associated with arteritis of cranial mesenteric artery resulting in thrombo-embolism, ischemia and infarction of large intestine (Slocombe and McCraw, 1976). This might explain the presence of focal areas of infarction in the present case resulting further into translocation of gut bacteria into systemic circulation and endotoxemia (Radostits loc. cit).

_Gasterophilus_ spp. larvae are largely considered to be non-pathogenic. However, gastric ulceration and perforation caused by larvae may result in acute peritonitis (Dart _et al._, 1987).

_Gastrodiscus_ spp. is a common intestinal parasite of equids. Although there are conflicting reports regarding their pathogenicity and their ability to cause clinical disease, such a heavy

**References**


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**Surgical Management of Rectovaginal Fistula in a Mare**

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Rectovaginal fistula (RVF) is an opening between the rectum and vagina which results in chronic contamination of the vagina with the faecal material. RVF is a relatively common injury sustained during foaling (Jalim and Mckinnon, 2010). Fistula most commonly occurs secondary to dystocia and usually in primiparous mares. These may be caused by foal’s nose or more commonly a foot (or both) being forced through the dorsum of the vestibule of vagina into the rectum. Spontaneous retraction or manual replacement of foal’s head or extremity into the correct position limits the injury to a RVF, but if parturition proceeds before correction the result is usually a third degree laceration. Conservative management of RVF may allow them to granulate and close by wound contraction (Colbern _et al._, 1985); however most will require surgical repair. This paper describes a case of successful surgical management of rectovaginal fistula in a mare.

**Case History and Observations**

A Three year old Kathiawari mare was presented to the Veterinary College and Research Institute

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Teaching Hospital, Namakkal with a history of passing dung through the vaginal passages. Anamnesis revealed that the mare foaled seven days back and during foaling it had an episode of dystocia with foal’s forelimb traumatizing the rectum and was protruded through the anus. The referring veterinarian attended the dystocia, repositioned the foetal posture and delivered a colt foal. The animal exhibited dyschezia with passage of dung through the vagina on the second day onwards. Clinical examination revealed a complete recto vaginal fistula 5 cm cranial to the dorsum of the vulval lips with lacerations. The animal was referred and admitted on seventh day and maintained with antibiotics and soft diet up to fourteenth day for the surgical correction. The haematological parameters were within the physiological limits.

Treatment and Discussion

The mare was prepared aseptically for surgical management of RVF. Pre-operatively soap water enema was administered to evacuate the rectum. The horse was anaesthetized with xylazine (1.1 mg/kg) and ketamine (2.2 mg/kg) and maintained with isoflurane. The mare was positioned in dorsal recumbency.

The transvaginal technique was employed for herniorrhaphy. The fistula was approached through the vulva. A circumferential strip of scar tissue was removed from around the fistula and the vulval lips. Horizontal dissection between the ventral wall of the rectum and dorsal wall of the vaginal was carried out carefully. The rectal defect was reconstructed polyglactin 9109 (Vicryl) No1 employing simple interrupted suture. The vaginal defect was reconstructed later in the same manner. Lacerations were sutured as per the defect. Post-operatively the animal was maintained with fluids and antibiotic for 7 days. The mare was administered 2 liters of liquid paraffin daily through nasogastric tubing and fed with 6 kg of bran in divided doses with hedge lucerne for 7 days. The animal had an uneventful recovery and discharged on the 10th day. The mare was re-examined after three months at the owner’s place and was found completely normal and ready for breeding. The method of repair for RVF depends upon the disposition of the mare, size and location of the defect in relation to the anal sphincter and the surgeon’s preference (Desjardins et al., 1993). Although some authors recommend immediate repair of RVF others claim that it is best to allow the wound healing by second intention for approximately four to six weeks before attempting surgical repair (Desjardins et al., loc. cit). The present case was operated at the end of the second week. Numerous techniques for the surgical management of RVF have been described in the literature (Schoenfelder and Sobiraj, 2004). It includes a horizontal perineal approach midway between the anus and vulva with dissection of the rectovaginal septum (horizontal perineal technique (HPT), the transvaginal closure of the rectal and vaginal defects, after excision of scar tissue around the fistula (transvaginal technique (TT), conversion of defect to a third degree perineal laceration (TDPL) followed by one or two stage closure, transrectal applications of staples, direct repair through the vestibule, direct repair through the anus and use of mucosal pedicle flap. The successful outcome of the present case of RVF included preoperative antibiotics, dietary management to reduce faecal output and maintain soft faeces to facilitate passage over the surgical repair, adequate dissection of the rectovaginal septum, avoidance of excess tension on the tissue over the edges apposed and closing with strong suture material.

References