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Sushma Prabhu

M.V. Sc. Scholar, Department of
Veterinary Surgery and
Radiology, Veterinary College,
Hebbal, Bengaluru, Karnataka,
India

Gurudev Karajagi

Assistant Professor (on contract
basis), Department of Veterinary
Surgery and Radiology,
Veterinary College, Hebbal,
Bengaluru, Karnataka, India

V Mahesh

Associate Professor, Department
of Veterinary Surgery and
Radiology, Veterinary College,
Hebbal, Bengaluru, Karnataka,
India

BN Nagaraja

Senior Professor and Head,
Department of Veterinary
Surgery and Radiology,
Veterinary College, Hebbal,
Bengaluru, Karnataka, India

Corresponding Author:

Sushma Prabhu

M.V. Sc. Scholar, Department of
Veterinary Surgery and
Radiology, Veterinary College,
Hebbal, Bengaluru, Karnataka,
India

Surgical repair of traumatic cleft palate in a cat

Sushma Prabhu, Gurudev Karajagi, V Mahesh and BN Nagaraja

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Abstract

A 2 years old tom cat was presented with history of fallen from a height, inappetence and lethargy for the past 3 days. Clinical examination revealed mild dehydration and a cleft in the hard palate, with no soft palate involvement. Thoracic radiograph showed no signs of pneumonia. Hematological and biochemical parameters were within normal limits. Surgical correction was performed by direct apposition of the defect. Following post operative care, the animal recovered uneventfully.

Keywords: Traumatic cleft palate, oronasal fistula, cat

1. Introduction

Cleft palate is congenital or acquired Communication between the oral and nasal cavities .it can cause contamination of nasal cavity with saliva or food (Sousa Filho *et al.*, 2016) ^[1]. The palate separates the nasal and oral cavities. Congenital abnormalities of the hard and soft palate may result from an inherited characteristic with incomplete penetrance. Cleft palate can develop due to trauma, such as a fall from a high elevation or foreign body penetration (Maretta *et al.*, 1991) ^[3]. Clefts palate can interfere with suckling, leading to nasal leakage of ingesta, sneezing, rhinitis, aspiration pneumonia, and weight loss (Garcia, 2006) ^[2].

Materials and Methods

A 2-year-old tom Cat was presented to the Department of Veterinary Surgery and Radiology, Veterinary College Hebbal, Bengaluru, with a history of falling from a height, inappetence, and lethargy for the past 3 days. Clinical examination revealed mild dehydration. oral examination revealed a cleft in hard palate and no involvement of soft palate (Fig. 1). On auscultation, moist rales were heard, thoracic radiography revealed no signs of pneumonia. Haematological parameters were within normal limits.

A surgery was scheduled for correction of defect by direct apposition. The surgical site was aseptically prepared. Anaesthesia was achieved using Inj. Diazepam at 0.5 mg/kg body weight IM and Inj. Ketamine at 25 mg/kg body weight IM. The cat was positioned in dorsal recumbency. The fistula was debrided to healthy, bleeding mucosal edges. The margins of the fistula were incised to elevate the edges sufficiently, allowing for approximation without excessive tension. The mucosa was apposed in simple interrupted suture pattern with Polydioxanone No. 2-0 suture (Fig. 2).

Following surgery, the patient received fluid therapy for five days. Medication Inj. Ceftriaxone at 20 mg/kg body weight was administered intravenously for 5 days. Oral intake commenced with liquids, gradually progressing to semisolid and then solid foods.

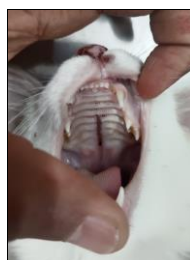


Fig 1: Photograph showing cleft palate before surgery



Fig 2: Photograph showing closed cleft palate using simple interrupted sutures

Results and Discussion

Postoperative evaluation was done till 2 weeks revealed healing without complications. The necessity for repair is often underestimated because of the mistaken belief that palatal defects will heal spontaneously. While small defects in the palate may close on their own through secondary healing, larger defects involving both the palatal mucoperiosteum and the underlying bone often do not heal completely. When this occurs, patients may experience a significant decline in quality of life due to complications such as oronasal fistulas, chronic rhinitis, and even the risk of aspiration pneumonia (De Paolo *et al.*, 2020; Reiter and Gracis, 2018) ^[1,4]. In order to prevent postoperative dehiscence or perforation, oral feeding should be avoided (Sager and Nefen, 1998) ^[5]. Other source recommend that soft food should be given for 2-3 weeks (Smith, 2000) ^[6]. The present case study, cleft palate was successfully corrected by direct apposition of defect.

Conclusion

Timely surgical intervention and appropriate postoperative care resulted in successful correction of the midline palatal defect, with complete recovery and no postoperative complications.

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Conflict of Interests

There is no conflict of interest.

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