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DISCHARGE INSTRUCTIONS

Client: Judy Challenger

Patient: Twister

Date: 10-8-13

Diagnosis: 340 degree circumferential left tarsal laceration, distal medial tibial cortical bone damage, partial to complete gastrocnemius tendon rupture, partial superficial digital flexor tendon rupture, partial extensor tendon rupture

History: Caught up in a hot wire fence the morning of October 1st, severe laceration to left tarsus; treated by Dr. Kristen Brown with 2g bute iv, 33ml gentocin iv, 37ml PPG im; the wound was cleaned, medial tarsal artery ligated, and the limb bandaged.

Examination: Pulse 60 beats/min, respiration 20 breaths/min, mucous membranes pale pink, CRT 2 seconds. Toe-touching lame in the left hind (LH) but able to bear some weight. 340 degree laceration around the left tarsus - plantar portion of laceration ~10cm proximal to point of hock, cut through the superficial digital flexor tendon (SDFT) and gastrocnemius tendon, small portion of the SDFT intact (~25%). Tarsal flexion without stifle flexion (indicative of gastrocnemius rupture). Unable to manually extend foot/fetlock with tarsus flexed (indicating intact SDFT/DDFT – deep digital flexor tendon). Medial portion of laceration through soft tissue of the distal tibia down to bone with a hemi-circular groove visible and palpable in the bone. Radiographically appears to be nearly through the cortex on the medial and dorsomedial surface. Dorsal portion of wound at level of distal TC/DIT/TMT joints, through soft tissue but not directly into the joint/joints; however, difficult to determine whether there was joint compromise and contamination. A portion of the extensor tendons were intact. There was minimal contamination in the wound.

Bloodwork: CBC, chemistry – no significant abnormalities; PCV dropped to 20 two days after the injury.

Treatment:

Initial treatment: Debride and lavage wound with Pulsevac, small artery ligation, wet to dry topical bandage, Robert-Jones bandage; intravenous antibiotics (ampicillin, gentocin), anti-inflammatory (phenylbutazone), anti-ulcer medication (Ulcergard), intravenous fluid therapy. Due to the severity of pain and anxiety the first 48 hours, he was treated with multiple doses of butorphanol and a lidocaine CRI.

Ongoing treatment: Intravenous antibiotics were given for 6 days, then switched to oral antibiotics (SMZ). Lidocaine CRI was discontinued after 48 hours as he became more comfortable. The bandage

was changed daily, the wound flushed with saline, and gentle wet gauze debridement performed before re-bandaging.

Case Progression/Assessment: Due to partial rupture of the caudal components of the reciprocal apparatus (gastrocnemius, SDFT), he was unable to fully weight bear on the left hind limb. A Kimsey splint was placed the first night to try to decrease anxiety from the inability to bear weight and subsequent knuckling of the fetlock joint. After he became less painful and anxious, the splint was removed due to the risk of rupturing the remaining tendons (from having the fetlock fixed in partial extension and the hock flexing as he bears weight) and having complete collapse of the limb. For the first 4 days, he lay down the majority of the time and was able to support his weight on the right hind (good limb) when standing. A toe-extension slip-on shoe was placed on the left hind foot to help prevent the knuckling of the fetlock joint when standing. Although there was a risk of fracturing the distal tibia each time he stood up, it was not practical to prevent laying down as this would place too much strain on the good limb and increase the risk of laminitis or breakdown. Using a full limb cast/bandage cast or Tomas-Schroeder splint on the injured limb was discussed; however, stabilizing the limb in this manner was not practical due to the severity and management of the laceration.

Beginning a few days ago, he began standing for long periods of time and attempting to bear weight on the injured limb to rest the good limb. Acepromazine was given multiple times with limited success to encourage laying down. He has progressively hyperflexed the fetlock joint to the point where he is now standing on the fetlock joint when attempting to walk. Digital pulses are increasing in the good limb and it is also starting to collapse more when he is standing. Due to the severity of the injuries, the reluctance to lay down, and the inability to stabilize the limb to allow healing of the tendons, his prognosis is grave.

Instructions

Medications:

- SMZ: Give 13 tabs orally twice a day. The pills can be dissolved in water in a syringe and should ideally be given 30 minutes before feeding. Stop giving the medication if he develops loose feces or diarrhea.
- Phenylbutazone (Bute): Give 1g twice a day.

Bandage:

- The bandage should be changed daily. Remove the bandage, gently lavage the wound with saline using a syringe, gently clean the wound with wet gauze, place damp gauze squares over the exposed tissue and bone, secure the gauze by wrapping cast padding in a figure 8 around the wound, and apply the outer bandage as follows - 2 rolls sheet cotton or 1 combine roll around distal limb (below the hock down to the foot), brown gauze tightly wrapped over the cotton, vetwrap over the brown gauze; the same materials as above over the hock (mid-tibia down to the proximal cannon), there will be overlap of the bottom of this bandage with the top of the distal limb bandage; repeat the same process (distal limb bandage then hock bandage) using 1 roll of sheet cotton or combine, brown gauze, vetwrap; apply Elastikon around the top of the bandage (not tightly), and around the fetlock foot.
- Antibiotic ointment or SSD (silver sulfadiazine) cream should be applied to superficial wounds over the right hock and any bed sores that develop. Place standing wraps on the other 3 limbs if possible.

Monitor:

- Inability to stand or right hind limb collapse when standing
- Infection of the wound or joint
- Development of bed sores on the other limbs
- Decreased appetite or fecal production

Housing/Exercise:

- Stall with deep bedding

Feeding:

- Grass hay

Recheck: Please have Dr. Alves assist with the bandage change tomorrow.

Thank you for bringing Twister to Crossroads Veterinary Clinic, we're very sorry his wound was so severe and that we couldn't do more to help him. Please don't hesitate to contact us if you have any questions or concerns.

Sincerely,

Mary Boyce, DVM, PhD, DACVS