Incisional Gastropexy for Treatment of Gastric Dilatation Volvulus
A 10 Minute “Solo” Incisional Gastroplexy Technique for Treatment or Prevention of Gastric Dilatation Volvulus: “The Smeakopexy” page 14
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Happy Spring! As we head into the nice weather months and the busy season at veterinary practices around the state please be aware that NYSVMS is working hard for you!

The Grassroots Legislative Network (GRLN) hosted their annual legislative reception on March 6 at the Fort Orange Club in Albany. This was the chance for members to discuss the important issues of veterinary practice with legislators. Thank you to all of the members who attended this event despite the weather and spoke on many different topics. It is through these events that we are able to educate our lawmakers one-on-one, and to advocate on your behalf.

It’s not too late to register for the NYS Spring Veterinary Conference May 4-6 in partnership with Cornell CVM at a brand new location the Westchester Marriott in Tarrytown. This conference offers 87 hours of continuing education from 4 tracks where you can earn up to 22 hours of CE credits. Go to www.nysvc.org for more information! One of our featured speakers at the conference, Daniel Smeak, DVM, DACVS, wrote the cover article, A 10 Minute “Solo” Incisional Gastropexy Technique for Treatment or Prevention of Gastric Dilatation Volvulus. Come check out the latest products from over 55 vendors in the exhibit hall and attend a do not miss brand new event Comedy & Cocktails featuring Kevin Fitzgerald, DVM veterinarian and stand-up comedian. And the annual Purple Party and Wine Wall is always a good time!

This issue’s legal article tells you what as veterinarians you need to know about equal pay including a definition of what it means and what effect it has and a description of NYS equal pay laws. This is a very timely issue that has received a lot of media attention the past few months and it is important to review the NYS laws.

And check out the idea that could be the next big breakthrough in animal health with a wrap up of the second annual Cornell Animal Health Hackathon on page 9.

Our new Power of 10 group held two programs in January and March discussing important topics including setting boundaries, how to avoid burnout and what to do when the Office of Professional Discipline comes knocking on your door. The facilitator of the January program, Julie Squires, Compassion Fatigue Specialist, has written an article on creating boundaries—something that I am sure we all struggle with. Establishing and enforcing personal and professional boundaries is not easy work.

It is hard to say no. But it is something that is important to your practice as well as your personal relationships.

As we head into warmer weather and the busy season, please know that NYSVMS is working hard on your behalf!

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What Veterinarians Need to Know about Equal Pay

Veterinarians, like any employer, are bound by federal and state laws designed to promote equal pay in the workplace. The federal Equal Pay Act was passed in 1963, and its New York counterpart, Section 194 of the New York Labor Law, followed shortly thereafter. Reduced to their essence, these equal pay laws prohibit employers from paying an employee less than another employee of the opposite sex for equal work performed in the same workplace.

But, by many accounts, workplaces throughout both the nation and New York continue to be plagued by lingering gender pay disparity despite the half-century old equal pay laws that prohibit such disparities. The wage gap persists. Consequently, it is imperative for veterinarians to remain familiar with the equal pay laws and to understand whether their compensation practices—even unintentionally—could be violating those and other laws that prohibit gender-based discrimination in the workplace.

Equal Pay—What Does it Mean?

New York’s equal pay law, much like its federal counterpart, generally prohibits two things: (1) employers cannot pay an employee less than another employee of the opposite sex for equal work performed in the same workplace; and (2) employers cannot ban employees from discussing their own rate of pay with others. While it is important to note that paying employees less than others based on their gender is also a form of gender discrimination, which is prohibited by other federal and state laws that apply to unlawful discrimination in the workplace, the focus of this article will remain on the equal pay laws.

Many veterinarians assume their veterinary hospitals comply with the equal pay laws. After all, they would never pay a male employee more than a female employee due to the belief that men deserve or need more money than females. Things aren’t always so obvious, however. The more likely equal pay violation will occur in a subtle way—perhaps inadvertently. For example, if a veterinary hospital’s male licensed veterinary technician is more successful in negotiating a higher rate of pay than the hospital’s female licensed veterinary technician, such a wage disparity could violate the equal pay laws. Whether or not a violation of the equal pay law exists often depends on whether one of several exceptions are present. Employers are prohibited from paying an employee less than another employee of the opposite sex for equal work performed in the same establishment, except for situations in which the employee is paid according to:

- a seniority system;
- a merit system;
- a system which measures earnings by quantity or quality of production; or
- a “bona fide factor” other than sex, such as education, training, or experience.

