



CAPITAL CITY SPECIALTY & EMERGENCY ANIMAL HOSPITAL

SURGERY NEWSLETTER

FEBRUARY 2025



Capital City Expansion

As many of you may know, Capital City Specialty & Emergency Animal Hospital purchased an adjacent 4000 sq foot unit to expand our hospital. Due to demand, we quickly grew from 58 employees when we first opened to nearly 160 within our first 12 months. We were bursting at the seams!

Steve Venman and his team at Interior Contracting & Management Inc. were fantastic and completed the build out before the expected due date, almost unheard of in the current construction climate. The new expansion includes an additional eight consulting rooms (for a total of 18 consulting rooms), a larger dental suite, a larger cardiology unit, a larger stock room, and a mezzanine for



the managerial and administrative teams. These changes allowed us to convert the old dental suite into a second radiology room and the old cardiology room into a second ultrasound room.

Email us if you would like to come by for a tour!



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CASE OF THE MONTH - ANTEBRACHIAL SOFT TISSUE SARCOMA RESECTION AND FREE-MESHED SKIN GRAFT RECONSTRUCTION

Dr. Sarah Boston, DACVS, ACVS Founding Fellow in Surgical Oncology and Oral and Maxillofacial Surgery

Duke is a 4-year-old neutered male Bernedoodle with a history of an intermediate grade soft tissue sarcoma (STS) on of the left mid-antebrachium that was diagnosed via incisional biopsy with his primary care veterinarian.

Duke was normal on physical examination except for the mass. He had a 1.5 X 2.5 cm mass on the left caudal antebrachium that was 5 cm below the olecranon. The mass was firm, slightly mobile, non painful, non ulcerated and subcutaneous.

Duke had a CT scan of the thorax, abdomen and left forelimb for local and distant staging, which showed a solitary, peripherally contrast-enhancing to heterogeneously contrast-enhancing subcutaneous mass adjacent to the mid-diaphysis of the left ulnar, compatible with malignant neoplasia without evidence of osseous involvement. There was no evidence of pulmonary metastatic disease or thoracic lymphadenopathy. Unremarkable abdomen.

Duke was taken to surgery for wide excision of the mass, which involved 3cm radial margins around the mass and the antebrachial fascia as the deep margin. The defect was repaired with a free mesh graft, which was harvested with separate gloves and instruments from the lateral thorax. The skin graft was sutured into the wound defect with simple continuous sutures along the periphery and intermittent sutures in each mesh hole. A sterile bandage with a Mepilex dressing and splint placed post operatively.



Figure 1: Left antebrachium after resection and placement of free mesh skin graft immediately post operatively.



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Duke was hospitalized overnight for supportive care and pain management. He was discharged the following day. Duke had bandage changes every 3-4 days for one month post operatively. Initially the graft was healing well, but a superficial infection developed, which was managed with oral antibiotics, Mepilex dressing and later topical Polysporin. Despite the infection and loss of ~30% of the graft, it continued to heal well.



Figure 2: Left antebrachium 2 weeks post operatively. Unfortunately, a superficial infection resulted in partial loss of the graft. However, there is still healthy granulation present and ongoing healing.



Figure 3: Left antebrachium 4 weeks post operatively. The defect has almost completely healed with a combination of full-thickness graft and epithelialization.

Histopathology was consistent with a high grade fibrosarcoma with complete margins. Immunohistochemistry was performed to rule out histiocytic sarcoma due to some of the features noted on the histopathology as well as the patient breed, this was negative. Adjuvant chemotherapy was discussed with the owners and they are considering this option. Chemotherapy for the treatment of high grade STS is controversial.

In many cases, antebrachial STSs can be managed with preservation of the limb. This is one example of a strategy for successful treatment of STS in this location without limb amputation.



DID YOU KNOW

What the Weirdest Thing I Have Ever Seen in Surgery Is?

One time, I did an abdominal explore on a dog that was devoid of abdominal organs. Or at least that's what I thought.

I was called in to perform an emergency laparotomy on a 2 yo MC labradoodle with an acute history of vomiting and inappetence. The patient had a history of foreign material ingestion and had an episode of lethargy and vomiting 7 days. A complete blood count and chemistry panel were performed and were largely unremarkable. A point of care ultrasonound exam was performed and there was found moderate free abdominal fluid. The sample fluid was consistent with a modified transudate and no intracellular bacteria were identified.

