Left Flank Abomasopexy

Intra-Operative Procedure

A left-flank laparotomy is performed using a 20- to 25-cm incision in the paralumbar fossa, as previously described. Caution should be exercised when entering the abdomen because a distended abomasum may lie immediately within the incision area. Usually, the abomasum is visible through the incision. An 8- to 12-cm simple continuous or interlocking suture line of heavy polymerized caprolactam, nylon, or polypropylene, is placed in the greater curvature of the abomasum 5–7 cm from the attachment of the greater omentum (Figure 13.5A). The serosa may be rubbed with a dry surgical sponge to mildly irritate the area and enhance adhesion formation. The suture bites pass through the submucosa, and a meter of suture material should extend from each end of the suture line.

Haemostats are placed on these suture ends in such a fashion that the cranial and caudal ends are easily identified. The abomasum may then be deflated using a 12-gauge needle and rubber tubing (Figure 13.5A) if this is considered necessary. The needle is placed into the dorsal portion of the abomasum and is inserted at an angle to obviate leakage when the needle is withdrawn. It is important that the abomasum not be deflated prior to the insertion of the suture; otherwise, the site for suture placement may be retracted away from the incision. The cranial end of the suture is attached to a large, straight, cutting needle or to an S-curved cutting needle; this needle is carried along the internal body wall to a position right of midline, but medial to the subcutaneous abdominal vein and 15 cm caudal to the xiphoid process. The forefinger protects the end of the needle, and the lateral fingers reflect the viscera away from the body wall and ahead of the needle. An assistant can apply upward pressure on the abdominal wall in the area where the needles are to be inserted through the body wall. An empty syringe case works well for this purpose. The needle is inserted quickly through the ventral body wall (Figure 13.5B). The assistant grasps the needle, and the caudal suture is placed through the body wall 8–12 cm caudal to the cranial suture. The assistant then grasps the two suture ends and applies gentle traction; at the same time, the surgeon pushes the deflated abomasum into its normal position. When the sutured area of the abomasum is lying against the floor of the abdomen, the assistant ties the suture ends together (Figure 13.5C). Care should be taken to tie the retention suture with appropriate tension. The surgeon should be able to have one finger snuggly between the abomasum and body wall when tied. Too loose may allow intestine to become entrapped in the suture loop while too tight may lead to tearing of the suture out of the abomasum. The flank laparotomy incision is closed routinely. The suture is left in place for 4 weeks; the ends are then cut as close to the skin as possible. This time is considered necessary to allow the development of adhesions sufficient to prevent re-displacement.