A “bona fide factor” warrants some further discussion. Under the less stringent federal law, pay disparity is allowed based on “any other factor other than sex.” Under the New York equal pay law, however, a “bona fide factor” must be present, meaning one that is not based on a sex-based differential in compensation and must be job-related and consistent with business necessity. A “business necessity” is defined as a factor that bears a manifest relationship to the employment in question.

Importantly, the “bona fide factor” exception is not absolute. That exception will not apply when an employer demonstrates that:

- The employer uses a particular employment practice that creates a disparate impact on the basis of sex;
- An alternative employment practice exists that would serve the same business purpose without producing the pay difference; and
- The employer has refused to adopt the alternative practice.

There are a great many scenarios that could fall within the “bona fide factor” exception. But a number of scenarios will often fall into a more gray area where the answer is not entirely clear whether the factor for a wage disparity is based on a “bona fide factor” or one of the other enumerated exceptions. In those cases, it is important for veterinarians to consult with legal counsel to ensure their compensation practices are in compliance with the equal pay laws.

Multiple Locations—What’s the Effect?
The New York equal pay law could also ban gender pay disparity, absent an exception, across a veterinary hospital’s multiple locations. This is again a departure from federal law, which treats each location as a separate establishment. According to New York’s equal wage law, employees are considered to work in the same establishment if they work “for the same employer at workplaces located in the same geographical region, no larger than a county, taking into account population distribution, economic activity, and/or the presence of municipalities.”

Takeaway

Ensuring whether a veterinary practice is in compliance with federal and state equal pay laws often requires an examination of the impact of its policies, rather than simply refraining from acting in a discriminatory manner. The intent behind equal pay laws is not simply to prevent blatant discrimination, but also to address unintentional, systemic practices that lead to a persistent wage gap between the sexes. In order to safeguard against potential liability, both financially and from a public relations standpoint, veterinarians should revisit their current business practices and examine their effects. Should your veterinary practice require further guidance, the attorneys at Jackson Lewis P.C. are well equipped to assist with any equal pay concerns, and can be reached at (518) 512-8700.

Nicholas Brdar, Esq. Frank Fanshawe, Esq. Jackson Lewis P.C.

1 N.Y. Lab. Law § 194
2 See, for example, 42 U.S.C.S. § 1981; N.Y. Exec. Law § 296(a)
3 29 U.S.C.S. § 206(d)(1)
4 See, i.d.
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Hackathon Inspires Innovations for Animal Health

In lofts that overlook Ithaca, N.Y., nearly two hundred students from Cornell University, Binghamton University, Georgia Tech, New York University, and Tufts University competed in January to see whose idea could be the next big breakthrough in animal health at the second annual Cornell Animal Health Hackathon.

Co-hosted by the Cornell University College of Veterinary Medicine and Entrepreneurship at Cornell, the competition invited students from any college or major to come up with innovative solutions in the animal health sector.

“The Animal Health Hackathon is intended to be an immersion learning experience for students to build business and entrepreneurship skills,” said Lorin D. Warnick, the Austin O. Hoey Dean of Veterinary Medicine at Cornell. “The veterinary profession continues to diversify, to fill vital roles in society and offering comprehensive business and entrepreneurship opportunities for students, is a core strategic priority for the college.”

The event kicked off with keynote speaker and Cornell alumnus Ted Sprinkle, CEO of Pet Partners LLC, who spoke to the crowd about his long and varied career in both veterinary medicine and business.

“Don’t let your degree get in the way of your thinking,” he said. “Don’t be pigeonholed into going one way when your heart is telling you to go another.”

During the weekend event, students formed teams and collaborated with veterinarian and entrepreneurial mentors—including two-dozen Cornell alumni—from around the country. After 50 original ideas were pitched and groups formed, 10 teams presented their concepts, each vying for $5,000 in cash and prizes.

“The energy and the passion in that room was palpable,” said Sprinkle. “Normally, at this stage of their journey, it can be hard to get students to sit down and take in the big picture—but the students at this event were definitely seeing the big picture.”

All innovations created at the hackathon had to address a problem in one of three categories: client and customer experience; diagnostics, prevention and treatment; or clinical workflow and compliance.

The judges evaluated the product or service on novelty, scale of impact and viability.

“The hackathon was refreshing—and essential in providing veterinary students with the reminder that there is so much more out there than our particular area, that much can be gained by collaborating with other professionals,” said Nicholas Walsh, a third-year Cornell veterinary student who returned to the event for a second year in a row to compete.

“The hackathon brings together so many diverse fields that can learn from each other, gain exposure to issues that have a broader context and build solutions together,” said Isabel Jimenez, a third-year Cornell veterinary student.

In addition to cross-college collaborations, students got to see their business ideas come to rapid fruition in the course of a single weekend.

