulting to the patient, he approaches the situation with what he calls a somewhat old-school plan that’s become his default. First, he confirms the location of the left pancreatic limb. Then, he uses 1 or 2 large-diameter sutures (e.g., #1 polydioxanone) to ligate the entire splenic vascular pedicle before removing the spleen in its twisted state.

With the spleen out, Boothe slowly untwists the pedicle, examines it for hemorrhage, and places additional ligatures or uses a high-energy sealing device as needed. “Now, one could argue that high-energy sealing devices could be used to work through the pedicle in its twisted state and deal with it that way,” he said, “but I think that sometimes it’s easier and quicker to get the spleen out and then deal with the pedicle as a separate structure.”

Because delayed hemorrhage is a possible postoperative complication, Boothe is careful to ensure that the vascular pedicle isn’t bleeding before closing the patient’s abdomen and performing intraoperative peritoneal lavage to evacuate the hemorrhagic effusion.

**Don’t miss a beat (particularly the irregular ones)**

Remember those mysterious postoperative cardiac arrhythmias associated with splenectomy? Boothe does too, which is why he recommended that splenectomy patients recover for 2 to 3 days after surgery at a 24-hour care facility or in a setting with overnight monitoring—“not necessarily with continuous heart monitoring,” he explained, “but just to make sure we’ve got good perfusion, good mentation, and good recovery from the procedure.”

Sarah Mouton Dowdy a former associate content specialist for dvm360.com, is a freelance writer and editor in Kansas City, Missouri.
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Get your message to veterinarians TODAY!
How to frame the pet health insurance conversation

Help your clients avoid “analysis paralysis” when choosing a pet insurance plan.

By William Hodges, DVM

With so many options available today, discussing pet health insurance with your clients can be complex and time-consuming. Some practices simply give clients a handful of brochures while others research the available options themselves and recommend that clients select from just 2 or 3 plans. In some cases, these tactics have left both veterinary practices and pet owners stuck in “analysis paralysis.”

But getting your patients insured doesn’t have to be difficult or frustrating. Here’s how to help your clients understand the benefits of pet insurance and enable you to deliver gold-standard care.

Start from the beginning

The best time to discuss pet insurance is the first time a client visits your practice with their pet. Many of these first-time patients are young and healthy, with no diagnosed pre-existing conditions. (No pet health insurance policy covers preexisting conditions.)

Discuss pet insurance in the broad context of the pet’s expected lifetime costs. Many pet owners need to be educated about potential pet health risks and the true cost of pet ownership to understand the benefits of financial planning and protection.

Simply handing a client some brochures is not proactive education. Instead, turn the interaction into a conversation during routine care. Speak to your clients the same way you might when discussing parasite prevention: Advise them that taking simple and affordable action today can mitigate future costs. Keep in mind that veterinary practices earn more money annually through insured pets than through uninsured pets.

Keep it simple

Giving pet parents too many choices can reduce the likelihood that they will move forward and enroll in any type of coverage. However, veterinary practices should not take a one-size-fits-all approach regarding pet insurance providers, either. The insurance discussion should be one of education and not necessarily specific recommendations. Educate your clients on the value and impact of insurance, then let them choose.

Some clinics opt to have an in-house “pet insurance expert” who researches various insurance providers and then creates a detailed pamphlet for clients. Others leverage third-party online pet insurance comparison/education websites that do this research objectively and help guide clients through the insurance buying process.

Including these resources on your practice website will make it easy for clients to dive in on their own for more detailed information about pet insurance options.

Also, use social media to generate positive messaging about pet insurance. This is often a much more laid-back format for discussion, but those digital conversations can be as impactful as in-person interactions.

Keep notes in pet records

To make it easier to know which patients are insured, make notes in the patient’s medical record. If they do have pet insurance, document the type of policy. This will help when making treatment recommendations and it changes the conversation substantially.

For example, let’s say you need to recommend a $5000 procedure. That’s a high cost for anyone. But if your client has a good pet insurance plan and you can inform them that 80% of that cost will be reimbursed, they will be more likely to follow your recommendation.

Also, inform clients during their visit about wellness benefits they can allocate. This will help them use those benefits before they run out at the end of the year.

Get your staff’s pets insured

Seventy-one percent of pet owners are more likely to buy pet insurance if their veterinary hospital’s team members have it themselves. If your staff members don’t use pet insurance, what signal does that send to your clients?

Some of your staff may provide treatment to their own animals free of charge or at a discount and feel they don’t need pet insurance. However, you must keep risk and liability in mind. Recent IRS regulations state that veterinary practices cannot offer staff discounts of more than 20% on services. Rather, the IRS recommends that practices offer products and services at cost plus 10%.

References are available at dvm360.com
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