

PROGNOSIS & COMPLICATIONS OF LEFT PARALUMBAR FOSSA ABOMASOPEXY

Prognosis and Complications Less information is available on the success rate of the left flank abomasopexy than for other techniques. The most commonly recognized complications of this technique are accidental damage to the milk vein, entrapment of omentum or small intestine between the abomasum and the ventral body wall, and improper positioning of the abomasum leading to partial outflow obstruction. Structures, particularly omentum, can be easily caught by the needle as the surgeon passes it blindly from the incision to the ventral body wall, or trapped between the abomasum and ventral body wall between the two sutures as the abomasum is pulled down. Structures may also be trapped between abomasum and ventral body wall if the abomasum is allowed to slip back away from the ventral body wall before it is tied. Redisplacement can occur if the sutures break, are placed in the omentum rather than the seromuscular layer, or pull through the abomasal wall. The risk of suture breakage increases when a clamp is used to stabilize the suture ventral to the abdomen in an area that will be involved in the knot. An inadequate number of bites in the abomasal wall or failure to pull the abomasum snugly to the ventral body wall increases the risk of suture pullout. Suture pullout can also result in localized or generalized peritonitis. Abomasal fistulation is of particular risk if multifilament nonabsorbable sutures are used to penetrate the mucosa. Proper technique and release of sutures 2 to 3 weeks after surgery can minimize the risk of these complications. In the author's experience, this technique has one of the steepest learning curves.