# The *Human* Side of Veterinary Medicine

## Learning from your own pet's euthanasia

We work on patients like this everyday. Do we know just how important they are? Perhaps other veterinarians can learn what I learned from my experience with my cat, Sally, during her recent illness.

I called my classmate, Robert McDonald. He's an expert, board certified, ACVIM, and glad to lend a hand on tough cases.

The phone signal traversed the eight-hour drive in seconds. "Robert, I have the biggest case I've ever called you about."

He laughed the typical Robert laugh. "I can't imagine that, Jim, what do you have?"

"Robert, my cat is sick, and I can't figure out what's wrong with her."

I felt as if I would die if Sally did, and I couldn't let her down by letting that happen. I read him the signalment, the history, and the laboratory results. He gave me sage advice, as always. And, as sometimes happens, he pointed out the facts that were there for me to interpret, but that I had overlooked. Sally was extremely lymphopenic, 601 lymphocytes/µl, and that means a guarded prognosis, at best.

Like millions of clients we see everyday, I am hopelessly attached to this plain gray tabby. She is an important part of our everyday lives, though my family tends to take her for granted. Though not a lap cat, she's always there, in our proximity, just within view. Although our interaction is limited to love bites and purrs and being close, we need her and she needs us. How often do we recognize the importance of that same relationship between our clients and patients, and that the client's life will change when that pet is gone?

Sally's condition worsened the next day, Friday. I tried to draw blood from her, but couldn't see her veins through my tears. I sent her to another classmate, Ron Hunt, who had compassion, capability, and an in-house blood analysis machine. He was only a few minutes' drive from my home. Her blood biochemical values had not changed much since her previous tests 48 hours before, but Ron couldn't get enough blood for a CBC. The updated status of her lymphocytes remained unknown.

Sally spent most of the night between us in bed, my wife's ear by Sally's nose as a constant respiratory monitor.

I called the teaching hospital at LSU early Saturday morning. Senior student Scott was on duty. He notified Dr. Lory Haug and she said, "Let's not wait until Monday. It sounds like your cat is going down pretty fast."

We reached the hospital early, and Dr. Haug instructed her students over the phone on how to begin until she arrived. She wanted blood samples drawn, and I warned Scott and Freyda, the other student on duty, that they were going to have to get all they wanted on the first try, because Sally's veins were terrible.

"I'm not very good at this." Scott confided.

"Want me to try?" I offered.

Big mistake—I tried and failed. I told Scott I was going to get out of their way, and I retreated to the hall where my wife, Brenda, waited anxiously. The next time I peeked into ICU, they had three full vials of blood. I apologized to Scott for my actions.

Dr. Haug arrived. She quickly introduced herself and went to work. "What's the patient's name?" she asked.

I was impressed. Even though she had not yet looked at the medical record, if she was going to be talking to this cat, she wanted to know what its name was, and address it appropriately. Though I feel my bedside manner is quite good, I resolve to remember her style.

The next five hours were a rush of activity—physical examination, neurologic examination, calls to specialists on standby, opinions exchanged, and students learning.

A barking dog came in with a cut on its paw. As Sally's owner, I wanted to tell them to give the dog something to quiet

Prepared by James W. Randolph, DVM, Animal General Hospital, 20005 Pineville Rd, Long Beach, MS 39560-3310. Others are encouraged to contribute to this feature. Please contact the editor-in-chief for details.



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it. I wanted to offer to suture the foot so the staff and students could concentrate on Sally. Brenda wisely asked whether I'd want someone in my clinic doing surgery on one of my patients, much less if that someone were in my mental state. I kept my mouth shut.

I wanted them to know that Sally was special, that she wasn't like any other cat they had ever seen before. I wanted them to love Sally like I love her. But loving Sally was not their job. That was my job.

During the physical examination Dr. Haug found some areas that appeared painful. Though Sally was only semiconscious, she reacted to the pain. As a pet owner, you want to tell this doctor to stop hurting your cat. As a veterinarian (there are moments of lucidity), you know the doctor is doing the correct things.

