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IN REVIEW IMAGING PROTOCOL: CHIARI-LIKE MALFORMATION & SYRINGOMYELIA MANAGEMENT OPTIONS CANCER AT ALL STAGES A REFERRING VETS GUIDE TO HIP DYSPLASIA REGULAR FEATURES CLIENT COLUMN & FITZ & PIECES

World-Class Veterinary Medicine, Hope and Healing

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CERVICAL SPONDYLOMELOPATHY

Exploring the diagnosis and complexities of wobbler disease By Professor Noel Fitzpatrick

1. What makes CSM a challenging diagnosis?

Cervical spondylomelopathy (CSM), often referred to as 'wobbler disease', is a multifactorial condition affecting the cervical spine in larger breed dogs – resulting in progressive compression of the spinal cord and nerve roots. Morphologic and biomechanical abnormalities of the cervical spine have been classified as either Disc-Associated Wobbler Syndrome (DAWS) or Osseous Associated Wobbler Syndrome (OAWS). Dobermans are predisposed to DAWS, but the disease can also occur in breeds such as Labradors and Dalmatians. Great Danes and Basset Hounds can be predisposed to OAWS.

DAWS involves protrusion of one or more degenerative cervical discs into the spinal canal, usually affecting C5-6 and C6-7, causing compression of the spinal cord or nerve roots. In OAWS the spinal cord is compressed as a result of malformation and proliferation of the osseous boundaries of the spinal canal (facets and neural arch). In both presentations, the spinal cord can be compressed chronically without major symptoms and then a minor incident can trigger deterioration, manifested as cervical pain (nerve root compression) or ataxia (spinal cord compression), which can progress to para or tetra-paresis / plegia.



(A) A post-mortem sample of a vertebra affected by osseous compression of the spinal canal (OAWS).
(B) Sagittal plane T2-weighted MRI scan of intervertebral disc protrusions at C5-6 and C6-7 (DAWS).

2. Why is advanced imaging crucial for an accurate diagnosis?

Survey radiography is not sufficient for the diagnosis of either DAWS or OAWS. MRI scans are considered fundamental to elucidate the degree of spinal cord impingement. Dynamic MRI imaging can be performed to investigate if a disc protrusion causes more compression in extension (dynamic) or if the degree of compression reduces when traction is applied to the neck (traction-responsive). A high-powered scanner which allows variable positioning is essential. CT scans optimally illustrate osseous margins and are important for measurement if surgery using implants is planned.

Images A-F are T2-weighted MRI sagittal and transverse images of a C6-7 intervertebral disc protrusion in a five year old Doberman affected by DAWS illustrating three different positions.

A, B Neutral; B, C Hyperextended; E, F Traction

The spinal cord is more compressed in hyperextension and less compressed when traction is applied. Note the increased signal intensity within the cord due to vasogenic oedema, gliosis and/or malacia. This may not resolve even after surgical treatment.











Lateral Radiograph (A) from a two year old 45kg crossbreed. The red line marks where the transverse CT and MRI images (B & C) have been obtained. Bot CT and MRI images demonstrate lateral impingemer of the spinal cord and neuroforaminae by the neural arch and articular facets. These images illustrate that radiography alone does not accurately represent the pathology of OAWS.

3. What treatment options are available?

Historically, many techniques have been evolved in an effort to achieve distraction of the disc space and alleviate compression in DAWS cases, with variable success. Dorsal laminectomy or facetectomy have been typical surgical interventions for OAWS patients. This can be successful, especially for single or double lesions requiring limited bone removal, but high morbidity has sometimes been experienced with extensive multiple site decompression and it can be difficult to remove bone from the neuroforaminae with a dorsal decompression.

We have developed and published outcome measures on a distraction-fusion system for both DAWS and OAWS patients that we have employed with considerable success for many years. This technique is unique to Fitzpatrick Referrals and involves distraction through insertion of a conical threaded spacer (Fitz Intervertebral Traction Screw, FITS) and a linkage system of plates and rods ('Fitzateur') which is custom made for each patient with exactly correct vertebral screw positioning.

