



SURGICAL MANAGEMENT OF CAECOCUTANEOUS FISTULA IN EQUINE-A CASE REPORT

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ABSTRACT

Caecocutaneous fistulas as a sequelae to penetrating trauma to the equine patient's abdomen are rarely reported. This case report describes surgical management of a caecocutaneous fistula in a eight year old horse occurred as a result of an acquired injury. The animal had an uneventful recovery after surgical repair on subsequent follow-up.

KEYWORDS: Equine, caeco cutaneous fistula, fistula,

INTRODUCTION

Enterocutaneous fistulae are rare in horses and occur most commonly as a complication of umbilical hernias or their treatment (Bristol, 1994) or penetrating trauma to the equine patient's abdomen (Vandana Sangwan *et al.*, 2010). Caecocutaneous fistula has been reported in association with umbilical hernias and following application of a hernia clamp as a treatment for an abdominal hernia (Auer and Stick, 1999). Azizi *et al.* (2013) reported surgical management of the trauma induced colocutaneous fistula in a horse. This case report describes occurrence of an caecocutaneous fistula in a mare as a sequela to an acquired injury.

CASE HISTORY AND OBSERVATION

An eight year old intact male horse was presented to the Teaching Veterinary Clinical Complex, Rajiv Gandhi Institute of Veterinary Education and Research, Puducherry, with a history of a nonhealing wound in the right lower flank (Fig.1). The animal had attempted jumping over a barbed fence and had acquired the injury one month prior to the presentation. On clinical examination, the animal was found to be weak and debilitated with partial feed intake. An oedematous swelling was noticed at the right lower flank, with dropping of digested food materials through a fistulous tract. Haematological evaluation revealed leukocytosis. Diagnostic ultrasonography confirmed the condition as caecocutaneous fistula and surgical correction was advised.



Fig.1. Photograph showing nonhealing wound in the right lower flank

TREATMENT AND DISCUSSION

The animal was stabilized with fluids and Inj. Streptomycin – Procaine penicillin (Dicrysticin- S Zydus AHL) @ 2.5 gm was administered i.m daily for 2 days. On third day, the animal was sedated with Inj. Xylazine (Xylaxin- Indian Immunologicals, Hyderabad) @ 1.1 mg/kg b. wt intravenously followed by inj. Ketamine @ 2.2mg/kg body weight (Mount Mettur Pharmaceuticals, Ltd, Tamil Nadu) was administered and 2% Lignocaine hydrochloride solution was infiltrated locally at the right

lower flank and the animal was kept on lateral recumbancy. The animal was placed on left lateral recumbancy. The skin around the wound edges was shaved after plugging the wound with sterile guaze and prepared for aseptic surgery using standard procedure. Under aseptic condition, the fistulous tract leading to the caecum was extended through an incision on the skin and caecal adhesions were relieved. The caecum was evacuated, and part of the wall of the caecum including the wound was partially exteriorized. The edges of the intestine were trimmed and closed by full thickness simple continuous layer reinforced by partial thickness inverting sutures using polyglactin 910 size 2 (Auer and Stick, 1999). The skin was sutured using black braided silk size 0 with a stent (Fig.2). Administration of Inj. Streptomycin – Procaine penicillin was continued for 5 more days and Inj. Meloxicam-10ml (Melonex-Intas Pharmaceuticals Ltd) was administered i.m daily for 4 days. The animal was maintained on intravenous fluids for next 7 days until it was discharged. Clobistol propionate – Gentamicin cream (Kiskin- Intas Pharmaceuticals Ltd) was applied over the suture line for 10 days. Therapeutic ultrasound massage was performed @ 0.5 W / cm² over the periwound area every day to hasten healing. The owner was advised to feed soft green laxative diet for one month in reduced quantity at frequent interval. The animal made an uneventful recovery after 10 days. (Fig. 3).



Fig.2. Photograph showing sutured skin

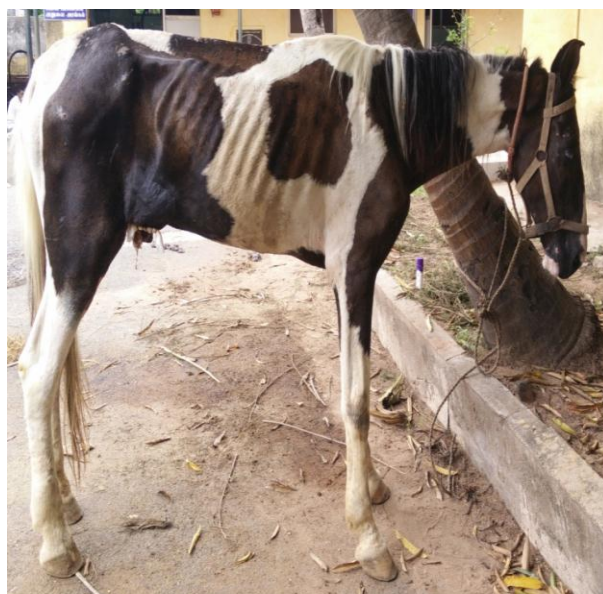


Fig.3. Animal on 10th day postoperatively

In the present case, the cecocutaneous fistula was reported to be developed as a result of a penetrating wound as against the etiological factors reported earlier (Auer and Stick (1999). The anaesthetic protocol employed in the animal was satisfactory. The animal was stabilized by conservative therapy before surgical procedure as reported by Marta Barba *et al.* (2013). The surgical procedure employed in the present case was in accordance with that suggested by Auer and Stick (1999). Bristol (1994) managed enterocutaneous fistulae successfully by en bloc resection of the body wall and intestine or by allowing second intention healing. Complications as reported by Bristol (1994) viz; fever, colic, incisional problems, and recurrence of the fistula were not noticed in this horse. Anand *et al.* (2014) reported successful surgical management of enterocutaneous fistula in a horse. Stent sutures were found to be effective in preventing infection and favoured healing of the abdominal incision uneventfully which is in agreement with that reported by Auer and Stick, 1999.

CONCLUSION

Caecocutaneous fistula in a eight year old horse occurred as a result of an acquired injury was surgically corrected.

CONFLICT OF INTEREST

We declare no conflict of interest

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