**Right Flank Laparotomy**

1. The Right flank is prepared for aseptic surgery.
2. Anesthesia is achieved by infiltration with a local anesthetic in a line block, inverted L block, or paravertebral block.
3. 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.
4. To incise the skin, reasonable pressure should be exerted on the scalpel to ensure complete penetration. This incision is continued ventrad, so the skin is opened in one smooth motion.
5. 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.
6. A similar incision through the internal abdominal oblique muscle reveals the glistening aponeurosis of the transverse abdominal muscle.
7. 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
8. If the viscera are in normal position, the duodenum will be encountered running horizontally across the dorsal part of the incision with the mesoduodenum dorsal and the greater omentum ventral. The pylorus and abomasum can be palpated ventrally.
9. The greater omentum may be reflected craniad to allow examination of the jejunum, ileum, cecum, and colon. The kidneys and pelvic region can also be palpated at this stage.
10. The rumen can be palpated as well as part of the reticulum and diaphragm feeling for adhesions between the two. The omasum, liver (the right-flank approach allows complete palpation of this organ), gallbladder, and diaphragm can be palpated cranially on the right side.
11. 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.