Dystocia in animals pdf

We were all there, 2am calving with a stubborn leg back or presented with one front leg and nose. Calving problems, also known as dystocia, seem to come as an integral part of supporting cattle, but the lasting effect that this initial experience can put on the calf's health and on its future can be dramatic. Studies show that animals that need help during the calving process are more likely to have respiratory or digestive problems later in life. Distocia comes in three forms: the mismatch between the size of the mother and the calf; abnormal performance in the birth canal; and maternal factors such as hypocalcemia. Of the three, the first and last is the most easily prevented, by using the appropriate bulls in the heifers, pelvic measurements and ensuring the good state of the body on the bulling and calving. During dystocia, or poor calving, the calf can starve oxygen, leading to blood becoming more acidic. This, in turn, can lead to depression in the central nervous system, which usually stimulates the rhythm of breathing. Sometimes, in cases where we believe there has been a long period of oxygen reduction, we can administer bicarbonate directly into the vein of the calf to try to balance the blood. Other ways in which you can reduce the risk after dystocia include stimulating normal breathing rhythm and clearing the airways fluid by stimulating the nostrils with clean straw or bedding and sitting the calf on the chest. It is also important to ensure that any calf, not just those born weak and in need of help, warm up in the immediate aftermath of birth. We always emphasize the importance of coloss whether, and these cases are no exception. These animals should receive 50 ml/kg, ideally within two hours of the birth of a good quality colosseme. This will provide the necessary nutrients and antibodies to the calf. There are several ways to reduce the risk of problems after poor calving, and we should strive to give these animals a little more attention and not forget about them once they hit the ground. This article was taken from our September Farm newsletter. Download the full newsletter to read about the bank's incredible August holiday weekend and information on improving weaning interest. From WikiVet English Introduction Dystocia refers to abnormal or difficult birth. This is expected to occur in about 10-15% of the heifers of the first calf and in 3-5% of mature cattle. In cattle, the most common cause is the disproportionateness of the mother's fetus, but the faulty temper is also often to blame. Early intervention minimizes the effects of dystocia on calves. Cows, and especially heifers, should be monitored regularly and assisted promptly if the second stage extended, that is, by more than an hour. Clinical approach Careful history should establish the duration of pregnancy, parity and problems seen during pregnancy. Also find out when the animal has started to strain and if there is water water liquid bags appeared. It is also important to establish what has been done so far by the farmer, including any drugs administered. Physical examination of dams that may have systemic diseases such as breast fever. Appropriate restraint and assistance should be sought, and initial treatment may include fluid therapy, pain relief and calcium. The position of the dam: cows must stand. Vaginal examination: The vulva, vagina and cervix should be evaluated for enlargement, xerion or injury. It should be used at all stages of the survey. The assessment of the fetus should establish its representation, posture and position and determine any tangible structures. The vitality of the fetus can be assessed by feeling impulses on the limbs or tongue. Anesthesia is not essential, but an epidural can be administered to help reduce stress. Manual correction of dystocia: relies on cravings to facilitate expulsion, pushing the fetus back into fallopian lumens to allow further manipulation, and expanding the limbs of the fetus. The ropes can be applied to both legs and head and the thrust is applied while manually extending the vagina and vulva. If the fetus is too large to be delivered vaginally, a C-section or fertility must be performed. Possible dam treatments include: pain and anti-inflammatory drugs: NSAIDs can be given at the beginning, short-acting steroids can help reduce swelling and swelling of antibiotics: given within days of calving due to a greater likelihood of complications such as preserved fetal membranes and metritus Prevention foetomaternal disportproion is a major factor in the dysporization of the chick-fit developmental development of the calf to a modest rate of growth during the pregnancy period. Restriction of nutrition in the later stages of pregnancy does not prevent a large calf and leads to poor birth and increased rates of dystocia. The pelvic heifer can be evaluated to select a replacement for the herd. Those chicks with a small pelvic area before the breeding season can then be culled or selectively with mating to light swelling of bulls, and those with a small pelvic area during pregnancy examination can be interrupted, culled, or identified for careful observation on calving. Some evidence suggests that culling heifers with the narrowest pelvic width may be more effective than culling based on the pelvic area. It is important that the chicks grow well and calves are down in 2 years soon. Sire Selection Sires can be chosen for the convenience of calving and calculated weights at birth. Many non-genetic factors affect birth weight, such as the age of the dam and the environment, and therefore genetic selection is not a reliable method of preventing dystocia. Early Intervention Not All Dystocia such as vices, and early