“I learned that it’s always valuable to step outside your comfort zone,” said Cornell veterinary student Amari Suskin-Sperry about her first hackathon experience. “From an initial concept to a fully-functioning app, my idea grew into a product in 36 hours.”

The grand prize winners developed HygenaPet—a $10 spray of beeswax and carnauba wax that owners can spritz on their dogs’ backsides, allowing the poop to slide right off the fur rather than stick.

Four more groups won additional honors in the event’s verticals. Encompass won the diagnostics and therapeutics vertical with an app that gathers client preferences and habits to help veterinarians customize care. CATCHer and Squeak tied in the customer experience vertical, each creating a smart trap for feral cats and mice respectively. CowFinder won the workflow vertical with a product that helps locate a specific dairy cow in a herd.

“The ideas they came up with are absolutely outstanding,” said judge Steve Ireland, director of marketing for Pet Partners. “I want to see some of them take it and run with it.”

“It’s inspiring to see such enthusiasm, creativity and innovative thinking directed toward animal health and veterinary medicine,” said Warnick. “My hope is that this will be just the beginning in terms of the entrepreneurial spirit that’s been sparked at this event. This was an important reminder that veterinarians can start software companies, apply new technology to diagnostic tests and treatment, start non-profit organizations or become industry executives.”

Photos: Cornell University College of Veterinary Medicine
Historically when discussing market conditions the veterinary practice sales market was split into an urban/rural divide. That changed in 2017 when consolidators indisputably established themselves as a fully separate marketplace, more volatile and deceptively difficult to navigate than the traditional vet to vet practice sale. Each of these markets has unique attributes and outlooks and must be considered, tracked, and navigated separately.

Consolidator Marketplace
If you think about your practice as an investment and have one producing associate, you should track this marketplace as closely as the stock market. After years of relatively steady prices in relation to earnings before interest, taxes, depreciation and amortization (EBITDA), the prices corporate consolidators would pay jumped significantly. They have always been higher than what a young veterinarian without financial backing could pay, but not enough to make most practice owners reconsider selling to a veterinarian or reconsider selling to their associate. All of that changed in 2017.

This is a direct result of trends outside of the veterinary industry, particularly in the private equity marketplace, paying high prices relative to EBITDA. Private equity investors buy and sell businesses similar to the way you buy and sell stocks. They have historically seen better investment returns than the stock market. After years of small increases in the number of corporate consolidators, private equity investors hungry for safe, affordable investments flooded the veterinary marketplace.

The flood of private equity money into the veterinary industry led to more companies buying veterinary clinics, resulting in a completely separate marketplace. With increased numbers came increased competition driving prices up, and now they are above what private equity companies are paying on average in other industries.

Most veterinarians still select one or two well-known groups and accept the highest offer. Veterinarians who use professional help and create a blind auction among investors in the marketplace made more than they ever thought possible.

Predictions
The consolidator marketplace is a seller’s market right now, both prices in relation to earnings and high competition among buyers. Additionally, this market continues to become more crowded, while tracking the data and attaining the highest possible market price is becoming increasingly complex.

So far in 2018 we’ve seen new records for negotiated prices and more investors entering the marketplace. The acquisition trend will continue, but the prices are much more volatile than the vet to vet market. If you have a two or more full-time doctor practice and have considered retirement within the next five years, I advise you to look into selling this year.

If you aren’t ready to sell yet, keep an eye on interest rates and stock prices. Interest will have the biggest effect on what consolidators pay. If stock prices come down closer to a historical average or below, investors will likely shift away from private equity and slowly drive prices down.

The Vet to Vet Sales Marketplace
Rest assured, young veterinarians still want and can buy your practice. Prices in the vet to vet marketplace are more consistent than corporate, but demand breaks into two sub-markets, urban and rural.

I use the terms “urban” and “rural” loosely, but generally each represents areas young people are moving to and where they are leaving. The market conditions come out of each market’s respective migration trends.

Here’s what the urban and rural markets share: practice value. While local demographic conditions such as property value and median income affect practice earnings, the price a veterinary clinic can sell for in relation to those earnings (EBITDA) is relatively consistent.

There is still the myth that a veterinary clinic is worth one year’s gross. Another common myth is that every practice is worth 70% of gross revenue, which is a misinterpretation of the truth. The 70% myth comes from when looked at over time, the average practice sells for 70% of gross. In reality, practices can sell in the vet to vet marketplace from around 45% of gross revenue up to 110%. If you examine the data more closely, you’ll see that average practice sales price has declined over time. If you look at sales price as a percentage of gross revenue in 2017 alone, it’s closer to 65%, as illustrated in Figure 1.

