Udder Amputation (Traditional Technique)

Position: Animal placed in dorsal recumbency

Sedation: General anaesthesia

- Create a fusiform skin incision so skin closure after the surgery can be done; a lateral incision is made and extend to the junction between the middle third and dorsal third of the udder. This will ensure that there is enough skin for closure and with very little tension
- Dissect towards the inguinal canal and ligate the pudendal arteries followed by the pudendal vein
- Repeat on the contralateral side
- Incise the loose fascia on the proximal aspect of both lateral laminae, starting the incision cranially and extending it caudally until the left and right perineal arteries and veins are located and double ligated
- Ligate the caudal superficial epigastric vein last. This is done to minimize systemic blood loss.
- Sharply transect the lateral laminae and extend the dissection on the dorsal aspect of the mammary bland to complete the excision
- To control postoperative seromas: Place two, 2.5 cm penrose drains In the space between the ventral abdominal fascia and the subcutaneous tissues on either side of the midline along the ventral abdomen
- Stab incisions are done to create portals for the drains to exit on the other side of the incision and secured to the skin using a single interrupted suture to avoid accidental drain removal

Closure

- Done in 3 layers
- Subcutaneous tissue – closed in 2 layers using a number 2 absorbable suture material in a simple continuous pattern.
- Every 2 or 3 cm, the subcutaneous sutures should penetrate the abdominal fascia to reduce dead space.
- The skin is closed in a forward interlocking pattern with a non-absorbable material (such as polyamide), and a stent is sutured over the incision to help diminish the tension on the incision.