

DYSTOCIA IN A CAMEL AND ITS CORRECTION WITH FOETOTOMY - A CASE REPORT

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The incidence of dystocia is low in the camels (Arthur and Al-Rahim, 1982; Tibary and Anouassi, 1997). However, because of the exceptionally long neck and extremities when it occurs, it is difficult to manage (Purohit, 2012). It is estimated that approximately 5% of all camelid births will require some assistance and 2% will require advanced obstetrical expertise (Tibary *et al*, 2008). Foetal dystocia predominate in camels and flexion of the limbs and or neck deviations are the common causes (Van Straten, 2000; Purohit *et al*, 2011). The correction of a limb flexion / neck deviation is possible in camels by manual extension and adjustment of extremities when camels are presented to clinicians within 12 h of second stage of labor (Purohit, 2012), although correction of more cranially deviated neck is not possible. Partial foetotomy of head and limbs is possible in camels using a cattle thygesons foetotome (Purohit *et al*, 2011; Purohit, 2012). When camels are presented beyond 48 h of second stage of labor, foetotomies are considered less rewarding (Purohit *et al*, 2011). Partial subcutaneous fetotomy of one limb followed by manual correction of the lateral head deviation is mentioned in this case report.

Case history

A 10 year old female camel in its third parity was presented to the Teaching veterinary clinical complex with a history of dystocia since last 16 hours. Both the water bags had ruptured and one foetal leg was protruding through the vulva. The animal was alert and active. The rectal temperature of the animal was 98° F and the respiration rate was 12 per min.

Handling of dystocia

The animal was restrained in a sitting position and 120 mg xylazine (Indian Immunological Ltd.) was administered IV for sedation. On clinical examination, it was found that the foetus was dead. It was in anterior presentation with dorso sacral position. One

fore limb of the foetus was protruding through the vagina and there was deviation of neck and flexion of one fore limb at the shoulder joint. Subcutaneous foetotomy of the extended fore limb was done (Fig 1) to create space in the birth canal for manipulation. A long obstetrical hook was inserted in the birth canal and placed at the eye ball socket of the foetus. The deviation of the neck was corrected by applying traction on the obstetric hook. Another forelimb was first flexed at elbow and then extended in normal position. After sufficient lubrication with liquid paraffin, traction was applied at the neck and one fore limb (Fig 2) and the foetus was delivered (Fig 3).

After care of the animal included IV infusion of fluids (2 litres Ringer lactate, 2 litres 5% dextrose, 450 ml calcium borogluconate), imidazole derivatives (Tinidazole 2 litres IV) and administration of antibiotics, anti-inflammatory and antihistaminic drugs. Antibiotics were also administered intrauterine. There was an uneventful recovery.

Discussion

Foetotomy appears to be difficult in camels (Purohit, 2012). More cranially placed lateral head and neck deviations may be at times beyond the reach of the clinician hand and thus difficult to correct manually. In the present case the lateral deviation of neck was not severe and the neck could be brought in the birth canal using a long obstetric hook which was placed in the foetal eye socket of the dead foetus before traction. The space in the birth canal was very narrow because of presentation of the animal to the referral centre after 16 h of dystocia onset. Space could be easily created in the birth canal for manipulation of the neck deviation by partial subcutaneous foetotomy of one of the limbs. It has been mentioned that foetotomies should be carefully performed in camels (Tibary *et al*, 2008; Purohit *et al*, 2011) as it can lead to laceration in the birth canal with

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Fig 1. Partial subcutaneous foetotomy of one fore limb performed using a foetotomy knife in a camel.



Fig 2. Application of traction on neck and one fore limb after postural correction in a camel.

resultant fatal haemorrhages. If the laterally deviated head and neck were placed more cranially it would have been difficult to correct the head deviation. Thus it was concluded that subcutaneous foetotomy can be performed in camels with dead foetus to create space for correction of the lateral head deviation however, if the head and neck are beyond the reach of the clinician in a sitting camel, caesarean section should be performed immediately.



Fig 3. Dead foetus of camel delivered after applying traction.

It was concluded that in the presence of proper dilation of birth canal the approachable deviation of the head and limbs can be corrected with manual manipulation and/or partial foetotomy.

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