

Case Report

**DYSTOCIA DUE TO FETAL ASCITES IN A CROSS BRED HOLSTEIN
FRIESIEN COW: CASE REPORT**

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Abstract: This article puts on record successful management of dystocia due to foetal ascites in a cross bred Holstein Friesian cow. A 3.5 year old H.F. cow in her 1st parity was presented to outpatient department of Veterinary Teaching Hospital, College of Veterinary and Animal Sciences, G.B. Pant University of Agriculture and Technology, Pantnagar with a history of complete term. Waterbag came normally but parturition did not progress. Per vaginal examination revealed a fetus with distended abdomen, and the case was diagnosed as dystocia due to foetal ascites. Following epidural anaesthesia, abdominal wall of fetus was punctured with an embryotomy knife and about 6-7 litres of clear straw coloured ascitic fluid was evacuated. After complete removal of ascitic fluid, fetus was removed by gentle traction.

Keywords: Dystocia, Foetal ascites, Holstein Friesian, cow.

Introduction

Foetal ascites is seen as an occasional cause of dystocia in many species but occurs most often in the cow (Roberts, 1971). Fetal ascitis is seen as an occasional cause of dystocia in many species but occurs more frequently in the cow and is associated with a dropsical condition of the uterus, mesotheliomas of the fetal abdomen and brucellosis. Ascites may be caused either by the overproduction or insufficient drainage of peritoneal fluid. Ascitic foetus in full term pregnancy may cause dystocia in cows (Arthur *et al.*, 1986).

Case history and observation

A 3.5 year old H.F. cow in her first parity was presented to outpatient department of Veterinary Teaching Hospital, College of Veterinary and Animal Sciences, G.B. Pant University of Agriculture and Technology, Pantnagar with a history of full term pregnancy and straining since last 6 hours after rupture of allanto-chorion without further progress in parturition. Feed and water intake was normal. The rectal temperature was 101.5°F; heart rate

was 68 per minute. Detailed per vaginal examination revealed cervix to be completely dilated with fetus in anterior longitudinal presentation, dorso sacral position with both fore limbs and head extended in birth canal. Traction in both fore limbs did not help to deliver the foetus. Detailed examination of the foetus revealed that fetal abdomen was markedly distended with fluid. Hence it diagnosed as a case of fetal ascites.



Fig. 1 Foetus with Ascites

Treatment and discussion

Epidural anaesthesia was administered using two percent lignocaine hydrochloride and guarded embryotomy knife was taken inside the uterus and foetal abdomen was incised at the flank region. About 6-7 litres straw coloured fluid escaped from fetal abdomen. As soon as fluid escaped from the abdomen, dead male calf was delivered applying gentle traction on both fore limbs.

The post-operative treatment included Inj. Intamox 4.5gm i/m for 5 days, Inj. Melonex 10 ml i/m for 5 days, Inj. Intavita 10 ml i/m for 3 days and Inj. Belamyl 10 ml i/m for 3 days on alternate days.

Ascites of fetus may be caused by the overproduction or the inefficient removal of the peritoneal fluid (Sloss and Dufty, 1980). The ascitis may be due to an anomaly in development leading to obstruction of the lymphatics and impaired disposal of peritoneal fluid. This may be linked to the diminished urinary excretion of water (Jubb and Kennedy, 1970). Since the abdomen of the fetus remains distended with fluid, it becomes nearly impossible to deliver the fetus to deliver the fetus without puncturing the abdomen.

References

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