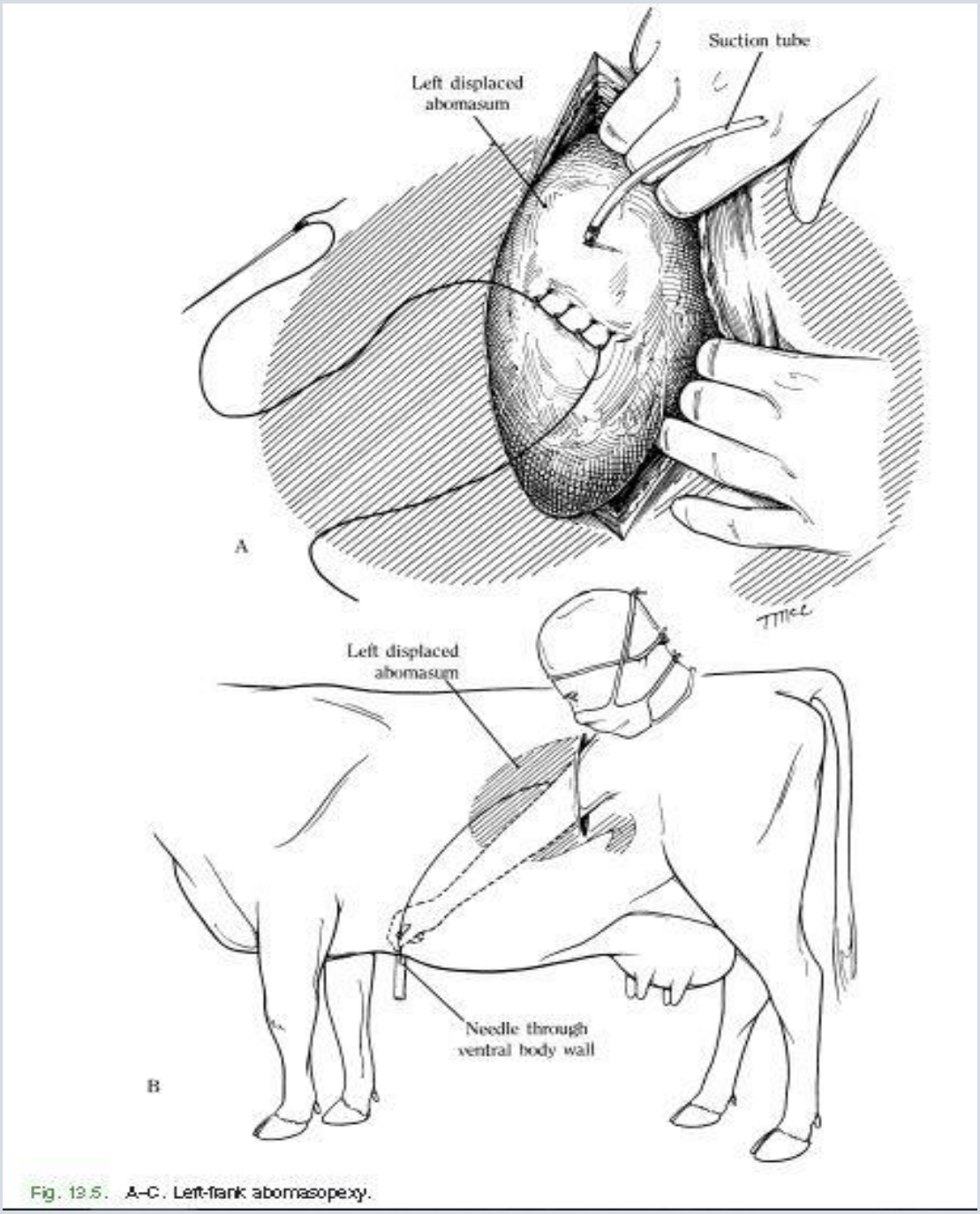

Fig. 13.5. A–C. Left-flank abomasopexy.

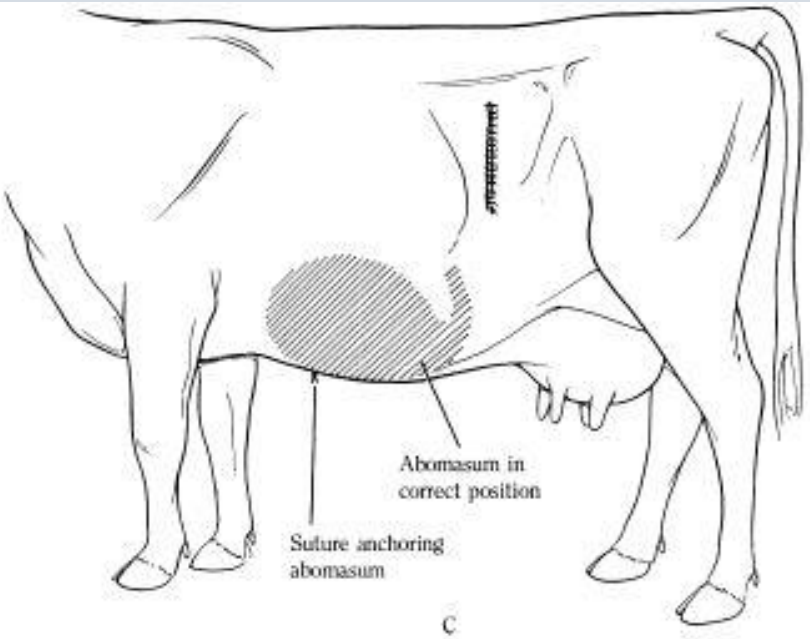

Fig. 13.5. *Continued.*

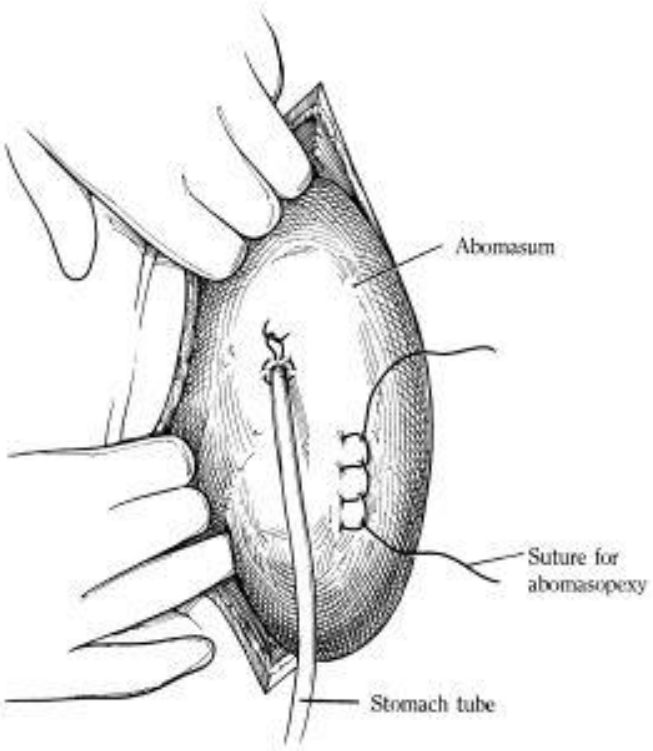

Fig. 13.6. The fluid within the abomasum is removed using a medium-sized stomach tube.