As you can see, even though the average practice sales price has declined, practices still sell for significantly more and less than 65% of gross revenues. While the urban and rural markets share pricing trends, they have completely different demand trends.

Urban Market
The urban market mainly consists of major metropolitan areas and surrounding suburbs. I include some smaller cites like Ithaca, because there are always Cornell CVM grads who consider moving back there.

Demand for practices in these markets is consistently high, but has picked up even more in recent years. The number of veterinarians selling has increased, but the buyer pool is consistently large enough that many buyers wait years to find a practice.

Predictions
Young people have been consistently moving to cities and surrounding suburbs since the industrial revolution and that has accelerated in recent years.
If you’re ready to sell, there’s a buyer for your practice. The most common mistake among urban practice owners is to assume that having one or two buyers is good enough. To realize the full market potential, you need to take advantage of the high demand, cast as wide a net as possible and create careful competition among buyers. Keep an eye on the increasing number of veterinarians 65 and older deciding to sell, as a flood of baby boomers could saturate the market right when you want to exit.

**Rural Market**
Practices sell, but outside of high demand areas, sellers need patience and consistent marketing efforts. There are many extremely profitable rural practices, as well as unprofitable practices with high potential. Usually these markets have lower competition and low real estate value, giving owners of profitable practices a very high standard of living. The struggle in selling rural practices is finding a buyer in the area or one willing to move there. If you’re planning to sell and live in a rural area, plan for at least a two year process.

**Predictions**
Migration away from rural areas has been consistent for generations and slightly increased with millennials. It’s harder to sell a rural practice on the vet to vet marketplace now than it was three years ago which will likely continue. Be sure to keep your practice profitable and up-to-date and keep an eye on your revenue. Practices grossing under $400,000 are nearly impossible to sell even in high demand markets. When the right buyer comes along, they could be looking at small towns all over the country, so you need to stand out. The other option is to grow the practice into a consolidator acquisition target. Most practices still sell to young veterinarians because they are committed to selling to a veterinarian owner/operator or the practice is too small for acquisition. This marketplace is much more consistent than the consolidator marketplace, but ongoing trends are becoming more prominent and the consolidator marketplace is having an effect.

Anything you have heard about the prices corporate consolidators paid, the terms of the deal, the number of consolidated practices or consolidators buying practices is outdated by the time you hear it. In other words, the marketplace for buying and selling veterinary clinics completely transformed in 2017 and continues through this year.

*Joe Stephenson, MA*
*Valuation Development and Sales Manager*
*Simmons Northeast*
Creating Boundaries: The Ultimate Self-Care

Ever find yourself saying “Yes” to something and then dreading it for days? When the event finally arrives, you show up a bit angry and resentful. Why can’t I say no? Why am I so concerned with what people will think if I just say no? Or maybe you’re more familiar with the feeling of being angry and taken advantage of. You call a client with bloodwork results and 15 minutes later you’re still on the phone and have answered every question imaginable. Why can’t I get off the phone in a reasonable time?

Or it’s your son’s birthday and you have plans to go out to dinner. Right before you are about to leave, your best client calls and wants you to euthanize her cat. But I don’t want to disappoint her you think. Or your son.

**It All Comes Down to Boundaries**

Boundaries. The line in the sand. The place where two things become different. What’s OK with you and what’s not OK with you.

Establishing and enforcing personal and professional boundaries is not easy work, but you can’t be compassionate without them. Self-love and self-care are one and the same and without boundaries we can’t effectively take care of ourselves. So how can we expect to effectively care for others? Boundaries are a way of not only respecting ourselves but protecting ourselves.

**Why We Lack Boundaries**

We are people pleasers. We want everyone to like us and we don’t want to “hurt anyone’s feelings.” So we agree to things we don’t actually want to do. We essentially lie because we believe that telling the truth will result in disappointing others. It most likely will. You have to make peace with disappointing others in order to take good care of yourself. And you can’t actually hurt anyone’s feeling. Our feelings come from our thoughts, not circumstances. We hurt our own feelings by what we think about circumstances.

We lack an understanding of boundaries. I know for sure you didn’t learn about boundaries in vet school. Most likely you learned how to not have boundaries, how to neglect your own needs. Is it any wonder we have so many veterinary care providers who are feeling exhausted and drained?

**Worthiness**

Many of us come with a “not enough” or “not worthy” tape playing on continuous loop. Some version of not being good enough or not worthy of having our needs met. We think “who am I to ask people to not text me from work unless it’s a true emergency?” I say “who are you NOT to?”

Others of us don’t feel comfortable standing up for ourselves but if we don’t others will see how far they can infiltrate our space. Boundaries prevent this.