The fusion devices can be deployed for single or multiple sites, and in conjunction with application of bone graft, promotes permanent fusion of the vertebrae. We have proven that both osseous and soft tissue compressive elements of the spinal cord and nerve roots can regress over time and that clinical improvement can be robust and resilient.

With some DAWS patients it may be advantageous to maintain motion at the affected site since fusion may result in stress concentration into adjacent sites, potentially predisposing to 'adjacent segment disease' or 'domino effect' whereby disc disease may manifest more readily at locations cranial or caudal to the fused site. At Fitzpatrick Referrals, we have developed and proved efficacy for a custom-made disc replacement ('Fitz-Disc') which spaces the vertebrae, maintains motion and is secured to the bone with screws to prevent loosening.

Are you interested in exploring treatment options for wobbler disease in more detail? Professor Noel Fitzpatrick will be presenting on this topic at the VET Festival. Join him on Friday 7th June at 11:35 in the neurology and neurosurgery tent.



radiograph of a custom-made Fitz-Disc – alleviating compression caused y disc protrusion between adjacent vertebrae whilst maintaining motion.



A 3D rendered CT scan of a FITS-Fitzateur device employed for multiple site distraction-fusion in DAWS or OAWS cases - providing immediate and resilient decompression of the spinal cord and nerve roots.

Chiari-like malformation and syringomyelia

Determining imaging protocol for an accurate diagnosis

By Professor Clare Rusbridge

What is Chiari-like malformation and how does it cause pain and syringomyelia in predisposed brachycephalic toy breeds?

Chiari-like malformation (CM), is a complex skull and craniocervical junction disorder associated with brachycephaly. Stated simply - the skull is too small for the brain and there is also overcrowding of the spinal cord in the cranial cervical vertebrae.

Syringomyelia (SM) is a disease of the spinal cord characterised by fluid-filled cavities (syrinxes) within the spinal cord substance. Syringomyelia occurs secondary to obstruction of CSF pathways – the cerebrospinal fluid, in which the central nervous system floats, is important for protecting the nervous system from the systolic pulse pressure and increases nervous tissue compliance (i.e. ability to deform under pressure). There are many theories on how syringomyelia forms - a key feature in the pathogenesis is obstruction of the subarachnoid space which results in fluid similar to CSF accumulating in the spinal cord damaging the vulnerable nervous tissue. In dogs, syringomyelia is more commonly associated with craniocervical (headneck) junction abnormalities typical of Chiari-like malformation. It can also occur where there are adhesions between the outer layers of the meninges for example in Pug myelopathy (associated with spinal arachnoid diverticulum and/or caudal articular facet hypoplasia, for example).

Chiari-like malformation associated pain syndrome (CM-P) is a syndrome of pain associated with CM – the most common reported signs are vocalisation (described as spontaneous, when picked up under the sternum, or when changing position especially at night), head scratching/ rubbing, reduced activity, reduced stairs / jumping ability, spinal pain, altered emotional state (behavioural change to more timid, anxious or aggressive), sleep disturbance and touch aversion.

Severe / symptomatic syringomyelia (SM-S) is the collection of signs of spinal cord disease (myelopathy) that occurs when the syrinx is wide. The signs depend on where the syrinx forms - for example, a dog with a syrinx in the neck may have phantom scratching and scoliosis whereas a dog with a wide syrinx in the lower cervical and upper thoracic spinal cord is more likely to have limb and spinal weakness. The most common signs of SM-S are phantom scratching, scoliosis, weakness and postural deficits.

Why are Chiari-like malformation associated pain (CM-P) and symptomatic syringomyelia (SM-S) hard to diagnose?

