Volume 14 | Issue 1 Article 8

1952

A Case of Extreme Parasitism

J. R. Terry
Iowa State College

CLINICAL MEDICINE

Index

1 **A Case of Extreme Parasitism.** On April 3, 1951, a bay mare was presented at the Stange Memorial Clinic for treatment of severe diarrhea. The patient was extremely emaciated and dehydrated; the anal sphincter apparently had little or no tonus. A fecal examination showed the presence of numerous Strongylidae ova. A blood analysis showed 61.5 percent hemoglobin and as the extreme dehydration had caused a hemoconcentration the anemia was actually worse than this would indicate.

It was realized that the horse was severely ill, and recovery doubtful, but because of sentimental reasons the owner requested that everything possible be done for this case. The treatment used might be called experimental as this case was extreme and required drastic action.

The patient was in no condition for antiparasitic treatment. Phenothiazine is toxic to the liver and red blood cells. As the hemoglobin and red cells were low in quantity, and a severe watery diarrhea is often an indication of liver damage it was decided to attempt to control the diarrhea and increase the red cells and hemoglobin as near to normal as possible before initiating treatment for the strongyles.

Over a two week period the patient was given 500 cc. of citrated whole blood per day as a hematopoietic stimulant. One and one-half lbs. of bismuth subnitrate were given the first day, 240 grs. of Tannalbin given daily for the first 10 days, one and one-half grs. of atropine sulphate daily for the last five days, vitamin B and calf scour compound and later in the course anti-histamine therapy was tried without results. Although the atropine sulphate appeared to halt the diarrhea for one day, it commenced again the next day.

The bismuth was given as a protective for the intestinal tract; the Tannalbin for its astringent action. Recent reports in the literature indicate that atropine sulphate is beneficial in stopping certain severe types of diarrhea.

Extreme thirst was noted throughout the course of the disease. The appetite fluctuated from fair to poor.

None of the above treatments seemed to materially affect the patient's continued diarrhea and progressive emaciation so on April 18 euthanasia was performed and the patient was presented for autopsy.

On opening the intestine the caeco-colic mucosa was found to be inflamed and edematous and contained actually millions

of strongyle larvae. The walls of the anterior mesenteric artery and its branches were one cm. thick and contained abscesses up to three mm. in diameter. Thrombi containing *Strongylus vulgaris* were persent. The small intestine contained about 100 ascarids, the stomach about 100 *Gasterophilus intestinalis* larvae and the same number of *G. nasalis* larvae were in the duodenum.

This was the worst invasion of the caeco-colic mucosa by larval strongyles ever seen on autopsy here at the clinic.

J. R. Terry '52

Bilateral Perineal Hernia

2 **Bilateral Perineal Hernia.** On March 30, 1951 an 8-year-old Boston Terrier male was admitted to Stange Memorial Clinic. The history was one of constant straining. Examination revealed a large swelling surounding the anus. A catheter was passed up the urethra and into the bladder without difficulty; hence it seemed doubtful if the bladder was contained in the hernial sac. A diagnosis of bilateral perineal hernia was made.

The patient was given 1¼ gr. of morphine sulphate and 1/40 gr. of atropine sulfate as preanesthetic medication. An enema was given. He was then placed on the table in sternal recumbency and the area surrounding the rectum was shaved, defatted with ether, and sprayed with 50 percent isopropyl alcohol. A purse string suture of catgut was placed in the anal mucosa closing the anus.

Ether was administered by inhalation to the stage of light surgical anesthesia. An incision was made on each side of the anus in the form of an arc. These incisions were approximately 2 in. from the anus and 3½ in. long.

The urinary bladder was found to comprise the contents of the hernial sac. The bladder could not be returned to the abdominal cavity due to its distension with urine. A hypodermic needle was inserted into the bladder and urine drained off and away from the area by means of a piece of rubber tubing coupled to the needle. The empty bladder was readily returned to the abdominal cavity.

By blunt dissection, the rectum was separated from the surrounding tissue except for the most dorsal aspect. Using No. 2 chromic catgut and a full curved needle, simple interrupted sutures were placed in the muscularis of the rectum, including as much of the perirectal tissue as possible. A small diverticulum of the rectum was tied off by inclusion in one of these sutures. The skin was closed with nylon suture material. The purse string suture was removed from the anus.

Since the prostrate gland was found to be enlarged, the surgeon considered it to be a contributing factor, if not the cause, of the straining which produced the hernia. A classical castration was performed in an attempt to secure reduction in the size of the prostrate gland.

The patient made an uneventful recovery except for a large perirectal blood clot. Two sutures of the right incision were removed and the clot grasped with blunt forceps. The following severe arterial hemorrhage was stopped by forcing a large sterile pack into the cavity and suturing the skin. This gauze pack was removed two days later. The patient was discharged from the clinic on April 25, 1951.

Kenneth J. Wales '52