Self-esteem and confidence

No question that enforcing boundaries is not easy and requires patience, diligence and practice, but consider the possibility that it’s these exact boundaries that will help build both your self-esteem and confidence.

**Where Do We Begin?**

Creating and Enforcing Boundaries

Sometimes a boundary may just be a simple “yes” or “no”. Yes to things that are good for us (help, for example) and no to things that are not good for us (working a rabies clinic on our day off). Where most go wrong is in believing that boundaries are to control other people. They are not. In their simplest form boundaries are about what you will do if someone violates your boundary.

“If you throw things, you will be escorted off the premises and no longer be a client here.”

“If I’m double booked in appointments I will sit down for a few minutes and eat my lunch.”

Start small

Find little things to start with such as telling friends you turn your phone on do-not-disturb at 9pm and that you won’t be answering texts after that time. You may likely have to remind them, that’s what it means to enforce boundaries. Once you get good at setting and enforcing small boundaries, then you can move to larger ones like setting boundaries with coworkers, clients and family, etc.

Use a mantra

Brené Brown, PhD, a research professor at University of Houston Graduate College of Social Work and author of the two #1 New York Times bestselling books The Gifts of Imperfection and Daring Greatly, uses the mantra “Choose discomfort over resentment” to remind herself to not be pulled into saying yes when she really wants to say no.

Practice, practice, practice

Start saying aloud (alone or to others) what it is you want to say. The more you become comfortable setting and enforcing your boundaries, the easier it will be.

**“Establishing and enforcing personal and professional boundaries is not easy work, but you can’t be compassionate without them.”**
“That sounds interesting but I cannot make it.”
“I only have 5 minutes in between appointments, but I wanted to call and let you know the good news about Rudy’s bloodwork results.”
“If you call multiple times throughout the day for an update on Max, I will only be able to speak to you after 4:00pm.”

Empathy, Compassion and Boundaries
Dr. Brown teaches “Empathy minus boundaries is not empathy. Compassion minus boundaries is not genuine…” She goes against the current belief that empathy can lead to burnout. Instead she feels that “empathy is not about feeling for someone but feeling with someone.” And in this way empathy actually can give back, tenfold.

Compassion fatigue has also been called empathy fatigue, but I believe it is when we get lost in feeling for others (rather than with them) combined with not having clear boundaries that we make ourselves vulnerable and drastically increase our chances for compassion fatigue.

But every day we get the opportunity to begin again. Every day we get another opportunity to create the life we want and shed the one that’s not serving us.

Don’t wait, today is a perfect day to start advocating for yourself and getting your needs met. ●

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Abstract
Gastropexy for treatment of Gastric Dilatation Volvulus (GDV) is often performed as an emergency procedure, therefore, an ideal method for gastropexy should be quick, safe and easy to perform. This article describes an incisional gastropexy technique designed to be readily performed by a surgeon without assistance for treatment of acute GDV and to prevent this condition. Like other successful permanent gastropexy techniques, this method apposes incised surfaces of the right abdominal wall and pyloric antrum. Illustrated technical details are included that allow the surgeon to readily create these incised surfaces, while avoiding potential complications such as inadvertent perforation of the gastric mucosa or diaphragm. In addition, standard gastropexy incision sites are described and shown to help prevent gastric malpositioning or outflow obstruction following surgery.

Introduction
When a dog develops gastric dilatation volvulus (GDV) or has gastric dilatation, simple repositioning of the stomach without a means of pyloric antral
fixation to the abdominal wall results in an unacceptably high risk of recurrent GDV (Glickman et al. 1998). Therefore, a right-sided gastropexy is recommended to prevent future bouts of GDV (Fossum 2002, Monnet 2003, Slatter 2003). Prophylactic gastropexy also dramatically reduces the risk of GDV in dogs with a familial history of this condition in first-degree relatives (Ward et al. 2003).

The goal of gastropexy is to create a permanent adhesion in an anatomic position between the stomach antrum and right body wall. Because gastropexy is often performed as an emergency procedure, an ideal method for gastropexy should be quick, safe and easy to perform. Simple suturing of the stomach to the abdominal wall without removing the serosa does not result in permanent fixation (Fossum 2002). It has been shown that raw gastric muscle must be in contact with incised muscle of the body wall long enough for permanent adhesions to form (MacCoy et al. 1982, Wacker et al. 1998). Various gastropexy techniques have been described that incorporate this essential principle. There have been a variety of permanent gastropexy techniques described some of which include tube gastropexy, circumcostal gastropexy, muscular flap gastropexy, belo-loop, and incorporating, and incisional gastropexy (Fossum 2002, Monnet 2003, Slatter 2003, Ward et al. 2003). Currently, a laparoscopic-assisted gastropexy technique (Rawlings et al. 2002, Naim et al. 2003, Slatter 2003 and intracorporeal gastropexy techniques (Mayhew 2009) are being utilized for practices equipped with laparoscopic equipment.

