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Surgical correction of cervical oesophageal obstruction in a two month male kid

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Abstract

A two-month-old male non-descript kid was presented with a history of anorexia, mild respiratory distress and progressive abdominal distension. Clinical examination revealed a palpable, movable mass along the left cervical portion of the oesophagus, consistent with an oesophageal obstruction. The animal was sedated using Inj. Xylazine at 0.1 mg/kg intramuscularly and anaesthesia was maintained with Inj. Ketamine at 5 mg/kg intramuscularly. Following routine aseptic preparation, a longitudinal skin incision was made over the left jugular furrow and a beetroot fragment was identified and successfully removed from the oesophageal lumen. The oesophageal incision was closed in two layers using 3-0 polyglycolic acid in a simple interrupted pattern, while the skin was sutured with 2-0 polyamide in a cross-mattress pattern. A nasogastric infant feeding tube was placed to facilitate enteral nutrition during the postoperative period. Postoperatively, Inj. Ceftriaxone and Inj. Meloxicam were administered for five days. Oral feeding was withheld for seven days, after which a soft diet was gradually introduced and the feeding tube was removed on the seventh postoperative day. The animal showed an uneventful recovery without any postoperative complications.

Keywords: Nondescriptive kid, Choke, Oesophagotomy

Introduction

Oesophageal obstruction (choke) is commonly encountered in cattle and buffaloes; however, it is only occasionally reported in goats. The relatively low incidence in goats has been attributed to their selective feeding behavior (Sanker *et al.*, 2010 and Raut & Aher 2017) ^[1, 2]. Anatomically, the oesophagus comprises four layers: the outer adventitial layer (tunica adventitia), muscular layer (tunica muscularis), submucosa (tela submucosa) and a mucosal layer (tunica mucosa) (Singh, 2017) ^[3]. The cervical portion of the oesophagus is structurally thicker, and its lumen exhibits a rosette-shaped configuration, which has been suggested as a predisposing anatomical factor for obstruction in this region (Sanker *et al.*, 2010). In contrast, the caudal segment is relatively narrow initially and then progressively widens distally. Oesophageal obstruction in ruminants has been associated with the ingestion of a variety of foreign materials, including vegetable matter, phytobezoars, leather fragments, wool balls, polythene sheets and rubber materials (Sanker *et al.*, 2010). The present paper reports the oesophageal obstruction in a two-month-old kid due to a foreign body and its management.

Case History and Observation

A two-month-old non-descript male kid was presented to the Teaching Veterinary Clinical Complex, Large Animal Unit, Madras Veterinary College, Chennai with a history of anorexia, mild respiratory distress and progressive abdominal distension of recent onset. Detailed clinical examination revealed a palpable, freely movable mass along the left cervical portion of the oesophagus, which was painful on manipulation. The mass was firm in consistency and suggestive of an intraluminal obstruction. Based on the anamnesis and clinical findings, a provisional diagnosis of cervical oesophageal obstruction was made. Haemato-biochemical values were within the normal range. Considering the progressive nature of the clinical signs and the risk of complications surgical management was planned and undertaken.

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Surgical Management

Preoperatively, the animal was appropriately stabilized to correct dehydration. As part of preoperative management, Inj. Ceftriaxone proxetil was administered intravenously at a dose of 10 mg/kg as a prophylactic antibiotic. Sedation was achieved using Inj. Xylazine hydrochloride at 0.1 mg/kg body weight intramuscularly, followed by induction and maintenance of anaesthesia with Inj. Ketamine hydrochloride at 5 mg/kg body weight intramuscularly. Following induction, the animal was placed in right lateral recumbency to facilitate surgical access to the cervical region. The surgical site was aseptically prepared, including clipping of hair and sequential antiseptic scrubbing. To provide additional intraoperative analgesia, 2% Inj. Lignocaine hydrochloride diluted with normal saline was infiltrated locally along the incision line, ensuring adequate local anaesthesia at the operative site. A longitudinal skin incision measuring 5–7 cm was made along the superior border of the jugular furrow, directly over the site of the swelling. Blunt dissection was carried out between the sternocephalicus muscle and the trachea, allowing identification of the oesophagus, which was recognized by its characteristic pink coloration (Fig. 1). A 2–3 cm longitudinal incision was made over the oesophagus and then obstructing beetroot fragment was carefully retrieved (Fig. 2). The lumen was flushed with sterile normal saline to minimize contamination and remove residual debris. The oesophageal mucosal layer was apposed using 3-0 polyglycolic acid in a simple interrupted (in–out–out–in) suture pattern. The submucosal and muscularis layer were subsequently closed with 3-0 polyglycolic acid using a simple interrupted pattern. The subcutaneous tissue was sutured with 3-0 polyglycolic acid in a simple continuous pattern and the skin was closed using 2-0 polyamide in a simple cross-mattress pattern. Following closure, an infant feeding tube was passed through the nasal passage to facilitate postoperative enteral nutrition and was securely anchored to the skin.



Fig 1: Esophagus between sternocephalicus muscle and trachea



Fig 2: Removal of beetroot piece from esophagus



Fig 3: 7th post operative day

Postoperative care & Discussion

Postoperatively, oral feeding was withheld for seven days and the owner was advised to administer soft food through the infant feeding tube to minimize oesophageal strain and facilitate optimal healing. Broad-spectrum antimicrobial therapy with Inj. Ceftriaxone at a dose of 10 mg/kg and Inj. Meloxicam at 0.2 mg/kg were continued for five days to prevent postoperative infection. The infant feeding tube was removed on the seventh postoperative day, after confirming satisfactory clinical progress and a soft, easily digestible diet was gradually introduced. The skin sutures were removed two weeks after surgery, following adequate wound healing. Throughout the postoperative period, the animal was closely monitored and recovery was smooth and uneventful, with no evidence of complications such as wound dehiscence, infection or oesophageal stricture formation (Fig. 3). In the present case, the primary objective of managing oesophageal obstruction was to relieve the impaction with minimal trauma to the oesophageal wall and to prevent secondary complications such as ruminal bloat, aspiration, or oesophageal necrosis (Shawaf *et al.*, 2017) [4]. Cervical oesophagotomy performed through a ventrolateral approach provided adequate access to the mid and distal cervical oesophagus and proved to be a practical and effective technique for the retrieval of the tightly impacted foreign body, supporting its utility as a reliable surgical option in similar cases of cervical oesophageal obstruction (Fubini, 2019) [5].

Conflict of Interest

Not available

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Not available

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