Dr. Haug announced that the primary problem, as determined by the neurologic examination, appears to be central. A CSF tap was next. Brenda and I authorized it.

A few minutes later, there was a scramble. I was dying to look, and ask why, but didn't. Dr. Haug said that she and another doctor, who have done over 100 spinal taps between them, could get no CSF from the cisterna magna, and would try a lower lumbar tap. Limited success resulted in enough fluid to determine that there were tons of neutrophils. Sally's spinal cord, and probably brain, were septic.

Further consultation with the neurologist worsened the prognosis. She's had cases of dry CSF taps before, and the cats had feline infectious peritonitis or feline immunodeficiency virus infection. A feline leukemia virus test was ordered, despite the fact that Sally had always been 100% indoors. The results of both tests were negative. The likelihood of feline infectious peritonitis being the primary cause was much higher, and the prognosis worsened.

A new problem reared its ugly head. After being masked down with isoflurane, Sally refused to breathe on her own. I asked for a resuscitation bag. Maybe too much oxygen and too little carbon dioxide was keeping Sally from breathing. I gave her several breaths of room air, but there was no change. I repeated the room-air bagging over a five-minute period, and still no change. Maybe some carbon dioxide from my lungs would stimulate her. I breathed into the endotracheal tube. After another five minutes, Dr. Haug ordered a respirator to be hooked up. We approved that, wanting to give Sally every chance.

Dr. Haug asked whether, if Sally developed cardiorespiratory arrest during the night, we wanted her resuscitated. We declined. Dr. Haug told us that feline infectious peritonitis was on the top of the differential list. Sally's pupils had remained dilated for hours. The isoflurane was discontinued hours before, and she had made no effort to breathe on her own. With these combinations of signs, the chances were high that her brain stem had herniated. If it had, she would not recover. Ever.

Did we still want to leave her on the respirator overnight? Brenda and I were in the ICU together, with Sally. All of the staff had left the room. Twenty kleenexes later, we decided on euthanasia.

"Dr. Haug, will you draw the euthanasia solution up for me, and I'll give it to her?" I asked. "You see, of all the members of our family, I'm the one she has the most trust in. When I hold her, she totally relaxes, totally trusting anything I do. If she has to be put to sleep, it should be by me, not by a stranger. She would expect that from me."

"I understand," said Dr. Haug. "Here's some heparinized saline flush, and 2 ml of euthanasia solution. We'll disconnect the respirator and leave the ECG hooked up."

They all left the room. Brenda didn't want to watch.

Sally and I had a little talk for a few minutes. I flushed her IV catheter, then injected the fatal solution. When the ECG monitor line went flat, I disconnected the leads and the IV set, and removed her endotracheal tube. We sat and talked some more. Sally always had this one thing she would do for me, and for no one else. By way of showing trust for me, when she was lying on her back in my arms, she would hang her head limp, as if she were dead. I put her in that position again, to see her that way for all time.

The very next day, back at work, I have an old patient to euthanize. I think about how mechanically I have done this procedure before, and about how important it was to me that Sally have it done with love, compassion, and emotion. When the heartbeat stopped, instead of turning this patient over to an assistant, I personally gave her the gentleness I would a live patient, the gentleness her owner would expect. The gentleness LSU gave Sally.

All of the doctors and all of the students had been so kind and understanding. I know it put a lot of pressure on them, working on a pet that belongs to a veterinarian, much less an irrational veterinarian. That pressure was magnified by the veterinarian's sobbing sounds that carried down the hallways. But they did their work like they knew it should be done, and they did a great job all the way through.

I insisted that a full necropsy be done on Sally to fully understand how this healthy, totally indoor cat could die at 11.5 years, when cats are supposed to live 20 to 25 years routinely. Maybe if I know all the facts I can deal with this loss. Maybe understanding will bring healing to the grief.



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