CM-P is a difficult diagnosis because the clinical signs are nonspecific or can have alternative explanations but should be considered in predisposed breeds who may have signs such as: a history of vocalisation described as without obvious trigger (when shifting position during recumbency and when being lifted under the sternum to a height), spinal pain, head and ear rubbing or scratching, refusal or difficulty jumping or climbing stairs, exercise intolerance/reduced activity, sleep disruption, or behavioural change described as becoming more anxious, aggressive, or withdrawn. SM-S can be challenging because although the MRI identification of SM is generally unequivocal, SM can be asymptomatic or an incidental finding on magnetic resonance imaging. This is more likely if the syrinx is narrow and symmetrical and if the spinal cord is not expanded by the syrinx.



Professor Clare Rusbridge will be presenting on Chiari-like malformation and syringomyelia at VET Festival on Saturday 8th June between 17:05 – 17:50 in the neurology and neurosurgery tent.

Diagnosis of CM-P and SM-S

MRI is undoubtedly the modality of choice to investigate CM and/ or SM. On making a diagnosis of CM/ SM there are key aims for the clinician.

- 1 To assess and document anatomical changes
- **2** To determine the cause of the SM and the full extent of the disease
- 3 Eliminate other potential causes of the clinical presentation and neurological localisation, for example intervertebral disc disease as an alternative explanation for spinal pain
- Assess whether the image findings are consistent with the neurological localisation and severity
- 5 To determine whether other diagnostic modalities are required – for example, a CT scan to characterise bony abnormalities that may need planning for surgical stabilisation

In order to assess the possibility or extent of CM and SM, the MRI protocol should be appropriate and should establish the longitudinal and transverse extent of the syrinx. If the cause of CSF channel disruption is not revealed by MRI then other imaging techniques may be appropriate.

What do the specialists suggest?

Given that MRI is the diagnostic modality of choice, it is recommended that any referring vet who is in doubt or in need of access to facilities, refers to a veterinary neurologist. However, it is not just about obtaining an MRI and we definitely recommend a consultation with a neurologist BEFORE the MRI because the MRI protocol should be tailored for CM-P or SM-S and/or the dog's clinical signs. It is suboptimal if the client spends valuable funds on imaging that proves to be of inferior diagnostic quality and/ or is a very limited study.



Cancer management - is it ever too late?

At Fitzpatrick Referrals Oncology & Soft Tissue, we can offer patient-tailored treatments for dogs and cats with all forms of cancer. Every animal's individual situation is assessed, and a unique plan is created. Michael Macfarlane, one of our senior oncology clinicians discusses the differences and similarities between individual investigations, and tells the story of Monty - a much loved Labrador with bags of energy who, despite metastases, received multiple treatments to manage his cancer, and sustained a longer quality of life as a result.

How do you assess the extent of a cancer?

'Staging' is the process of evaluating where in the body cancer is located. This process is tailored to suit the likely pattern of spread of certain cancers. Mast cell tumours are a common type of cancer we see; aggressive variants can metastasise to lymph nodes, and then the liver and spleen, but rarely to the lungs. Another common type of cancer, osteosarcoma, rarely metastasises to lymph nodes or the liver and spleen but commonly metastasises to the lungs and bones.

Therefore, depending on the type, size and location of the tumour, staging can involve:

- Palpation and needle biopsy of lymph nodes
- Imaging of the chest with CT scan or radiographs- our fantastic CT scanner (Toshiba Aquilion 160 slice) can do this quickly and in detail, radiographs are less detailed, but can sometimes be performed without sedation
- Imaging of the abdomen, either with ultrasound or CT scan, possibly sampling any suspicious areas with a needle
- Other, less common tests such as bone marrow sampling or blood tests

Finding the 'draining lymph node' of a tumour is important to be able to correctly identify whether spread has occurred. Sometimes there are many possible draining lymph nodes. This previously made it difficult to identify the right one. We are now able to use a technique called lymphangiography to do this reliably.



The image above shows what happens when an injection of contrast is given into the area around a tumour.

We can then sample or remove the identified draining lymph node as appropriate. This technique is helping to improve outcomes, especially with tumours such as melanomas and mast cell tumours.