We went to surgery. Upon entering the abdomen, I was shocked. There was no GI tract. No kidneys. No bladder. No omentum. Just a pink, flat, smooth dorsal wall of the abdomen. There were three purple, beet-like projections at the cranial aspect of the abdomen. Completely bewildered, I phoned a friend. We pieced together that this was most likely a condition called sclerosing-encapsulating peritonitis.



Sclerosing encapsulating peritonitis (SEP) is a chronic form of peritonitis characterized by fibrosis and thickening of the visceral and parietal peritoneum with massive adhesions of the abdominal organs. Peritoneal inflammation and intestinal adhesion cause clinical symptoms, such as anorexia, and vomiting, and ascites.



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While well-described in humans, what we do know in veterinary medicine is gleaned from a few case series and case reports.

The etiology of SEP is often unknown in animals, but in humans, it can stem from abdominal neoplasia, peritoneal dialysis, and other conditions that cause subclinical abdominal inflammation. Prognosis in animals is generally considered to be grave and three cases have been known to survive beyond five months; one successful long-term outcome was achieved with surgery and tamoxifen.



With this information, I made an tentative incision into the thick, pink wall of tissue, I confirmed it was a fibrous cocoon approximately 4 mm thick. The abdominal contents were adhered to one another in an immobile wad in a sea of foul-smelling, inflammatory fluid. Gentle dissection of any organ resulted in significant tearing of serosal tissues. The owner was called intraoperatively and the decision was made to euthanize on the table due to poor prognosis. Post-mortem, the abdomen was explored a focal area of omental adhesions was appreciated in the descending duodenum and a perforating toothpick was identified mid jejunum. I presume that the toothpick had caused significant damage to the duodenum the week prior, coinciding with the first onset of clinical signs. This likely caused the abdominal inflammation that stimulated the SEP. My guess is that the most recent onset of clinical signs had been caused by the toothpick perforation and that no bacteria could be identified on cytology during workup because the fibrous wall cocooned the abdominal contents completely.



MEET OUR TEAM

Jessica

Head Imaging Technician

Bonjour, my name is Jessica. I started my career almost 20 years ago in specialty surgery where, for 9.5 years, I got to work alongside great surgeons. My time in specialty surgery taught me so much but a change was needed to expand my knowledge and skills. So, I made the switch to Oncology and Internal Medicine. I spent 4.5 years combining my interests in both specialties. This role allowed me to expand and continue honing my skills with advanced imaging modalities.

I became solely an imaging technician in 2021. In this role, I perform sedated orthopedic radiographs, CT scans and MRIs. My current daily role at Cap City includes organizing multiple CT scans, orthopedic x-rays (from total hip replacement templating to follow-up orthopedic radiographs). As our caseload continues to grow, I am excited to have welcomed two additional team members to the imaging department, which allows us to efficiently handle the busy workload while continuing to maintain high-quality care.

Outside of my professional life, I am an avid sports enthusiast. I enjoy playing softball, tennis, golfing, precision sports,



including archery and darts. Additionally, I love spending time in nature, especially hiking with my dog, Darlene. It's a good thing she's pretty because she sure is a ball of energy with a whiff of lovable crazy. Our adventures often lead us to beautiful trails and the soothing nature sounds allow total disconnection from my busy mind.

Overall, my career in veterinary medicine has been a remarkable journey filled with growth, continued learning, and a profound love for animals. I look forward to what the future holds and the many more lives I can touch through my work alongside the amazing team at Cap City.



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REFERRALS

As the largest specialty hospital in the National Capital region with five small animal surgery specialists (Drs. Julius Liptak, Jeff Biskup, Lea Mehrkens, Phil Larose, and Sarah Boston) we are able to offer the complete range of surgeries to our referring veterinarians and owners. From TPLOs to total hip replacements, from basic to complex fractures and luxations repairs, from hemilaminectomies for dogs with IVDD to brain tumor resections, from cystotomies to portosystemic shunt attenuations, from laparoscopic spays,

gastropexies and cholecystectomies to subcutaneous ureteral by-pass and thoracoscopic lung lobectomies, and from cutaneous tumor resections to limb-sparing surgery and oral and maxillofacial tumor resections, we do it all. Not only do we do it all, but we do it all on weekdays for elective and emergency cases and after hours on weekends for emergency surgeries. We also have 24/7 support from our emergency team as well as specialists in anesthesia, emergency and critical care, and internal medicine.

To refer cases to our surgeons, go to our website at <https://capcityvet.com/surgery-referral-form/>, or call or email Jenn at (613) 244-7387 or surgery@capcityvet.com.



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