# MASH

MELBOURNE ANIMAL SPECIALIST HOSPITAL

## WINTER NEWSLETTER 2026

### Welcome to the latest edition from Dr Ralph Webster


As always, we would like to thank our referring veterinary community for the trust you place in our team. We greatly value the collaborative relationships we share with practices across Victoria and remain committed to providing specialist and emergency care that supports both you and your clients.

At MASH, our services continue to grow across Emergency and Critical Care, Internal Medicine, Orthopaedic Surgery, Soft Tissue Surgery, Neurosurgery, Diagnostic Imaging, and Anaesthesia. We remain focused on providing collaborative, patient-centred care while supporting referring veterinarians through accessible communication and practical clinical support.

We are also continuing to expand the educational resources available through our website, including information and articles designed for both referring veterinarians and pet owners.

We hope these resources provide practical support for your teams and clients alike.

**Scan the QR code:**
To explore our growing online resource library.

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# EQUIPMENT HIGHLIGHT

**We are proud to have *Covidien RapidVac Smoke Evacuator* units installed in all our operating theatres at MASH, to enhance air quality and help protect our team in theatre.**

*Covidien RapidVac Smoke Evacuator Unit*

As veterinary practice continues to advance, it is now increasingly common for general practices to have access to monopolar electrosurgery within their theatres.

The benefits of electrosurgery are substantial, particularly through improved haemostasis, surgical efficiency, and tissue handling. However, alongside these advances comes increased awareness of the occupational health considerations associated with surgical smoke generated during electrocautery. Surgical smoke contains ultra-fine particles and volatile compounds that may pose respiratory health risks to theatre personnel with repeated exposure over time. Studies have shown that chronic exposure to surgical smoke is comparable to significant cigarette smoke exposure for operating room staff, highlighting the importance of effective smoke management.

At MASH, we utilise Covidien RapidVac smoke evacuators in each of our surgical theatres to help reduce airborne contaminants and improve theatre air quality for our teams. While smoke evacuation systems have traditionally been more common in specialty and human healthcare settings, reconditioned units are now becoming increasingly available at a reasonable price point, making this technology more accessible for general practice.

*Smoke Evacuation Electrosurgery Pencil*

For practices already utilising electrosurgery, smoke evacuation may represent another practical step in the ongoing journey of incremental improvement in theatre standards, staff wellbeing, and workplace safety.

# 5 QUESTIONS IN 5 MINS

**Dr Alison Stickney, *Internal Medicine Specialist* and *Head of Internal Medicine at MASH***

**Q1:** Do you remember when you first decided you wanted to become a veterinarian?

Yes, I was in high school in year 10 and we had to do a poster on what career we were interested in. I had always had a love of animals from a young age but was also keen on a career in the health sector so becoming a veterinarian seemed to be a great fit. My career teacher told me it was too competitive to get into the course, and to not bother trying - I showed her!

**Q2:** Was there a defining moment when you decided to become a specialist?

Not a single moment, but I became very keen on medicine in my first year after graduation. I remember referring a pyrexic dog to a medicine specialist, and I was so far off the mark with the diagnosis! I thought that specialist was so clever, and they inspired me to do further study and improve my diagnostic skills.

**Q3:** What is the biggest challenge as a full-time working mum and veterinary specialist?

The juggle is hard and the guilt is constant. I feel guilty when I have to walk out of work on time to pick up the kids. I feel guilty when I'm at work late and miss dinner. Finding balance has always been an issue for me.

**Q4:** What is your favourite case / disease / condition to treat?

I love diagnosing and treating immune-mediated polyarthritis in dogs. Often these patients are referred after a prolonged period of illness, and I can diagnose them and make them feel so much better within 12 hours (my record is 2 hours from admission to diagnosis on a Friday afternoon!).

I also love treating FIP in cats now - used to be my least favourite disease, but now it makes me very happy to diagnose one!