Is staging essential?

Some tumour types are not likely to spread, or we know that the identification of tumour spread will not affect the outcome or plan. Therefore, staging is often recommended, but not essential. Small mast cell tumours with no concerning features of growth (redness, swelling, rapid growth) are an example of where we proceed without staging. If these tumours are removed and results from the lab are favourable, the procedure is very likely to have been curative. Staging will always be discussed on an individual basis.

What do we do with the results of staging?

The over-arching philosophy we apply to treatment of dogs and cats is the same regardless of the type and location of their cancer. This is to take steps to improve or maintain a good quality of life above focusing solely on curing or treating cancer.

'Clear' staging often means that we can recommend treatments which have a good chance of allowing a favourable long-term outcome. On the other hand, many dogs and cats that we see will be diagnosed with metastatic cancer, either at the hospital or prior to their arrival. This is often not as bad news as feared and there are typically several options that can be pursued.

To do this, we may use one or a combination of cancer treatments, supportive or palliative medication tailored to the staging results. Many dogs can live with and be well with cancer for some time with the correct support.

Is surgery still an option if cancer has spread?

For certain cancers, we will operate if cancer spread is identified and if we know that there is a good probability that it will contribute to allowing a happy life for a reasonable time. Excellent examples of this include anal sac tumours, where we frequently remove affected lymph nodes, knowing it will help dogs to defecate more easily and mast cell tumours, where outcomes are improved when tumours are removed, even if there is spread. In addition, if there is a lump which is causing pain or discomfort and it can be removed easily- this is an option, even if cancer spread is identified.

What about other options?

Palliative care is the provision of treatments to improve quality of life. Although we have classically thought of this as mostly being pain relief, there are a whole host of treatments which can be used to provide an improved quality of life. Even if there is advanced cancer, small changes to routine, medications or supplements can make a difference and we welcome referrals of dogs and cats with all stages of cancer.

What if it is difficult to travel to and from Fitzpatrick Referrals?

After staging, we are able to formulate a treatment and care plan. If this involves continued care at the primary care practice, we are more than happy to share the care and to provide ongoing advice as needed.

Michael will be presenting throughout the day on Friday 7th June in the oncology tent at VET Festival

CASE STUDY Monty - living life to the full despite advanced cancer

Monty was a beautiful Labrador who received treatment with us for just under three years. He was referred after removal of an anal sac tumour at his primary care practice. An increased calcium level is a common problem with anal sac tumours. Monty's high calcium level continued to rise after surgery, which arose suspicion that the cancer may have spread.

The tumour was indeed found to have spread to lymph nodes in his abdomen and surgery was performed to remove them. This had the effect of reducing the hypercalcaemia caused by the tumour which had been making him feel unwell.

As Monty's cancer had the potential to recur after surgery, he was given chemotherapy. Although he remained well, a routine CT scan identified the tumour regrowing and another surgery was performed. He was then started on a drug which has recently shown to be effective at controlling this cancer- Palladia. This did appear to be more effective and the next CT (11 months after diagnosis) was clear. Then, 19 months after his initial diagnosis, further recurrence was identified and removed.

Monty continued treatment with Palladia although this was eventually stopped and the tumour grew back, 26 months after the initial appointment. It was decided at this time that surgery was not the best option. Without any 'anti-cancer' treatment but with a lot of love and care from his family (including five star dinners from roast lamb to gammon) and a combination of medications to reduce the effects of the cancer on his body, Monty remained well for a further nine months.

Monty brightened our day when he came to visit us, and we are fortunate to have been able to have looked after him for such a long time. He is a good example of using advanced methods to detect cancer and carefully selected multimodal therapy in order to prolong a good quality of life for longer than we would have expected. Two additional drugs which helped in Monty's case were bisphosphonates and amantadine. These are both a crucial part of our ability to provide effective palliative care. We use bisphosphonates and particularly zoledronate regularly to help with both hypercalcaemia and bone pain. The amantadine made a big difference to his demeanor and was used to control discomfort, both from his osteoarthritis and any pain caused by the tumour.

