

Thoracic Oesophageal obstruction in a Marathwadi Buffalo

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Oesophageal obstruction has been occasionally recorded in buffaloes, camels and small ruminants. Cervical choke is common in ruminants but obstruction of thoracic oesophagus is rare (Tyagi & Singh 1993-94).

History and Clinical Examination

A seven year old marathwadi buffalo was presented to Teaching Veterinary Clinical Service Complex, COVAS, Udgir with the history of absence of feed and water intake, salivation, coughing, inability to swallow feed and water and regurgitation of feed and water through nostrils.

The clinical examination revealed Rectal temperature-103°F, Heart Rate - 73/min. Respiration Rate - 38 /min. There was moderate tympany. Animal was given small quantity of water to drink which was regurgitated through nostrils. Stomach tube end passed from oral cavity into the oesophagus which strucked at the level of cardiac part of oesophagus and do not passed into the rumen of the animal completely.

Depending upon the history and clinical examination, the case was diagnosed as thoracic choke and surgical intervention i.e. Rumenotomy was planned.

Surgical Treatment

Left mid flank lapratomy was performed under inverted 'L' block with local infiltration. A six inch long skin incision was taken on mid left flank, the Subcutaneous tissues, muscles and peritoneum were cut with myo scissor and abdomen was entered. The rumen was grasped and was fixed with Weingart's rumenotomy ring with forceps after sufficient drapping of abdominal wound. The rumen was incised by taking seven inch long cut on it and fixed to Weingart's ring. Three fourth content of rumen were evacuated and cardiac opening of oesophagus was palpated by passing hand through rumen which revealed three pieces of leather obstructed into cardia.

The obstructed material was removed manually. The edges of rumen were cleaned with mild solution of potassium permagnate and sutured with cushing followed by lembert sutures with catgut No. 1. The peritoneum and muscles were sutured in two rows with continuous lockstich sutures by catgut No. 2 and skin was sutured with simple interrupted suture by nylon.

Post - operatively animal was given, Inj. D5 2 lit I/V, Inj. RL 2 lit I/V, Inj. Streptopenicillin 2.5 gm I/m, Inj. Ketoprofen 10 ml I/m, Inj. Multivitamin 20 ml I/V daily for 5 days. Boost up bolus 2 O.D. were given orally for 4 days. Daily dressing of surgical wound was performed for eleven days. Sutures were removed on twelfth Post-operative day. Animal recovered uneventfully.

Discussion

Choking of oesophagus is most commonly caused due to piece of mango turnip, potato or apple (O'conner in 1980). In the present case, the choking was observed by ingestion of leather piece may be due to pica or indiscriminate feeding habit of the animal. Radostitis (2000) reported that choke may be observed due to ingestion of pieces of leather and plastic which may lodge into thoracic part of oesophagus. The symptoms observed in present case i.e. anorexia, salivation, tympany, regurgitation might be due to obstruction of thoracic part of oesophagus by pieces of leather. Tyagi and Singh (1994) reported similar symptoms in thoracic oesophageal obstruction. Singh and Singh (1994) suggested barium meal contrast radiographic examination for diagnosis of thoracic choke.

References

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