**Q5:** What advice would you give now to your 21-year-old self?

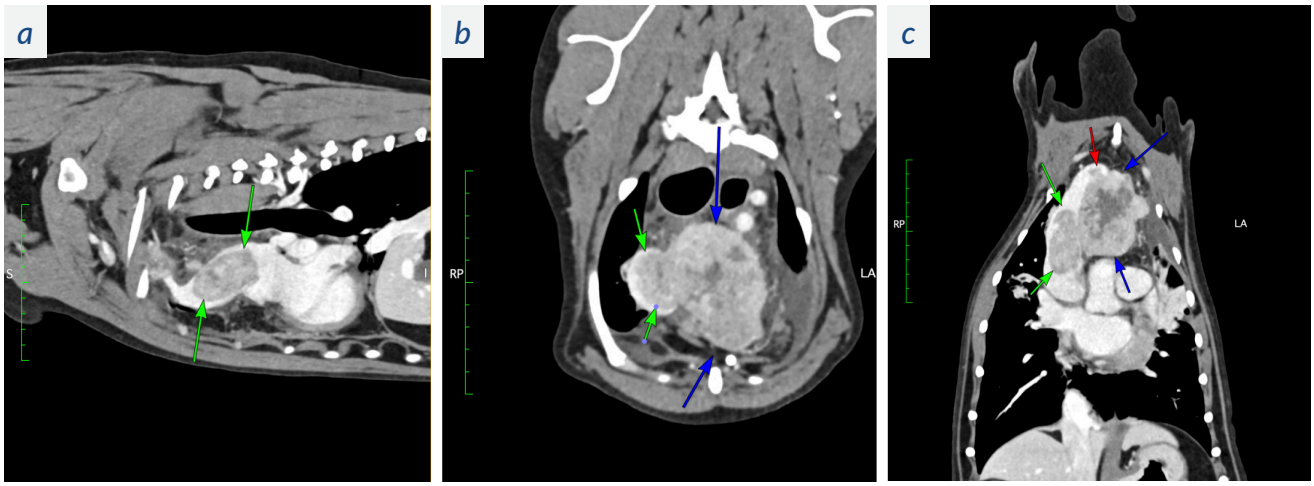
Enjoy the journey. Achieving goals is great, but if you don't enjoy the process, life goes by too quickly and all you've done is work!

**Bonus question:** What is your favourite part about working at MASH?

The team is so welcoming and supportive of each other. The culture here is really positive, and that's something very special.

*Alison with her senior nurses Erin (L) and Bella (R)*

# WHAT IS YOUR DIAGNOSIS?




*CT images of a 10yo MN Mix-Breed dog presenting in respiratory distress. (a) sagittal view. (b) transverse view. (c) transverse view.*

Our ECC team recently saw a 10yo MN Mix-Breed dog, weighing 50kg, which presented in respiratory distress. The respiratory signs had progressed over the previous 12 hours, and the dog had previously been well.

The main clinical exam findings were dull lung sounds, RR 80/min, HR 120/min, no murmer, temp 39.1, and SpO2 88%. After initial stabilisation with flow-by oxygen and butorphanol sedation, POCUS ultrasound was performed. This quickly identified a large volume pleural effusion. Emergency thoracocentesis retrieved an enormous volume of pleural effusion – 1.6L from the left side a further 800ml from the right side, a total of 2.4L! The characteristic white-milky appearance of the effusion immediately arose suspicion for a chylothorax, although a septic exudate (pyothorax), or another non-septic exudate remained possible.

In-house cytology found large numbers of small lymphocytes, typical of a chylous effusion, later confirmed by the pathologist. Cardiac disease was considered unlikely based on absence of a murmer, and a normal LA: Ao ratio, and total protein of 40g/L (more consistent with an exudate than a transudate). Once the patient was stabilised, a CT scan was performed. Unfortunately, the CT (above) found a large cranial mediastinal mass invading the cranial vena cava. Treatment options were limited, and the owners decided not to proceed further. Although this case resulted in euthanasia, the owners were grateful for the immediate relief provided by thoracocentesis.
They we also grateful to have a definitive diagnosis within a few hours of arriving at our hospital.

