RUPTURE OF THE UTERUS WITH DISLOCATION OF THE FETUS INTO THE PERITONEAL CAVITY IN A NON-DESCRIPT BUFFALO: A CASE REPORT

S. Manokaran

ABSTRACT

A case report on rupture of the uterus with displacement of a live fetus into the peritoneal cavity and its successful treatment in a non-descript buffalo have been recorded.

Keywords: rupture of uterus, fetus, peritoneal cavity, non-descriptive buffalo, laparotomy

INTRODUCTION

Spontaneous rupture of a bovine uterus, possibly followed by partial or total displacement of the fetus into the peritoneal cavity is an uncommonly recorded complication of late pregnancy (Arthur et al., 1996). The present report records a case of uterine rupture and subsequent escape of a live fetus into the peritoneal cavity.

CASE HISTORY AND CLINICAL OBSERVATION

A full term pregnant non-descript buffalo on its second calving was brought to the PREPAERE Veterinary Hospital with the history of continuous straining and anorexia for the previous two days. The owner observed relaxation of sacro-ischiatic ligament 72 h before and mild mucus discharge for the previous 10 h. The clinical examination of the animal revealed temperature of 38.7°C, restlessness, frequent lying down and getting up, enlarged vulval lips and colostrum secretion from the udder. Per vaginal examination revealed a four-finger dilated cervix. It was possible to reach internal os of cervix, but neither the water bag nor the fetal extremities could be palpated. On rectal examination, the presence of a fetus in the peritoneal cavity could be detected.

TREATMENTS AND DISCUSSION

It was decided to perform laparotomy. Tranquilization was achieved with triflupromazine hydrochloride (Siquil, Sarabhai Zydus) at the dose rate of 10 mg/45 kg (i/m). The animal was restrained in right lateral recumbency and the left flank was prepared for aseptic surgery. Laparotomy was performed through oblique incision. The skin, subcutis, abdominal muscles and parietal peritoneum were incised to reach the peritoneal cavity. A live female fetus (32.8 kgs) was delivered from the peritoneal cavity after ligation of the cord. The placenta appeared healthy and was removed. The gravid uterine horn was found to be involuted.
to a considerable degree with a longitudinal tear on its ventral surface. The uterine tear was repaired by Cushing’s followed by Lembert suture using catgut No. 2. The peritoneal cavity was flushed with 5 litres of normal saline and 5 gm of streptopenicillin was sprinkled in to the cavity. The abdomen was closed in a routine manner. The animal was administered inj. DNS (4 litres, i/v), inj. streptopenicillin (5 gm, i/m), inj. chlorpheniramine maleate (300 mg, i/m), inj. oxytocin (50 IU, i/v), inj. meloxicam (150 mg, i/m) and inj. belamyl (10 ml, i/m). The fluids, antibiotic, antihistamine and anti-inflammatory were continued for 5 days and recovery was uneventful.

Uterine rupture was usually the result rather than the cause of dystocia, the predisposing causes being uterine torsion, fetal emphysema, chronic perimetritis and abnormal fetal size and also the abnormal fetal movement. It may occur spontaneously or possibly be associated with violence in advanced pregnancy (Roberts, 1971). In many cases, the fetus dies with its membranes becoming walled off as a sterile foreign body in the ventral portion of the abdominal cavity (without external symptoms) or adhesions may develop with abdominal organs (with external symptoms). In the present case, however, the predisposing cause(s) could not be ascertained. The fetus survived in the peritoneal cavity because the cord was not twisted and the placenta was healthy and in such cases survival of the fetus in the peritoneal cavity for periods up to 7 days have been reported (Arthur et al., 1996).

REFERENCES

Roberts, J.S. 1971. Veterinary Obstetrics and Genital Diseases, 2nd ed. CBS Publishers and Distributors, New Delhi, India.