The objective of this article is to illustrate a novel gastropexy technique that incorporates the raw muscle surfaces between the stomach and abdominal wall, and that is very safe and quick to perform in my hands. Incisional gastropexy is one of the easiest of the techniques previously listed, especially for inexperienced surgeons. However, previous descriptions of incisional gastropexy may be somewhat confusing because the gastropexy sites are vaguely illustrated and explained, and this can lead to a number of iatrogenic complications.

In this article I chose to use series of pictures of a patient to help illustrate and describe this novel technique so important details can be shown, and the reader can more fully understand the procedure. Potential complications such as unnecessary hemorrhage in the abdominal wall, gastric perforation, malpositioning of the stomach, or diaphragmatic disruption are avoided with this technique. Due to the limited scope of this article, I refer readers to other veterinary sources for important information about the management of patients with this condition (Bojrab 1983, Monnet 2003, Slatter 2003).

**Technique**

With the animal in dorsal recumbency, aseptically prepare the ventral abdomen past the flank folds laterally, and 10 centimetres cranial to the xiphoid extending to the pubis. The surgeon stands on the LEFT side of the patient for the best exposure to the gastropexy site; the figures in this article are viewed from this perspective. Hence, the cranial aspect of patient shown in this series of images is to the right.

Create a linea alba incision from the xiphoid to umbilicus. This incision should be long enough to perform gastropexy and allow complete abdominal exploration. If more cranial exposure is needed in deep-chested dogs, continue to cut the linea incision (cranial but superficial to the xiphoid cartilage) with Mayo scissors. Remove the falciform fat to access the abdominal wall gastropexy site. If the gastropexy is done to treat, rather than prevent GDV, decompress the stomach and reposition the antrum to its normal location. Evaluate the stomach for evidence of necrosis after repositioning. Resect or invaginate necrotic stomach wall as the surgeon prefers (Monnet 2003). Evaluate the spleen for irreversible changes, such as necrosis or venous thrombosis and perform a splenectomy if necessary. Explore the entire abdomen and correct any problems encountered before performing the gastropexy.

Grasp the right side of the cranial abdominal wall incision, evert and roll the wall to allow palpation of the chondral aspect of rib twelve. The twelfth rib can be identified by palpating its cartilaginous margin that ends several centimetres caudal to the xiphoid cartilage.

The reader should note that there are individual breed differences in the location of the chondral aspect of ribs eleven and twelve. The eleventh rib can be used alternatively if the cartilaginous end of this rib is located several centimetres caudal to the xiphoid (Fig. 1). Remove the falciform fat and isolate the twelfth rib with your thumb and index finger and pull the rib away from deeper structures (Fig. 2). Place two towel clamps around the isolated rib approximately five to six centimetres apart from one another (Fig. 3). The cranial clamp should be positioned at the end of the twelfth rib approximately 5 centimetres caudal to the xiphoid (Fig. 1). Elevation of this rib by the towel clamps helps stabilize the rib and retracts it away from the diaphragm. In one stroke, directly incise over the twelfth rib with a scalpel blade between the towel clamps (Fig. 3). The transverse abdominal muscle will separate at once, exposing the cartilaginous rib. This incision can be done safely since the incision is directly over the stabilized rib preventing accidental blade damage to surrounding structures. The abdominal wall incision is about midway between the dorsal and ventral aspects of the right abdominal wall (Fig. 4).

To choose the correct site for the gastric antrum incision, draw an imaginary line from the lesser curvature parallel to the long axis of the dog. The stomach incision site is midway between the pylorus and the imaginary line (Fig. 5). Orient the stomach incision parallel to the long axis of antrum, and midway between lesser and greater curvatures to avoid damage to stomach vasculature. If you are a right-handed surgeon, lift up the stomach body with the left middle finger leaving your thumb and index finger free. Thoroughly wipe and dry your left thumb and index finger with a dry sponge. Carefully wipe the surface of the proposed antral gastropexy site (Fig. 6). Pinch about 4 centimetres of the antral site (full-thickness) between the thumb and index finger (held parallel to the long axis of the antrum) (Fig. 6). Lift the pinched stomach wall until the mucosa distinctly slips out from between the fingers. What remains grasped after this manoeuvre is just the serosa and muscular layer of the stomach wall.