A REFERRING VETS GUIDE TO HIP DYSPLASIA

By Sarah Girling

Recognise and differentiate the varying degrees of pain

Acute pain may manifest as restlessness or difficulty getting comfortable, struggling to get up, or a sudden reaction to unexpected pain which manifests as whining, crying, biting or hiding or escaping. Chronic pain gives the appearance of tolerance, often without perceived signs of pain or lameness. Equally the patient's family perceives pain and describes this to manifest as an altered gait or altered behavior. Recording a patient's daily level of activity provides a very objective measure for review, and a useful indicator when assessing response to treatment.

We predominantly see our patients at two phases as hip laxity progresses to coxofemoral osteoarthritis. Typically, phase one is the juvenile patient (five to twelve months) suffering from hip laxity, whereby the femoral ligament is stretched and oedematous, joint fluid is increased and the joint capsule is stretched at the origin and insertion points. Phase two is the mature patient with developed osteoarthritis; the original strain on the joint capsule, inflammation and increased joint fluid progresses to joint capsule thickening and periarticular fibrosis.

PHASE ONE JUVENILE: TREATMENT OPTIONS

Healthy, active, pain-free pets are important family members. But our pets do not speak and we should be able to understand when they are in pain. Unfortunately, hip dysplasia (HD) is an all too common, developmental orthopaedic condition resulting in osteoarthritis (OA). Osteoarthritis causes discomfort, chronic aching and pain. So it is important for the primary care vet to engage with the insidious nature of this condition and recognise the varying manifestations of pain and furthermore when to act and refer to a specialist.

When do I refer?

Identifying the stage the patient is at assists the veterinarian's understanding of underlying pain and combined with an assessment of the impact on the patients' quality of life, will allow you to develop an appropriate course of treatment. If you ever need assistance with radiographs and imaging, or would prefer to seek surgical treatment from a specialist, don't hesitate to get in touch.

Management options

Management is divided into medical/conservative (exercise modification, pharmacologic/analgesia and rehabilitation) and surgical.

Radiographic assessment with examination of joint laxity (Bardens or Ortolani sign) under anaesthesia enhances the veterinarian's understanding of the individual's condition. Furthermore, if osteoarthritis is not evident, then the patient may be appropriate for early surgical intervention such a pubic symphysiodesis (JPS) or double pelvic osteotomy (DPO).

PHASE TWO MATURE: TREATMENT OPTIONS

Medical management	Multimodal analgesia		Medical management	Multimodal analgesia
Rehabilitation	Exercise modification (restricted activity should only be temporary)	1		Neutraceuticals
	Physiotherapy and hydrotherapy		Rehabilitation	Exercise modification
Surgical	Juvenile Pubic Symphysiodesis (JPS)			Physiotherapy and hydrotherapy
	Triple or Double Pelvic Osteotomy (TPO/DPO)		Surgical	
	Total Hip Replacement (THR)			Total Hip Replacement (THR)
	Femoral Head and Neck Excision (FHNE)			FHNE

Total hip replacement and the mature patient

Total hip replacement (THR) is a long term solution to hip pain for the immature and mature patient. Osteoarthritis will never go away and the impact on the patient is insidious.

The success rate is 95% and the patient regains normal gait, trot and gallop, normal activity, and they are free of chronic aches and pain.

At Fitzpatrick Referrals, we use the universal BioMedtrix THR system which comprises CFX (cemented) implants made from cobalt chromium alloys and BFX (biological) implants made from titanium alloys with a cobalt chromium articulating head. The CFX Micro and Nano hip system is our primary recommendation for small breed dogs and cats affected by SCFE (slipped capital femoral epiphysis), osteoarthritis, avascular necrosis or femoral head fracture failure. It provides a superior functional and pain-free improvement when compared to FHNE.

What to expect?

