

POST-PARTUM UTERINE PROLAPSE IN A MURRAH BUFFALO- A CASE REPORT

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ABSTRACT

The present communication reports a case of uterine prolapse in a pluriparous Murrah buffalo and its successful treatment by reposition at proper anatomical site and treatment.

Keywords: uterine prolapse, Murrah buffalo, clinical management

INTRODUCTION

A prolapse of the uterus is effectively the whole of the uterus turning inside out and hanging out of the vulva of the buffalo (Roberts, 1971). Prolapse of the uterus is a common complication of the third stage of labour in the buffaloes (Joseph *et al.*, 2001). Compared to the vaginal prolapse, the uterine prolapse is larger, longer (usually hanging down to the hocks when standing), more deep red in color and covered with the “buttons” where the placenta was attached (Figure 1) (Arthur *et al.*, 1996). There seem to be two age groups that are susceptible to this condition, heifers and older buffaloes. When heifers suffer from a prolapse it is due to the uterine muscle becoming exhausted from the calving process. When the calf is finally expelled, the uterus flops out with the calf. In older buffaloes, it is often associated with milk fever.

The uterus like the other muscles in the body, requires calcium to contract. In a buffalo with milk fever, the uterus fails to contract as the calf is being passed and again flops out with the calf. To avoid problems with uterine prolapses, try to decrease the potential for the buffaloes being affected by the predisposing factor above.

A uterine prolapse is considered a medical emergency; therefore, this condition is life threatening. If the affected buffalo is not treated quickly, she could go into shock or die from blood loss. A veterinarian should be contacted for assistance with this procedure. If the uterus is pushed back improperly, it could result in internal bleeding and death of the buffalo.

CASE HISTORY AND OBSERVATION

A ten-year-old Murrah buffalo in fifth parity was presented to the College of Veterinary Science and Animal Husbandry, DUVASU, Mathura with a history of a normal parturition. A normal female calf had been born six hours before. The uterine horn was prolapsed along with the fetal membrane. The buffalo was healthy and in a standing position. The prolapsed mass was hanging from the vulva. The rectal temperature was recorded to be 101°F. Eye mucous membrane was congested. The placental cotyledons were attached to the maternal

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Figure 1. Showing uterine prolapse in buffalo.



Figure 2. Showing clinical management of uterine prolapse.

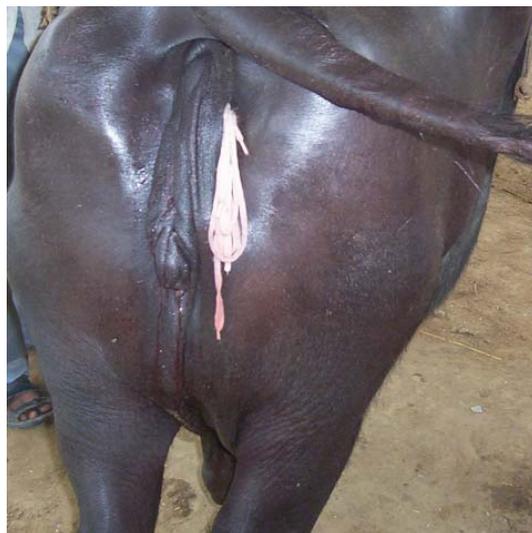


Figure 3. Showing clinical management of uterine prolapse.

coruncles. Severe bleeding was noticed. The newborn was apparently healthy and trying to suckle her mother.

CLINICAL MANAGEMENT

Considering the severity of the case and the owner's agreement, the prolapsed mass was washed carefully with warm saline. Epidural anesthesia was given with 2% Xylocaine to prevent straining. The fetal membranes were detached manually with fingertips from the maternal coruncles avoiding bleeding. Then the uterine mass was again washed with saline and finally with 1:1000 potassium permanganate solution. Then it was replaced to its normal anatomical position. To prevent further complications, intra-uterine antibiotic treatment was also done. Then the purse string suture with sterile shoe laces around anterior vagina was done (Figures 2 and 3). A truss was applied to prevent recurrence due to tenasmus. The animal was treated with antibiotic, anti-inflammatory, antihistaminic, analgesic i/m and i/v fluid therapy. The same treatment was followed for three days and vaginal suture was removed after one week. The animal became healthy with plenty of milk production and normal fertility.

DISCUSSION

The usual sequel of uterine prolapse is haemorrhage, shock, septic metritis, peritonitis, infertility or death. Sometimes in delayed cases, partial contraction of cervix interferes with proper repositioning, resulting in recurrence of prolapse. But in this case, after detaching the fetal membranes, the prolapsed mass became lighter

and less voluminous, so it was easy to reposit as described by Bhoi and Parekar (2009). Moreover we applied a truss, so even in the presence of a tenasmus, the recurrence was noticed. Uterine prolapse is predisposed to a violent tenasmus and retention of fetal membrane in this case as reported by Roberts (1971).

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