Urinary Calculi in a Boston Terrier

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An Esophageal Foreign Body in a Cat. On the evening of January 9, 1962, a young domestic feline was admitted to the Stange Memorial Clinic. The history offered was that the patient had been very irritable and had convulsed the previous evening. Prior to the sudden onset of symptoms the animal was apparently normal.

The following day a rather firm, well defined swelling was evident on the left side of the neck and mandible. Pressure on this area was evidently very uncomfortable to the patient and would invoke a coughing spasm. Food was refused but some water was taken. Cardiac and respiratory rates were greatly increased. The pulse was estimated to be 240 and the temperature registered 104.8° F. A diagnosis of a abscess was made at this time. Pen-Strep medication, I. M. twice daily, was ordered with an initial dose of 1 cc.

By the second day of hospitalization the swelling had decreased along the mandible and was more localized in the area of the pharynx. The patient's temperature was 102.6° F. and its appetite was near normal. The patient had reportedly coughed many times during the night.

On the third day post-admission, the swelling on the neck broke open and a creamy exudate drained from it. Upon palpation an inch long sewing needle with thread attached was located and removed. The patient's temperature was 102.4° F., so antibiotic medication was continued. The abscess continued to drain for two days. During this time the patient was handled carefully to prevent any further trauma to the area and reduce the possibilities of a fistulous tract developing from the esophagus.

Urinary Calculi in a Boston Terrier. The most common locations of urinary calculi in the dog are the renal pelvis, the urinary bladder and the male urethra. Most of these calculi are formed in the bladder. The chemical composition of cystic calculi is predominantly triple phosphates. Alterations in the pH together with the presence of bacteria, casts, epithelial cells and foreign material acting as a nucleus, predispose to calculus formation.

A four-month-old female Boston Terrier was admitted to the Stange Memorial Clinic on November 11, 1961. The history presented was that two months previously the owner had noticed blood-tinged urine being passed by the dog. He also noted that the urine would clear up for a day and then reappear blood-tinged. At times there would be a urinary incontinence. Previous medication was not known. The dog’s diet consisted of hamburger, steak and milk.

When the dog was examined in the clinic, the bladder was expressed with some difficulty. A short, quick flow of
urine was dark colored and contained blood clots. A urinalysis gave the following clinical picture: specific gravity, 1.048; reaction (pH), 7.5; sediment — triple phosphate, red blood cells, white blood cells, bacteria, and swollen epithelial casts. A radiograph was taken and showed the presence of concretions in the bladder. The patient was treated with a urinary antiseptic and Jenotone (Jen Sal) for two days before the surgery was performed.

The patient was given morphine at 10:50 A.M. on the day of surgery. At 11:10 A.M. she was anesthetized with pentobarbital sodium injected intravenously. The abdomen was prepared for aseptic surgery. A two and one-half inch midline incision was made three inches posterior to the umbilicus. The bladder was exposed and wrapped in a towel soaked with warm, sterile saline. A three-fourths inch incision was made in the apex of the bladder and cystic calculi were removed. The bladder and urethra were flushed with sterile saline. The bladder was sutured with #00 catgut using two layers of infolding sutures. The peritoneum and rectus sheath were sutured with interrupted #00 catgut sutures. The skin was sutured with Vetafil using interrupted sutures.

The patient was given one-half cc. of penicillin-streptomycin combination and placed in a recovery cage. She made an uneventful recovery from the anesthetic. The next day, the patient was very active and feeling good, but was continued on penicillin-streptomycin therapy for a few days following surgery. She was able to urinate although not in normal amounts. The pH of the urine was about 6.5. It was recommended that the dog be given a multiple vitamin preparation containing vitamin A.

This case is a good example of a diagnosis and successful treatment of urinary calculi in a dog. The age of the patient is noteworthy.

James F. Lucas '63

A peculiar lipoma of the dog. On October 18, a seven year old female cocker spaniel was presented to the small animal clinic with a large swelling on the medial and caudal side of the right hind leg and right inguinal area. The dog had a history of being hit by an automobile approximately six months previously, but the owner did not observe any after effects following the accident. About two months ago the animal was being clipped and the swelling was noted on the caudal and medial side of the leg. No history was obtained as to whether the swelling had increased over the two month period before it was brought to the clinic.

Upon examination and palpation the swelling was noted to be fairly soft and without a great deal of fluctuation. The swelling extended from the right inguinal area to the medial and caudal side of the right leg. Conditions considered were: a femoral hernia, an inguinal hernia, or a neoplasm of some type. The external inguinal ring could not be palpated, and it could not be determined if there was any abdominal viscera in the enlargement. The swelling did not seem to be firm enough to be a tumor unless it was a lipoma.

From external examination alone the cause of the enlargement could not be diagnosed.

The dog was prepared for surgery. The area was clipped, shaved and painted with pheno-mercuric nitrate. The patient was anesthetized with two ml. of pentobarbital sodium using one-half grain of morphine as a preanesthetic. The dog was rather old and somewhat overweight so caution was used in administration of the anesthetic.

A four inch, slightly oblique, longitudinal skin incision was made in the right inguinal area. The mass, which was covered by a muscle sheath, was observed and palpated again. The muscle sheath was then incised, and a large lipoma was revealed. The lipoma was bluntly dissected out. It was encapsulated by the thin muscle sheath capsule and was easily removed. The size of the lipoma was approximately six inches by four inches by two inches. (Fig. 1) The mass was nearly avascular so there was only a limited amount of hemorrhage which was quickly controlled with a sterile gauze pack. The muscle sheath was sutured with interrupted sutures using #0 gut. A continuous subcuticular suture of #00 gut was placed