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Clinical management of total uterine prolapse in indigenous goat: A case report

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Abstract

A 3-year-old non-descript doe presented with complete uterine prolapse following manual extraction of twins, accompanied by straining, depression, dehydration, hyperthermia, and tachycardia. Both uterine horns were everted, with soiled and inflamed mucosa, exposed cotyledons, retained fetal membranes, and bleeding. Following epidural anaesthesia, the uterus was cleansed, oedema reduced, and manually repositioned, followed by vulval retention suturing and supportive therapy with oxytocin, fluids, calcium borogluconate, antibiotics, analgesics, and antihistamines. The doe recovered uneventfully, demonstrating the importance of prompt and appropriate intervention in managing complete uterine prolapse in goats.

Keywords: Total uterine prolapse, Indigenous goat, Doe, Epidural anaesthesia

Introduction

Case history and clinical observation

A 3-year-old non-descript doe was presented to the Veterinary Dispensary as an emergency case with complete uterine eversion following manual extraction of a twin pregnancy. The animal had been straining continuously and exhibited uterine eversion for approximately 3 hours prior to presentation (Fig.1). On arrival, the doe was standing but appeared depressed and dehydrated. The rectal temperature was 39.8 °C, and the heart rate was 102 beats/min, indicating hyperthermia and tachycardia. Clinical examination of the perineal region revealed complete eversion of both uterine horns, with the uterine mucosa exposed, soiled and inflamed. The cotyledons were clearly visible, along with a portion of intact chorioallantoic membrane was observed from the prolapsed uterus.

Treatment and Discussion

Treatment was initiated with epidural anesthesia by administering 2 ml of 2% lignocaine hydrochloride into the sacrococcygeal epidural space to desensitize the perineal region and prevent straining. The doe was positioned on a sloping surface with the head directed downhill, keeping the hindquarters elevated, thereby allowing gravity to facilitate uterine replacement. Gross debris was removed from the exposed mucosal surface by thorough washing with lukewarm water followed by normal saline to reduce edema. The retained fetal membranes were manually detached from the caruncles, and the prolapsed uterus was rinsed with 1% potassium permanganate solution and subsequently treated with 0.5% povidone-iodine solution to minimize contamination. The prolapsed uterus was then elevated to the level of the vulva and carefully repositioned into the vaginal canal by applying gentle, sustained manual pressure with the assistance of another person. The uterine body was repositioned first, followed by the uterine horns. Following successful repositioning, vulval retention sutures were applied to prevent recurrence of the prolapse (Fig.2). Oxytocin (15 IU, IM) was administered to promote uterine involution. Supportive fluid therapy consisting of 300 ml of 5% dextrose normal saline and 100 ml of calcium borogluconate was administered intravenously. To prevent post-operative complications, ceftriaxone (2 mg/kg body weight), flunixin meglumine (1.1 mg/kg body weight), and chlorpheniramine maleate (1 ml, IM) were

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administered for three consecutive days. The doe recovered uneventfully following treatment, with no recurrence of uterine prolapse observed during the follow-up period. Uterine prolapse is an obstetrical emergency that usually occurs during the third stage of labour, following expulsion of the fetus and separation of the fetal cotyledons from the maternal caruncles (Noakes *et al.*, 2001) ^[5]. In small ruminants, complete eversion of both postpartum uterine horns is commonly observed (Selvaraju *et al.*, 2010; Senthilkumar, 2014), although in the present case, uterine prolapse occurred following forceful delivery of the kid. Uterine prolapse may also be associated with uterine inertia, retention of fetal membranes, or complications following abortion (Arthur *et al.*, 1997) ^[1]. Occasionally, the intestines or urinary bladder may become entrapped within the everted uterus, necessitating careful examination and replacement. Prompt treatment is essential because prolonged exposure and interference with the blood supply can result in congestion, oedema, cyanosis, necrosis, gangrene, shock, and even death (Kapadiya *et al.*, 2015) ^[4]. The primary objective of treatment is gentle replacement of the prolapsed uterus followed by measures to maintain it in its normal position. Before

replacement, the prolapsed mass should be gently cleaned with an appropriate antiseptic solution to reduce contamination and the risk of toxæmia; however, aggressive cleaning should be avoided because it may damage the endometrium and facilitate systemic absorption of toxic contaminants (Scott and Gessert, 1998) ^[7]. Following replacement, oxytocin (10 IU, intramuscularly) may be administered to enhance uterine tone, while calcium borogluconate should be given when clinical signs of hypocalcaemia are evident, as hypocalcaemia is frequently associated with uterine prolapse (Fubini and Ducharme, 2006) ^[3]. Broad-spectrum antibiotics administered for 3-5 days after replacement are recommended to prevent secondary bacterial infection (Plunkett, 2000; Borobia-Belsue, 2006) ^[6, 2]. Prognosis largely depends on the duration of prolapse, degree of tissue damage, and extent of contamination. Early intervention is particularly important because delayed treatment can compromise uterine blood supply and adversely affect survival and future fertility; however, when tissue damage is mild and replacement is performed promptly, subsequent fertility may remain unaffected.



Conflict of Interest

Not available

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Not available

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