**Left Flank Laparotomy**

The left flank is prepared for aseptic surgery.

Anesthesia is achieved by infiltration with a local anesthetic in a line block, inverted L block, or paravertebral block.

A 20- to 25-cm dorsoventral skin incision is made 4cm caudal and parallel to the last rib and 6 to 8cm ventral to the transverse process of the lumbar vertebrae.

To incise the skin, reasonable pressure should be exerted on the scalpel to ensure complete penetration. This incision is continued ventral, so the skin is opened in one smooth motion.

Separation of the skin and subcutaneous tissue reveals fibers of the external abdominal oblique muscle and fascia. This layer is incised vertically to reveal the internal abdominal oblique muscle.

A similar incision through the internal abdominal oblique muscle reveals the glistening aponeurosis of the transverse abdominal muscle.

Then the muscle is picked up with tissue forceps and is nicked with a scalpel in the dorsal part of the incision to avoid cutting the rumen. The incision through the transverse abdominal muscle and peritoneum may be extended with scissors or a scalpel for entrance into the peritoneal cavity

The caudal abdominal cavity is explored first including the urinary bladder, uterus, left kidney, dorsal and ventral sacs of the rumen, and intestinal mass.

To reach the cranial abdomen the arm is passed ventral to the superficial layer of the greater omentum and directed cranially to locate the pylorus and pyloric part, body, and fundus of the abomasum, the omasum, and the reticulum.

All parts of the reticulum must be palpated to verify whether adhesions and/or abscesses are present.

The right side of the reticulum and left lobe of the liver, where abscesses are most often found, must be especially evaluated. The diaphragm, apex, and parietal surface of the spleen are also palpated.

Any adhesions found in the cranial abdomen must be assessed with gentle palpation to avoid disruption and minimize the risk of spreading inflammation.

The incision is closed in 3 layers.

The peritoneum and transverse abdominal muscles are closed together with a simple continuous suture pattern using no. 0 or no. 1 synthetic absorbable suture from dorsal to ventral.

The internal and external abdominal oblique muscles may be closed with a second simple continuous layer using no. 1 synthetic absorbable suture.

Generally, skin closure is performed with a continuous Ford interlocking pattern using heavy polymerized caprolactam (Vetafil™).

At the surgeon’s option, 2–3 simple interrupted sutures may be placed in the ventral aspect of the incision. This measure allows easy drainage if infection develops in the incision.