

SURGICAL MANAGEMENT OF NECROSED RECTAL PROLAPSE IN A DOG

N. Nagaraju¹, B.R. Balappanavar¹ and L. Ranganath²

¹Assistant Professor, Department of Surgery & Radiology, ² Dean, Veterinary College, KVAFSU, Hassan (Karnataka).

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Five year old male dog was brought to Veterinary College Hospital, Hassan with a history of complete rectal prolapse, tenesmus and anorexia. The prolapsed mass was necrotic and irreducible. Resection of prolapsed mass and anastomosis resulted in complete recovery after ten days.

Keywords: Anastomosis, Prolapse, Tenesmus.

Rectal prolapse can occur with any condition that causes prolonged tenesmus (Sherding, 2003). It is most common in heavily parasitized animal that have severe diarrhea and bowel irritation. Other causes includes, dystocia, urolithiasis, intestinal neoplasms and foreign bodies, prostatic disease, perineal hernia, constipation congenital defects and postoperative tenesmus after anal or perianal surgery (Engen,1990; Patel and Patel, 2015). Rectal prolapse is more common in males than females.

The diagnosis of rectal prolapse is made by visual examination of tube like mass of varying length protruding from anus. In animals with rectal prolapse of long duration, the protrusion is usually longer; mucosa

appears red or black and may be ulcerated or necrotic.

A nondescript male dog aged five years was presented to Veterinary College Hospital, Hassan with a history of discomfort, straining, not passing feces and with black colored prolapsed rectal mass. Upon examination, the prolapsed mass was like a tennis ball size and necrosed on the ventral and lateral side, slightly red on dorsal side (Fig.1). A probe was passed to confirm it as rectal prolapse. Per-rectal examination revealed enlarged prostate gland. Hemato-biochemical examination revealed leukocytosis rest other values were within the normal range. It was decided to go for rectal mass resection and anastomosis of the bowel.



Fig.1- Necrosed Prolapse Rectal Mass



Fig.2- Fixing Prolapsed mass with a plastic syringe

The animal was preanesthetized with atropine sulphate 0.04mg/kg and thriplupromazine 0.5mg/kg I/V and anesthetic induction was done with 2.5% thiopentone sodium and maintainace with isoflurane inhalant anesthesia. The dog was positioned

in the sternal recumbency with hind limbs spread over the padded edge of the table. A plastic syringe of suitable size barrel was cut towards tip to make uniform passage, then soaked with saline was passed into the lumen of the bowel and was fixed with 18 G needle

(Fig.2). The prolapsed mass was resected 1 to 2 cm from anus and anastomosis was performed by single layer closure and simple interrupted suture with a 2-0 using polyglycolic acid 910 synthetic suture material. At last, the fixed syringe was removed to check the patency of lumen. Again the same Plastic syringe was reintroduced into rectal lumen and syringe end was anchored to perineal skin with 2-0 polyamide suture material. Postoperatively animal was administered with inj. ceftriaxone @ dose rate of 25mg/kg for 7 days and application of proctosedyl antiseptic ointment per rectally. The owner was advised to give soft diet for 10 days. The plastic syringe barrel was removed on 10th postoperative day. The dog recovered uneventfully.

The prolapsed rectal mass was necrosed and irreducible without evidence of perineal hernia could be due to prostate involvement as it was confirmed on pe-rectal examination.

Tumors and perineal hernias are the other causes for rectal prolapse in middle and old aged dogs as also recorded by Sherding (2003).

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