

Clinical Article

**SURGICAL RETRIEVAL OF FOREIGN BODY IN DOG –
A CASE REPORT**

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Abstract: A six month old male Dobbermann was presented to Department of Veterinary Surgery and Radiology, Veterinary College, Bengaluru with a complaint of anorexia, chronic vomition and not passing motion since four days. Abdominal palpation revealed hard intraabdominal mass and survey radiograph of lateral abdomen revealed air filled intestinal loops. Upon 24hours barium contrast radiograph confirmed intestinal obstruction. So emergency enterotomy was performed and foreign body is retrieved and it was a ball. The animal was recovered uneventfully without any complications

Keywords: Spherical ball, Enterotomy, Contrast radiography.

INTRODUCTION

Ingestion of foreign bodies is attributed to their indiscriminate feeding habits (Ellison, 1990). All age groups of dogs are affected, but usually young dogs (mean age, 3.5 to 3.7 years), ingest a large variety of nonlinear Foreign bodies (Capak *et al.*, 2001). Gastrointestinal foreign bodies may cause complete or partial obstruction. The size of the foreign body determines whether obstruction is partial or complete. Life-threatening complications caused by fluid and electrolyte imbalances, hypovolemia, and toxemia may be associated with intestinal foreign bodies (Papazoglou *et al.*, 2001). Surgical interventions related to the treatment of small intestinal obstruction represents approximately 0.5-1 percent of all surgical procedures in dogs (Crha *et al.*, 2008).

CASE HISTORY AND OBSERVATION

A six month old male dobbermann was presented to Department of Veterinary Surgery and Radiology, Veterinary College, Bengaluru with a complaint of anorexia, chronic vomition and not passing motion since four days. On physical palpating a hard mass felt at the mid abdomen. Survey radiograph of lateral abdomen revealed air filled intestinal loops. Upon 24hours barium contrast radiograph revealed radio-opaque foreign body in intestinal loops.

Based on clinical signs and radiographic findings the condition was diagnosed as intestinal obstruction. So it was decided to go for emergency enterotomy and foreign body was retrieved.

TREATMENT

Surgical site was prepared aseptically by shaving midline. Premedicated with Atropine Sulphate @ 0.04mg/Kg. Bwt. S/C, and preanesthetic was Xylazine @ 1mg/Kg. Bwt. I/M. After 10min induction anesthesia was done by Thiosol 2.5% to effect and maintained with same. A linear ventral midline skin incision was made, followed by subcutaneous tissue, linea alba and peritoneum. Entered into abdomen & affected intestinal loops was exteriorized to the incision site. At cranial margin of the mass, enterotomy incision made at antimesentric border and foreign body was removed and it was a spherical ball. The area was thoroughly cleaned and enterotomy incision was closed by simple interrupted pattern but knots are placed inside the lumen by using chromic catgut no. 2-0. Abdominal cavity was flushed with worm normal saline. The linea alba closed with polyglactin 910 by interrupted pattern, subcutaneous by simple continuous pattern by using chromic catgut and skin by horizontal mattress by using polyamide. Wound was cleaned and dressed.

Post-operatively combination of Ceftriaxone and Tazobactam at the dose rate of 20mg/Kg. BWt. was given for 7days. Fluid therapy for three days twice a day and Metriz 100ml daily for 3days. Orally starts on 4th day after surgery by liquid and slowly semisolids and solids. Wound was dressed every alternate day and skin sutures were removed on 10th day.

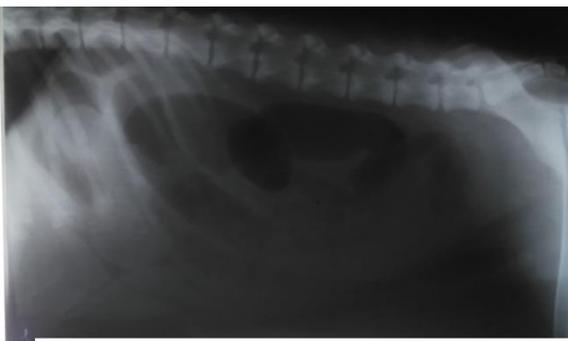


Fig 1: Radiograph of lateral abdomen showing air filled intestinal loops



Fig 2: Contrast radiograph of lateral abdomen showing radiodense foreign body



Fig 3: Ventral midline incision is made to explore the abdomen



Fig 4: Jejunal loops exteriorized to surgical site and obstructed site is noticed



Fig 5: Incision made over foreign body



Fig 6: Spherical ball removed from jejunal loops

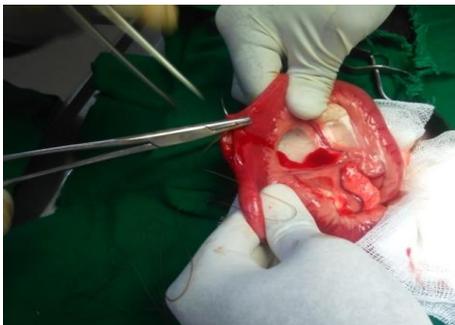


Fig 7: Performing intestinal anastomosis



Fig 8: Skin closed in routine manner

DISCUSSION AND CONCLUSION

Alimentary tract obstruction was one of the most common ailments noticed in dogs. The incidence rate of GIT obstruction is very high in young male dogs due to their voracious, indiscriminative feeding habits and playful nature (Kumar *et al.*, 2000). All along the length of gastrointestinal tract foreign bodies causes obstruction but jejunum is the most common location (Hayes G, 2009). In the present case spherical ball was obstructed in distal segment

of jejunum. Some small, sharp foreign bodies, such as pins, sewing needles, and fish hooks that are found in asymptomatic animals may be treated conservatively and they may pass uneventfully, because of contact between mucosa of intestine and foreign body results in local dilation of intestine called as mural withdrawal reflex (Guilford *et al*, 1996). An enterotomy is performed in the antimesenteric border distal to the foreign body and the foreign body is removed. Incisions over the foreign body or proximal to the obstruction in the distended intestine may interfere with normal intestinal healing, possibly because of some degree of vascular compromise of the intestinal wall and therefore such incisions are not recommended (Orsher and Rosin, 1993). The enterotomy site is closed in a single layer with a simple interrupted or continuous suture pattern, by using 3-0 or 4-0 synthetic absorbable sutures such as polydioxanone or polyglyconate (Weisman, 1999). One of the most common and serious complication after retrieval of foreign body is dehiscence of the enterotomy incision with subsequent leakage of intestinal contents into the peritoneal cavity, resulting in peritonitis (Papazoglou *et al.*, 2001). In this case none of the complications were observed, animal recovered uneventfully.

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