At initial consultation, we take the time to help the families appreciate the importance of hip pain and osteoarthritis as a lifelong condition. We provide information and manage expectations to help with family decision-making and to ensure they are comfortable with post-operative care, complications and the appropriate timing of any surgical intervention. At the same time, radiographic assessment is performed. A second appointment is then made for surgical intervention. It is important that patients do not suffer any obvious infection (dental disease, pyoderma, pyometra, UTI, otitis externa) in the weeks immediately prior to surgery, as this would increase the risk of post-operative infection. Patients remain with us for three to five days and are discharged when we are satisfied their pain is adequately managed. Post-operative confinement and exercise control is essential to reduce the key complications of prosthetic dislocation. Clients who do not wish to comply with this regime should be discouraged from embarking on this journey. At discharge, we provide physiotherapy guidelines and help the patient into the car. Further re-examination is planned for six and twelve weeks post-surgery. Physiotherapy follow-up is provided as necessary.

Remember we tailor a treatment plan for the individual; no two patients with this condition are the same and all respond differently.

If you need help interpreting radiographs or deciding on a treatment plan, please phone 01483 423761 to discuss or send your patient along for an assessment. Join Sarah in the orthopaedics tent at VET Festival on Friday 7th June to hear more about the treatment of hip dysplasia



Your next case coming to the practice is a small breed dog with a history of progressive pelvic limb lameness. The top differentials for this presentation are patellar luxation and cranial cruciate ligament disease. But what about the patient with concurrent patellar luxation and cranial cruciate ligament disease? How do we reach a diagnosis of this challenging combination of diseases and how do we return the patient back to function?

Up to 25% of patients with patellar luxation are affected by concurrent cranial cruciate ligament (CCL) disease (Campbell, 2010). Older patients and those individuals with a higher degree of luxation were more likely to be affected by CCL disease. When faced with the challenge of a dog with a low grade chronic MPL (medial patellar luxation) and an acute clinical deterioration, evaluation for the presence of concurrent cranial cruciate ligament can help identify the true cause of deterioration in the patient's lameness.

For patients with partial CCL disease, clinical presentation varies from mild to moderate weight-bearing lameness that worsens after strenuous exercise with stiffness commonly seen after rest. Meniscal injuries and complete rupture of the CCL can lead to acute deterioration. Dogs with patellar luxation can present varying levels of disability ranging from skipping lameness to inability to jump.

Differentiating between MPL, and MPL with concurrent CCL disease, is challenging. You must evaluate the patella and stifle stability separately. The stability of the patella should be evaluated during flexion and extension as well as during internal and external rotation of the tibia. Patients with concurrent CCL tend to have a stifle effusion with palpable fibrosis on the medial aspect of the stifle for more chronic cases (medial buttress). CCL disease is confirmed during physical examination by demonstration of instability during the cranial drawer manoeuvre and tibial compression test.

The classical radiographic presentation in patients with MPL and CCL are demonstrated in the radiographs in this article. A full pelvic limb radiographic evaluation, including ventro-dorsal extended hips and orthogonal views of the stifles, is recommended before making any surgical decisions. The complexity of MPL and concurrent CCL disease means treatment must be tailored to the individual taking into account patient size, skeletal conformation and grade of patellar luxation. We focus initially on stabilising the stifle; usually utilising a variation of tibial plateau levelling osteotomy (TPLO), followed by stabilisation of the patella using a combination of Patellar mechanism realignment and sulcoplasty. In some cases, we may have to carry out both tibial and femoral osteotomy to achieve stifle and patellar stability.

We are always happy to offer advice on these complex presentations and see them as a referral if you so wish. We will give you an insight into our expertise in TPLO and why this surgery remains the primary technique we call upon - despite the ever-expanding surgical repertoire available for the management of cruciate disease.