With Metzenbaum scissors, create a partial thickness gastric antral incision by cutting to the base of the pinched wall towards the tips of the fingers (Fig. 7). Since the gastric mucosa has been squeezed away from the pinched wall, no perforation into the stomach is possible and only the seromuscular layer is incised (Figs. 7 and 8). The stomach incision should be 3-4 centimetres in length. If this technique is performed incorrectly and gastric mucosa is perforated inadvertently, close the mucosa with 3-0 absorbable suture material.
Conclusions
Gastric dilatation volvulus is a common, life-threatening problem in large deep-chested dogs and its reoccurrence is high if a right-sided gastropexy is not performed. Therefore, gastropexy is recommended for every patient with GDV, and also for susceptible patients with a history of gastric dilatation. After stabilization, surgical correction of GDV should be performed without delay because of the higher anesthetic risk of the patient. Small animal veterinarians see dogs with GDV and sometimes there is no avenue to refer the dog for treatment. Consequently, it is important that the gastropexy technique can be performed simply without the aid of an assistant. This technique, as described, can be easily performed alone. The towel clamps help elevate and stabilize the twelfth rib with one hand so the other can make the muscle incision with one bold stroke. As the rib is held elevated, the abdominal wall incision is created well away from the diaphragm and deeper vascular structures. Because the incision is made directly over the rib, it is safe to make a deep cut to expose raw tissue edges suitable for permanent adhesion formation. The described stomach slip technique allows the solo surgeon the ability to stabilize the stomach and, simultaneously, create a deep but partial thickness stomach incision without risking perforation of the mucosa. With the site readily exposed with towel clamps, preplaced stay-sutures keep stomach and abdominal wall layers well apposed so that suturing is easy since there is no tension on the incised edges during suture placement.

This incisional gastropexy technique integrates known gastropexy principles that are documented to result in permanent adhesions between the stomach and abdomen (Fossum 2002, Monnet 2003). The author has been using this successful technique for more than 20 years in his surgical practice. Even thought this technique is designed to be simple and rapid, the authors encourage inexperienced surgeons to practice any unfamiliar surgical procedure on cadavers first before attempting to perform the technique on a clinical patient. ●

References


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Figure 1: The gastropexy site over the 11th or 12th rib is highlighted in red (left). (Right) On a ventral thoracic view in a cadaver, the abdominal wall incision site is 5 cm caudal to the tip of the xiphoid cartilage and is about 5 cm in length (yellow line).
Figure 2: The falciform fat is removed from the celiotomy incision (dotted line) and the full-thickness right abdominal wall is pulled forcibly to the right to expose the rib margin seen under the peritoneal surface (Top). “X” marks the cranial part of the celiotomy incision, the base of the xiphoid cartilage. (Bottom 2 images) While holding the abdominal wall to the right, the 12th rib is palpated and fixed between the surgeon’s index finger and thumb.

Figure 3: Towel clamps are placed through the transverse abdominal muscle and around the isolated pinched rib. Transverse abdominal muscle is incised directly over the isolated rib which is held up and exposed by towel clamps.

Figure 4: Towel clamps are removed (just for illustration purposes) after the incision is completed to show the location of the abdominal incision when it is completed. Note the correct site of the 5 cm incision is about 5 cm caudal to the xiphoid cartilage. In a real clinical case, the towel clamps are left in place to hold and expose the incision site until the gastropexy is completely sutured.

Figure 5: The correct antral site for the stomach wall incision (oval black mark). The site is midway between the lesser and greater curvatures, and midway between the pylorus and antral-body line (black line).

Figure 6 (top and bottom): After the surface and fingers have been wiped dry (top), the full-thickness stomach wall is pinched between the thumb and index finger at the correct antral site denoted in Figure 5 (bottom). The area is pinched and lifted such that the mucosa is felt to slip out away from the grasped (isolated) serosal and muscular layers.

Figure 7: The mound of stomach wall held with the index finger and thumb is cut just adjacent to the fingers (top) with Metzenbaum scissors. Since the mucosa has slipped out of the grasped stomach wall the cut simple cannot penetrate the stomach lumen. (Middle) Thumb and index fingers are placed at the “x” marks. The incision is oriented as depicted as the purple line between the “x” marks. Completed incision (bottom)
Figure 8: After cutting the serosal and muscular layers, the intact whitish bulging mucosa is exposed. The incised stomach wall edges are now ready to be sutured to the abdominal wall incision margins.

Figure 9: Position the pylorus in a craniodorsal direction and knot preplaced stay sutures at the opposite sides of the incision, holding the stomach and abdominal wall incisions in apposition.

Figure 10: The “deep” (greater curvature side) edge of the stomach incision and dorsal edge of the abdominal wall incision are sutured together with continuous 2-0 prolonged absorbable monofilament suture.

Figure 11: The ventral portion of the abdominal wall incision is apposed to the adjacent stomach wall incision.

