© 2016 IJSRST | Volume 2 | Issue 5 | Print ISSN: 2395-6011 | Online ISSN: 2395-602X
Themed Section: Science and Technology

Obstetrical Management Of Post-Partum Uterine Prolapse in A Non - Descript DOE - A Case Report

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ABSTRACT

A 4 years old non-descript doe in its second parity was reported with the history of protrusion of mass through the vulva after normal kidding. On clinical examination, it was confirmed as total uterine prolapse. After stabilizing the animal, the prolapse mass was replaced manually and a course of parental antibiotic, analgesic and fluid therapy were administered. The doe recovered uneventfully.

Keywords : Uterine prolapse, Eversion, Non-descript doe.

I. INTRODUCTION

Uterine prolapse is common problem in cattle, buffaloes, occasional in sheep, less common in goats and rare in mares (Hanie, 2006). It is simply an eversion of the uterus which turns inside out as it passé through the vagina. It may occur during the third stage of labor or immediately after parturition or several hours after parturition occasionally. Postpartum prolapse if it occurs 24 hours after normal kidding is extremely rare and is complicated by partial closure of cervix or replacement difficulty or even impossible (Fubini and Ducharme, 2006). Uterine prolapse associated with severe edema, trauma of the mucosa, contamination and fatal hemorrhages should be considered as emergency with grave prognosis. The prognosis depends on the severity of the case, degree of damage and contamination, duration of its existence or how quick it is attempted with suitable treatment or management. The present paper reports the successful clinical management of postpartum uterine prolapse in a nondescript doe.

II. METHODS AND MATERIAL

Case History& Clinical Observations

A 4 year nondescript doe in its second parity was presented to the campus hospital with a history of kidding and eversion of uterus (Fig 1). She delivered a live female kid and showed symptoms of abdominal distress and frequent straining. The previous delivery was normal. On clinical examination, the animal was apparently healthy with slight increase in physiological parameters like body temperature, respiration and heart rates. The prolapsed uterus was swollen, necrotic and contaminated with dirt, faeces, straw and debris.

III. RESULT AND DISCUSSION

Treatment & Discussion

Following clinical examination, the doe was stabilized with intravenous fluids and was given posterior epidural anesthesia (2% xylocaine 2ml) in the 1st inter coccygeal space in standing position to avoid straining. Sensitivity around the perineal region was assessed by pricking with a 20gauze needle. After proper lubrication, the prolapsed mass was lifted to the level of ischial arch and urine was evacuated by catheterization. This was done to relieve the pressure on the broad ligament and to restore the normal circulation. The perineum along with prolapsed mass was washed with water to remove the dirt, straw, faeces and debris and then followed by normal saline, cleaned with 2% potassium permanganate solution (Hosie, 1993). The necrotic area in the prolapsed mass was debrided. The uterus was smeared with saturated sugar solution to reduce the edema and the prolapsed

mass was gently pushed inside, placed in position with due care by gentle pressure with cleansed fist. Once the uterus is in position, Oxytocin (10 IU) was administered intramuscularly to enhance the uterine motility. The proper replacement was confirmed by passing the hand up to the apex of both the uterine horns. Postoperatively the doe was administered Intacef@1000 mg. IM, Melonex@1 mg/4 kg b-wt. IM and 150ml DNS (5%) IV for 5 consecutive days. The uterine prolapse can be replaced with the animal in standing and recumbent position (Hanie, 2006). Prolapse of the uterus normally occurs during the third stage of labor at a time when the fetus has been expelled and fetal cotyledons are separated from the maternal caruncles (Noakes *et al*., 2001). The ultimate goal in the treatment aspect of the prolapsed mass is the replace and retains the organ in position. However, in the present case proper reposition did not warrant any retention techniques as no recurrence was observed (Fig.2). Potential factors that can predispose to uterine prolapse include a difficult kidding that causes injury or irritation of the external birth canal, severe straining during labor or excessive pressure applied when pulling a kid, fetal over size, retained fetal membranes, chronic disease and paresis (Murphy and Dobson, 2002). An injectable broad spectrum antibiotic once administered for three to five days after replacement of the prolapse may prevent secondary bacterial contamination (Borobia-Belsue, 2006). Exact etiology of the uterine prolapse is ambiguous (Noakes *et al.*, 2001). Hormonal imbalance/excessive relaxation/stretching of the pelvic and the perineal regions may be the cause of the postpartum uterine prolapse. Complications develop when lacerations, necrosis and infections are present/when treatment is delayed. Hemorrhage, thrombo embolism and shock are potential seqeulae of prolonged prolapse. Animals with postpartum prolapse may conceive again if they are properly managed. With prompt therapy and precise repositioning of the uterus, the prognosis is good and in delayed case it is poor (Risco *et al.*, 1984). It is better to decrease the potential for the doe being affected by a predisposing factor to avoid problems with uterine prolapse. In the present paper, the successful recovery could be due to early presentation, prompt replacement and proper post-operative care.

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