KNOW YOUR KNEES

Understanding concurrent patellar luxation and cranial cruciate ligament disease

By Miguel Solano and Pádraig Egan

To find out more about treatment options for patellar luxation, join Miguel on Friday 7th June at 16:10 in the VET Festival orthopaedics tent



Medio-lateral view of a stifle of a dog showing classic signs of cranial cruciate ligament disease: osteophytes at the level of insertion of the cranial cruciate ligament (A); increased opacity displacing the infrapatellar fat pad cranially and the subgastrocnemius fascia caudally (B); osteophytes at the apex of the patella (C); and new bone formation along the femoral trochlea (D). Notice the good patellar covering by the femoral groove.



Medio-lateral view of a stifle of a dog showing classic signs of patellar luxation; (B) increased opacity displacing the infrapatellar fat pad cranially and the subgastrocnemius fascia caudally; osteophytes at the apex of the patella. Notice the poor patellar covering by the femoral groove.



Medio-lateral view of a stifle of a dog showing classic signs of concurrent MPL and cranial cruciate ligament disease: osteophytes at the level of insertion of the cranial cruciate ligament (A); increased opacity displacing the infrapatellar fat pad cranially and the subgastrocnemius fascia caudally (B); osteophytes at the apex of the patella (C); and new bone formation along the femoral trochlea (D). Notice the shallow femoral groove with poor patellar covering.



By Sara Black

Client Column | Bree Black

Bree is a two year old, very active and loveable Springer Spaniel. She is a Level One Ground Scenting Search and Rescue Dog with London Search & Rescue. She is also training in the Search Dog Heroes Project. Being such a fast-moving girl, it wasn't always obvious to me but I was noticing that she limped sometimes on her front right leg. We tried various things with our local vet but she never limped or showed signs of pain when we were there. We then got some x-ray pictures done which is how we ended up at Fitzpatrick Referrals.

Throughout the consultation, I had everything explained about what had been found - both elbows had dysplasia, and her right shoulder needed a bit removed and a plate put in. She also had a luxating patella. The thought of my active girl being on lead walks for three months was horrible but

PROMISE

Orthopaedics & Neurology

it's not long considering how many more years we hope that she has to live. Surgery would give her the chance to be pain-free, so I left Bree in the capable hands of orthopaedic Senior Surgeon James Guthrie for four days. I received a call daily with her progress which helped to reassure me.

Bree's recovery seemed slow to me but was on target. I had a couple of panic moments in the first few weeks but my phone calls were answered and my mind put at ease.

I'm pleased to say that Bree has made a full recovery and is back at training - progressing better than ever now her discomfort, that she hid so well, has been removed. I am eternally grateful to James and the team at Fitzpatrick Referrals. It is a joy to watch a Springer having so much fun in life. Even when she's working, she is having fun. All for the love of a ball!

Fitz & Pieces

CPD dates for your diary - Eashing

25th June : Miguel Solano Wobbly knee caps – the ins and outs of treating patellar luxation

30th July : James Guthrie Carpal conundrums and tricky toes: recognising and managing conditions of the distal limb

27th August : Cameron Black and Fiona Doublebday Hope vs hype - regenerative and conventional treatment modalities in the management of musculoskeletal disease

To book visit: <u>fitzpatrickreferrals.co.uk/CPD</u>

Welcome Laura Largan

We are pleased to announce that Laura Largan has been appointed Head Nurse at our oncology and soft tissue centre. Laura has joined us with extensive experience across both primary and referral practice. She gained her first taste of referral nursing at our orthopaedic and neurology centre – spending nearly five years expanding her knowledge with us before moving on to numerous referral practices across the South East. Laura has also completed an ILM course in leadership and management.

Cruciate? Elbow? Patella? We can see right now. We can also see left now.

We will see your client for these cases within 48 hours*

*See website for details - Orthopaedics and Neurology fitzpatrickreferrals.co.uk/48hr-promise

IN AN EMERGENCY To discuss a case or for any urgent or emergency referrals, please call us

For orthopaedic and neurological emergencies 01483 423761

For oncological and soft tissue emergencies 01483 668100

For more information visit fitzpatrickreferrals.co.uk



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