Figure 12: Completed gastropexy closure (Top). Two continuous suture lines hold the stomach to the abdominal wall securely. (Bottom) “Smeakopexy” site one-year after treatment for acute GDV in a German shepherd dog.
VOLUNTEER AT THE

HALL OF VETERINARY HEALTH

AT THE GREAT NYS FAIR!

NYSVMS will once again host the Hall of Veterinary Health at the Great NYS Fair in Syracuse, promoting veterinary medicine to the public in a fun, hands-on way.

Volunteers are needed to staff the Hall each day. Several new interactive exhibits were added last year including Comparative Anatomy featuring real animal skulls, Dress Like a Surgeon, Teddy Bear ER, Journey Through Imaging, Preparing your Pet for a Vet Visit and Building your own Stethoscope!

The Hall also features daily live presentations with animals ranging from reptiles to birds to mini ponies as well as daily first aid demonstrations.

Volunteers receive two complimentary admission passes and one parking pass. If you are interested in volunteering, please send your name, address, email, phone number and the date(s) you would like to volunteer to staff@nysvms.org.

Check out the Hall of Veterinary Health section on our website: www.nysvms.org which includes a video of highlights from last year’s event.
Lance Karcher ‘85
Lance F. Karcher, DVM, of Westbury, N.Y., passed away on January 28, 2018. He grew up in Jamesville, a rural farm community in upstate New York. He attended Cornell University as an undergraduate, as well as Cornell University College of Veterinary Medicine. He graduated in 1985 and practiced upstate for one year before returning to Cornell to complete his residency in large animal medicine for two years. Upon completion, he became Board certified in large animal internal medicine and was practicing on Long Island since 1989. He taught an equine studies course a C.W. Post College and also Suffolk Community College at Knoll Farm. He was a member of NYSVMS and Long Island VMA.

He was the beloved husband to Sarah, father to Molly and Rachel and son of Betty and the late Glen.

Robert Toole ‘89
Robert J. Toole, DVM, of Cazenovia, N.Y., passed away unexpectedly February 28, 2018 at home. Dr. Toole grew up in the Cazenovia area and graduated from Cazenovia High School. He later graduated from Cornell University with a Bachelor of Science degree, Virginia Tech with a Master’s degree in Animal Science and his Doctorate of Veterinary Medicine from Cornell University CVM. Dr. Toole was a well-known and respected veterinarian throughout Central New York for his expertise in dairy reproduction and was licensed to practice in New York, Pennsylvania and Florida. He held his private practice since 1989, specializing in large animal veterinary medicine, herd health, bovine reproduction, embryo transfer, genetics and he was also a veterinary consultant for Animal Medic. Dr. Toole had a lifelong passion for dairy farming and owned the dairy farm he grew up on, Longview Ridge Farm.

Dr. Toole’s affiliations included the American Embryo Transfer Association, the American Veterinary Medical Association, NYS Veterinary Medical Society and the American Bovine Practitioners Association. He was a member of the Tuscarora Lake Association and Eastern Hills Bible Church.

Dr. Toole is survived by his wife of 36 years, Karol M. Toole; his son, Thomas Toole and three brothers. He was predeceased by his parents, Robert and Mary Toole and by his son, Andrew T. Toole.

IN MEMORIAM
Colleagues Who Will Be Missed

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Penfield Veterinary Hospital is seeking a part-time/full-time associate veterinarian to join our four doctor practice. Penfield Veterinary Hospital is part of Monroe Veterinary Associates, the area’s largest independently veterinary owned organization. We provide a supportive mentoring environment and offer generous salary and benefits including health insurance, CE opportunities, 401k, and advancement/ownership opportunities. New graduates welcome. $1000 sign-on bonus and $1500 relocation reimbursement. Contact Amy Laukaitis, COO, at (585) 271-2733 ext. 127 or email: mvalaukaitis@yahoo.com. Check out our websites: www.penfieldvet.com or www.monroevets.com.

**Hudson Valley**

Full or part-time associate veterinarian for 5 doctor practice. Lower Hudson Valley, N.Y., one hour north of New York City. Fully equipped, modern hospital, friendly staff and experienced veterinarians. Small animal medicine and soft tissue surgery. Email or fax resume to: hrthog@yahoo.com, goosepondmanager@yahoo.com or (845)783-5719.

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**New York City**

Looking for a part-time associate for busy animal hospital in the Riverdale/Kingsbridge section of the Bronx, N.Y. Requires a minimum of two years experience and prefer a completed internship. Person must be easy to work with. Spanish speaking a plus. Schedule and salary will be discussed in person. Must have a NYS license. Contact Scott Luckow, DVM, by email at: bdwyvet@aol.com.

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