### Differential diagnosis for chylothorax:

- Idiopathic (most common)
- Congestive heart failure
- Constrictive pericarditis
- Pericardial effusion
- Neoplasia
- Trauma
- Thoracic surgical complications
- Heartworm
- Systemic fungal disease
- Thromboembolic disease in the CVC
- Anything that disrupts the thoracic duct as it drains into the cranial vena cava

*ANSWERS: CT images of a 10yo MN Mix-Breed Dog presenting in respiratory distress. The dog was subsequently found to have a chylothorax. (a) cranial mediastinal mass (blue arrows) invading the cranial vena cava as a large filling defect (green arrows)– sagittal view. (b) Cranial mediastinal mass (blue arrows) invading the cranial vena cava as a large filling defect (green arrows) – transverse view. (c) cranial mediastinal mass (blue arrows) invading the cranial vena cava as a large filling defect (green arrows) with second site of cranial vena caval invasion (red arrow)*

# TIPS AND TRICKS

Our senior surgery nurses, *Milly Reid* & *Emma Bruggeman*, share 5 quick tips and tricks for a great general anaesthetic for our GP colleagues.

## 1 The importance of patient warming

Actively warming the patient during induction and preparation time helps maintain a normal temperature, allowing for a smoother and quicker recovery. Hypothermia in patients has been linked to delayed recoveries, post-anaesthesia, hypoventilation, decreased organ function (specifically kidney and liver), and an increased incidence of post-op infection.

## 2 Capnography is your friend

Capnography measures the carbon dioxide (CO2) in an exhaled breath. Having access to and using a capnograph also allows for the diagnosis of hypoventilation and hyperventilation, apnoea, exhausted soda-lime, leaks in the breathing circuit, connectors or ET tubes and oesophageal intubation. Normal values range between 35mmHg and 45mmHg for a healthy patient. Below 35mmHg may indicate hyperventilation, leaks in the circuit or ET tube, hypothermia or a light anaesthetic plane. Values above 45 mmHg may indicate hypoventilation, CO2 re-breathing (possibly due to exhausted soda-lime), an obstruction in the ET tube or hyperthermia.

## 3 Pre-oxygenate whenever you can

Pre-oxygenating a patient using a well-fitted mask for as little as 5 minutes prior to induction increases the patient's oxygen saturation after pre-medication and can prolong the rapid desaturation if difficulties arise during the intubation process.

## 4 Using ideal body weight versus actual body weight

Assessing overweight patients based on ideal bodyweight and body condition scores allows for more accurate medication. Thoroughly assessing patients and assigning them a body condition score prior to surgery can help provide adequate pain relief, sedation or fluid therapy.

For example, a Labrador may weigh 40kg on the scales and have a body condition score of 8/9. If this patient's ideal body weight is 35 kg, medication and fluid therapy should be based on that ideal body weight.

## 5 Dealing with low blood pressure under anaesthesia

If hypotension arises under anaesthesia, a Doppler is a great tool to confirm this if you have access to it. A doppler reading will give you a systolic blood pressure for a dog and an approximate mean arterial pressure (MAP) reading for a cat. If the Doppler value confirms hypotension, bring this to the attention of the attending veterinarian, and openly discuss a plan with them, such as decreasing isoflurane, determining when a fluid bolus is necessary versus using medications such as Atropine, Glycopyrrolate, and/or a Dopamine CRI.

# DID YOU KNOW?

**A new medication may help reduce the incidence of Feline Lower Urinary Tract (FLUTD) cats re-obstructing.**

A recent study from the University of Minnesota, St Paul, Minnesota found a drug called LORAZEPAM reduced the incidence of recurrent obstruction in FLUTD cats (JAVMA, May 2026). This prospective, double-blinded, randomised trial involved 80 male cats. The cats received standard treatment for urethral obstruction, as well as either Lorazepam or Placebo for 1 month after hospitalisation for urethral obstruction.

The study found that those cats given Lorazepam had a significantly reduced incidence of obstructing again, as well as a lower incidence of lower urinary tract signs after discharge. The medication was shown to be safe but can cause sedation and ataxia. In our experience this can occur particularly if combined with gabapentin. The ECC team at MASH are excited to start using this new medication to help improve outcomes in our FLUTD cats.

## OPEN ACCESS ARTICLE:

Lorazepam reduces recurrence of urethral obstruction in male cats: a prospective, randomized, double-blinded, placebo-controlled study.

*Alexa Splittstoesser DVM, Jessica Kerley, Jody Lulich, Aaron Randall PhD and Kelly Tart DVM, DACVECCI; JAVMA* ***Volume 264 (2026): Issue 5 (May 2026)***

Scan the QR code to access the full article.