COMPARING THE INCIDENCE OF CELIOTOMY INCISIONAL DRAINAGE AFTER A LARGE COLON RESECTION VERSUS OTHER LARGE COLON LESIONS WITH A PELVIC FLEXURE ENTEROTOMY

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Background: Incisional infections from ventral midline celiotomies have numerous, multi-factorial etiologies including surgical trauma, prolonged anesthesia time, suture material (Vicryl), suture pattern (near-far-far-near), long incision length, use of post-operative bandaging, and post-operative incisonal edema. A direct comparison of the incidence of incisional infection by the type of large colon surgical procedure has not been described.

Objectives: To compare the incidence of incisional drainage after a pelvic flexure enterotomy versus a large colon resection.

Methods: Medical records from Chino Valley Equine Hospital were reviewed for colics with large colon lesions that received either a pelvic flexure enterotomy or a large colon resection. Data included history, signalement, surgery report, anesthesia report, and examinations up to at least 10 days post-operatively.

Results: From June 2007 to December 2016, 237 out of 600 exploratory celiotomies had large colon lesions necessitating a pelvic flexure enterotomy, with 26 (10.97%) of those incisions developing drainage. During the same time frame, 34 large colon resections were performed with only 1 developing drainage (2.94%).

Conclusions: When compared to other large colon surgical lesions, large colon torsions resulting in large colon resections often have prolonged anesthesia time, longer incision lengths, increased risk of ingesta contamination to the incision, and significantly increased post-operative pain. With the listed risk factors, large colon resections do not appear to have an increased likelihood of developing incisional drainage when compared to pelvic flexure enterotomies.

Ethical animal research: Not required. Source of funding: None. Competing interests: None.