Journal of Advanced Veterinary Research
Volume 1 (2011) 74-75 **Case Report**

Gastrotomy for Retrieval of Thoracic Oesophageal Foriegn Body Using Long Forceps Technique in Three Dogs

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(Recieved 20 May 2011/ Accepted 10 July 2011)

Abstract

Three dogs age between 3- 6 years old was presented to the Department of Veterinary Surgery and Radiology with the history of anorexia, attempt for vomiting, regurgitation, dysphagia, gagging, mild salivation after taking a piece of bone. Clinical examination revealed heart rate and respiratory were within physiological limits. Lateral plain radiograph of thorax revealed radio opaque foreign body was lodged between heart and diaphragm. Surgical invention was planned to retrieve thoracic oesophageal foreign body through gastrotomy incision. This clinical paper reports the successful surgical management of thoracic oesophageal foreign body through gastrotomy incision using long forceps without complication.

Keywords: Oesophageal foreign body; Gastrotomy; Long forceps

Introduction

The ingestion of a foreign body is common problem in dogs. Rarely foreign body may become blocked in the oesophagus, particularly near the caudal oesophageal sphincter or between the heart and diaphragm which is the most inaccessible part of the oesophagus and it is easy to retrieve thoracic oesophageal obstruction through gastrotomy incision using long forceps (HunYoung *et al*., 2009).

Case history and observations

Three dogs age between 3- 6 years was presented to the Department of Veterinary Surgery and Radiology, College of Veterinary Science, Sri Venkateswara Veterinary University, Tirupati Andhrapradesh, India with the history of anorexia, attempt for vomiting, dysphagia, gagging, mild salivation for 2 days after taking a piece of bone. Clinical examination revealed heart rate and respiratory were within physiological limits. Lateral plain radiograph of thorax (Fig. 1) revealed radio opaque foreign body was lodged between heart and diaphragm (Kaiser *et al*., 2003). Surgical invention was planned to retrieve thoracic esophageal foreign body through gastrotomy incision using long forceps (Fig. 2).

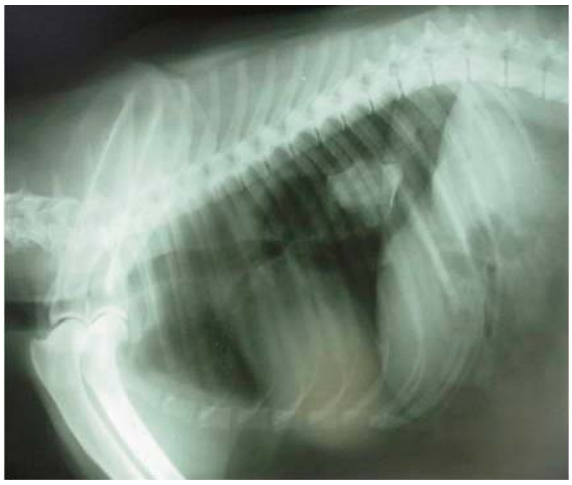

Fig. 1. Lateral plain radiograph show thoracic oesophageal obstruction.

Treatment and Results

Under aseptic precaution site was prepared for gastrotomy. Atropine sulphate at 0.044 mg/kg body weight subcutaneously and xylazine hydrochloride at 0.5 mg/kg body weight intramuscularly were

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given as premedication. Ketamine hydrochloride was given at 8.0 mg/kg body weight intramuscularly and anaesthesia was maintained with the combination of Ketamine hydrochloride-Diazepam10:1 ratio. To dislodge the foreign body in to the stomach stomach tube were used unsuccessful. Gastrotomy was performed through ventral midline incision from the xiphoid to the pubis. Abdominal wall is then retracted using Balfoure retractor. Stomach was isolated from the abdominal content with moistened laparotomy sponges to reduce the contamination and incision was made at ventral aspect of the stomach between the greater and lesser curvatures, through the incision long foreceps (HunYoung *et al*., 2009) was introduced gently to dislodge the bone piece (Meffert, 2010) from the oesophagus and removed through stomach (Haragopal and Suresh Kumar, 1996). Gastrotomy wound incision was closed by simple continuous followed by cushing suture pattern (Fig.3) using 2/0 chromic catgut.

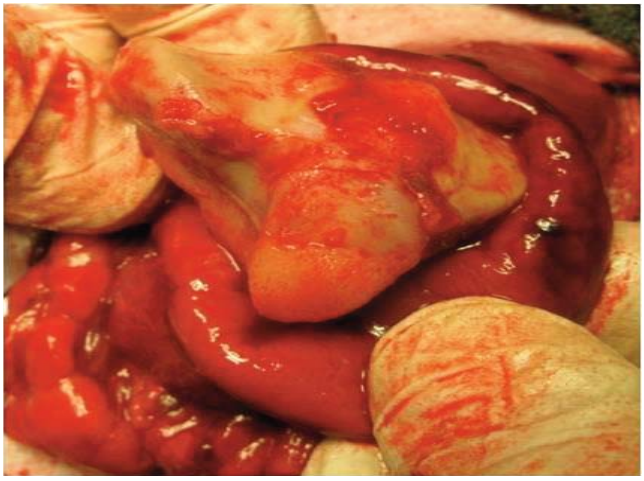

Fig. 2. Retrieved foreign body (Bone) through stomach

Fig. 3. Showing gastrotomy closure- Cushing suture pattern

Post operatively animal was maintained with intravenous dextrose normal saline and ringers lactate for first 5 days twice daily followed by once daily along with liquid diet, ceftriaxone at 10 mg/kg body weight and dexamethazone 0.5 ml/kg body weight and ranitidine hydrochloride 0.5 ml were given intravenously for 5 days with alternate day dressing with povidone iodine ointment. All the animals were recovered uneventfully on 9th post operative day.

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