DALE QUINN

Dale is a 3-year-old, male neutered, mixed breed dog. He was presented to Absecon Veterinary Hospital on November 7, 2020 for not acting quite himself for two days. On November 5, 2020, Dale ate normally but then vomited immediately after his meal. He vomited again that night and urinated in the house, which was abnormal for him.

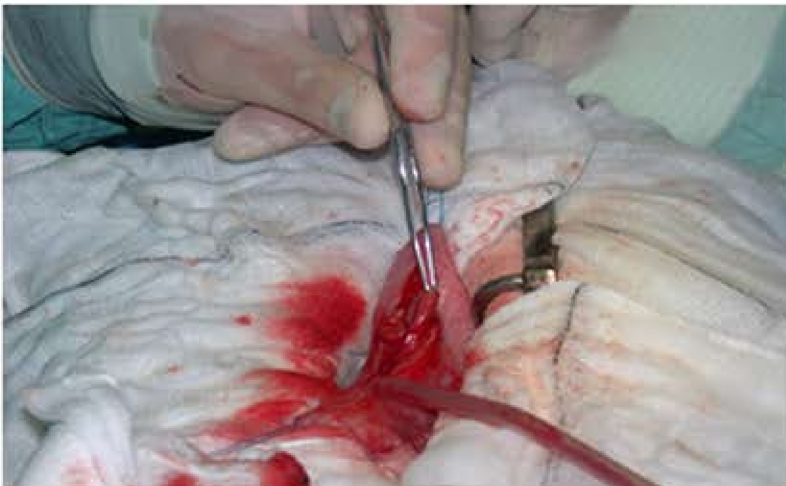
The next day, Dale became lethargic and would not eat for the owner. Every time he drank water, he would vomit. Dale has a history of
ingesting foreign objects and the owner had found a chewed piece of a baby gate.
Diagnostics were performed. Radiographs indicated a gastric, anchored, foreign body with a linear component and plication in the small
intestines. Blood work showed neutrophilia, hyponatremia and hypokalemia. The owner was then contacted to discuss surgery and hospitalization.

Dale was admitted to the hospital. Pre-operatively he received intravenous fluid resuscitation, pain management, gastrointestinal protectants and antibiotics. He was then prepared for and taken to surgery.

Abnormal material was found in the stomach and small intestines. Initially, a gastrotomy was performed.

The foreign material (plastic and string) was found to be anchored at the pylorus. An incision was made to release the anchor and the large portion of the foreign object was removed via the gastrotomy site.

Multiple enterotomy sites were made to remove the linear foreign material. Several segments of devitalized intestine were appreciated, and some areas appeared to be perforated.



Due to this finding, a resection and anastomosis was performed. Approximately 18 inches of small intestine was removed. The intestine was ran again from the stomach to the colon where suspect foreign material was found in the colon and able to be milked out caudally and removed from the colon.

An orogastric tube was passed to relieve gas and to empty gastric residuals. A nasogastric tube was placed prior to recovering patient from anesthesia.

Post-operatively, Dale recovered well from anesthesia. Supportive care was continued overnight with the addition of metoclopramide in IV fluids.

The following morning on physical exam, the patient was quiet and depressed. He was very tense and uncomfortable on abdominal palpation. Dale was continuously regurgitating. He was ambulatory on all four limbs and walked outside. He urinated and regurgitated more. A urine sample was acquired. The urine specific gravity was > 1.050. There was limb edema, a slight weight gain and bilateral nasal discharge (purulent from right nares) present. His mucous membranes were injected with mild hypersalivation. He had an increased respiratory effort; harsh lung sounds on auscultation (no crackles or wheezes at that time) and had developed a soft cough. Dale was tachycardic with hyperdynamic pulses. Pulse oximetry was 93% to 95% on room air, non-invasive blood pressure via Doppler was 200mmHg. The nasogastric tube was in place but not patent.
A second peripheral intravenous catheter was placed and blood samples were drawn and submitted in-house for packed cell volume, total solids, electrolytes and albumin. A 3mcg/kg bolus of fentanyl was administered and a constant rate infusion started at 3mcg/kg/hr.

There was mild peritoneal effusion on AFAST, concern for septic abdomen. A cytology of the fluid showed red blood cells and neutrophils. There were no bacteria seen. A 20mL/kg crystalloid bolus was started. A radiograph showed nasogastric tube was in the esophagus. The tube was advanced and a second radiograph was performed to confirm placement.

The tube was aspirated and 325mL of gastric residuals was removed. Blood work showed hypoalbuminemia, mild thrombocytopenia, slightly improved hyponatremia and resolved hyperkalemia. There was concern for aspiration pneumonia, ileus and esophagitis.

Dale continued to improve throughout that day, night and into the next day. He was eating well, no longer regurgitating and started to pass stool. His blood work results were improving, and he had minimal abdominal fluid on AFAST (routine finding post-operatively). We were able to transition him to oral medications, and he was discharged on the evening of November 10, 2020.