

# MANAGEMENT OF RECURRENT RECTAL PROLAPSE IN A PUP BY COLOPEXY

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Rectal prolapse in dogs is a consequence of disorders such as diarrhoea, tenesmus, lower urinary tract and prostatic diseases that produce persistent straining (Sherding, 1996). The prevalence is highest in young, unthrifty parasitized dogs with severe diarrhea (Johnston, 1985). For recurrent prolapse, a prophylactic colopexy should be considered (Sherding, 1996). This paper reports a case of rectal prolapse associated with intussusception, and its surgical management by a prophylactic colopexy.

A three-and-a-half months old female Spitz puppy, weighing 1.72 kg was presented with a tubular pink mass protruding through the anus (Fig. 1). Reduction of the prolapsed mass and retention by purse-string suture was attempted earlier with no success. The prolapsed mass was cylindrical in appearance with a luminal opening at its end. Probing with thermometer between the prolapsed mass and anal sphincter revealed rectal prolapse but not telescoping of intestine. Abdominal palpation revealed sausage shaped intra-abdominal mass, giving a suspicion of an associated intussusception. An exploratory laparotomy and surgical correction was resorted to, immediately.

General anaesthesia was effected with 1 mg of Xylazine intramuscularly, followed ten minutes later by an intramuscular injection of 15

mg Ketamine. Ceftriaxone sodium @ 20 mg/kg was then given intravenously to provide a perioperative antibiotic umbrella.

A ventral midline celiotomy was performed and the intestines were exteriorized. An intussusception was noticed at the illeo-colic junction. The prolapsed mass was reduced by applying traction on the colon. The viability of the telescoped intestine was poor, so resection and oblique end-to-end anastomosis was carried out using No.5.0 PGA. To reduce the diameter of the colon, cushioning sutures were applied in the antimesenteric border of the descending colon (Fig. 2). This was followed by colopexy by placing three interrupted sutures into the seromuscular wall of the descending colon and transverse abdominal muscle with vicryl No.3-0. Linea alba and skin were apposed by No. 5-0 PGA and silk. Animal had an uneventful recovery.

Abdominal exploration helped in identifying and correcting the intussusception associated with rectal prolapse and also reduction of the prolapsed rectum. Application of cushioning sutures along the antimesenteric border of the descending colon successfully reduced the diameter of the

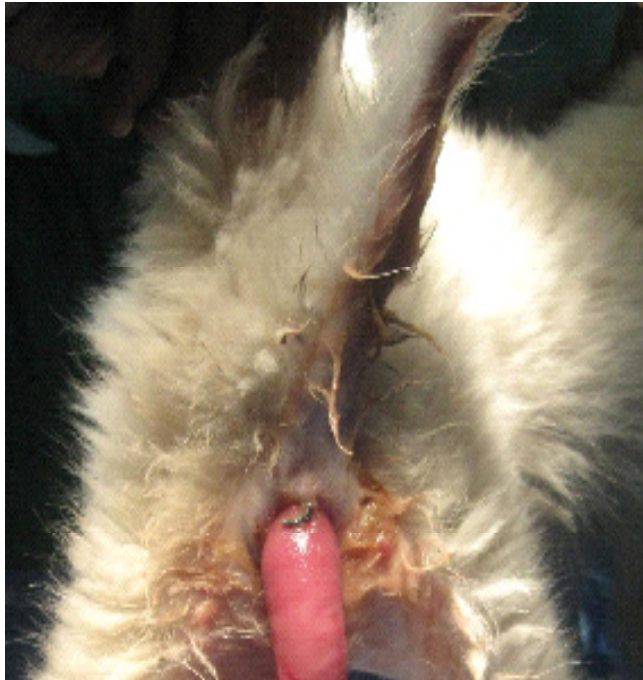
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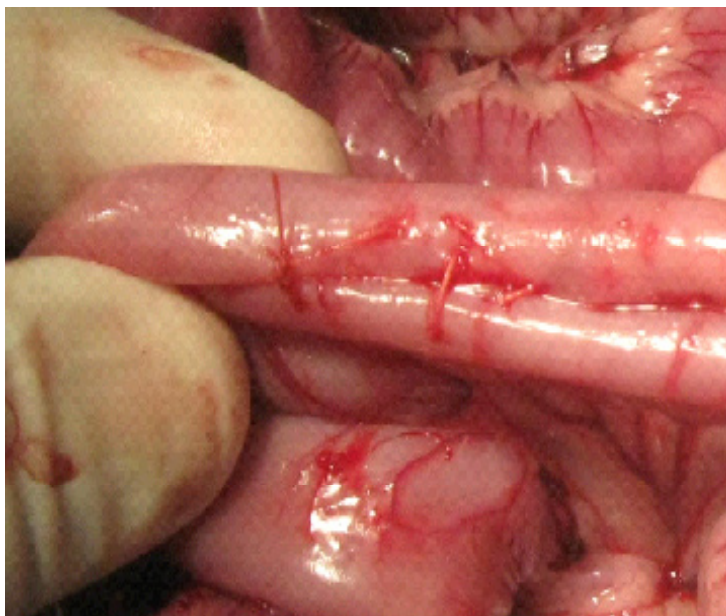
dilated colon. Colopexy was found rewarding in preventing the recurrence of prolapse of the rectum. These findings were in accordance with those of Johnston (1985) who suggested colopexy following reduction of prolapsed rectum, to prevent recurrence. Prolapse of longer duration and the tissue having poor viability should be managed either by mucosal

resection or complete resection and anastomosis (Niebauer, 1993). The colopexy technique does not affect intestinal function adversely (Popovitch *et al*, 1994). Permanent fibrous adhesion occurs after colopexy and it maintains reduction of the prolapse (Mattieson, 1985). It can thus be concluded that recurrence of rectal prolapse should be prevented by colopexy and the cause of tenesmus should be diagnosed and resolve

**Fig. 1**  
**Protruding mass**



**Fig. 2**  
**Cushing suture – Antimesenteric border**



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