intervention is paramount in ensuring a live birth. Farm workers should be trained to deal with the dystocia and recognize when further assistance is needed. Delay in providing assistance can mean the loss of a calf or injury and even the death of a cow. However, it is important to give the dam enough time to expand before applying the traction. Aftertaste dystocia complications lead to an increased risk of aftertaste complications in cattle, such as: Preserved placenta: usually treated with manual removal or oxytocin. Metrit: which can lead to toxemia and laminitis and should be treated aggressively. Cervical uterine uterine lapse tears rupture of the uterus hemorrhage in the perineum dystocia - Cattle Training Resources Flashcards Test their knowledge using flash card-type issues of pastoral medicine FOR 10 Links Kahn, C. (2005) Merck Veterinary Guide 9th Edition merck and Co Frame, N. (2006) Cattle Dystocia Management In Practice 28:470-476 Tweet WikiVet® Introduction - Help WikiVet - Report the problem of Chapter 42 Parturia and Distocia (difficult births) occurs when the first or second stage of childbirth is delayed and help is required for delivery. There are no clear boundaries between dystocia and euthanasia (normal birth), but guidelines based on the progress and duration of childbirth can assist the veterinarian and the manufacturer in deciding when to intervene in the birth process. In the last century there has been a significant improvement in the methods of delivery and resuscitation of calves. Only in the last three decades, however, has research been effectively focused on the causes and management of dystocia. This may be due to the wider implementation of herd health programs and the use of computers to facilitate data management. Incidence of dystocia varies, but is generally more common among first calf heifers because they have not yet reached their mature size and then decreases with age.1 Death due to dystocia or as a result of injuries sustained during childbirth is the most common cause of calf loss within the first 96 hours after delivery, with most losses occurring within the first 24 hours after delivery.2 ,3 Subsequent pregnancy rates among dams that suffer from dystocia are also reduced.4-6 Although it is not possible to eliminate dystocia, improvements in the management of heifers during their development and the observation of cows and heifers during calving season are crucial to reducing calf loss. This chapter begins with a description of the normal parturition process. Diagnosis and treatment of dystocia are described further. Finally, the importance of disease control and prevention is in the area of management used to reduce the incidence of dystocia, with a focus on specific control measures. Over the course of the weeks of weeks the dam is preparing for the birth of the fetus and the onset of lactation. The increase in queering may begin in heifers in 5 to 6 months of pregnancy, but may not be obvious in pluripara cows until the last weeks of pregnancy. In dairy cows, iron can swell, and in severe cases swelling can be so extensive that it requires part induction or the beginning of milking a few days before calving. Initial secretions that can be expressed from breast viscid and pale yellow to amber in color. As you approach the part, the colossum is released from white to yellow, muddy and opaque. Pelvic ligaments relax under the influence of estrogen, relaxin and the general hormonal environment that initiates parturia; the gluteal muscles are sinking, the tail is becoming more visible, and the cranial boundary of the cruciate ligament becomes less tense. A few hours before the calving, the vulva becomes edematouse, and the cleft lengthens. Unfortunately, none of the signs of approaching the part is specific enough to give an accurate prediction of the exact calving time; thus, veterinarians were ordered to refrain from making too positive or definite statements about the exact timing of the spread, as subsequent events would often fail to prove him wrong. 7 Once started, calf delivery is an ongoing process, but for the convenience of discussion, most authors divide the work into three stages or stages. The first stage of childbirth signals the er beginning of childbirth and is characterized by progressive relaxation and enlargement of the cervix.8.9 Increased release of the adrenocorticotropic hormone (ACTG) and associated cortisol from the adrenal glands of the fetus leads to an increase in the enzyme level of 17 -hydroxylase in the placenta of the fetus.10 This, In turn, reduces the production of placental progesterone, allowing pregnenolone to be metabolized to dehydroepiandrosterone. The maternal plasma of progesterone concentrations is then reduced because pregnenolone is diverted to estrogen production, and the maternal plasma estrogen concentrations subsequently increase. In addition to converting progesterone into estradiol, fetal corticoids also cause the placenta to synthesize prostaglandin F2 (PGF2). PGF2 synthesis helps to undo the progesterone block to myometric contraction. As both estradiol and prostaglandin become elevated, myometrium becomes more mottled and begins to show noticeable contractions. In addition, PGF2 causes lutein of the pregnancy body to regress, contributing to the reduction of progesterone. As the pressure inside the uterus continues to increase, the fetus turns so that its performance with front legs and head pointing to the caudal aspect of the dam. This rotation is important to ensure smooth delivery. If the fetus does not reach the right position, or posture, due to illness or lack of space, dystocia can occur. The outer cervical wasps of cows can be relaxed enough to recognize two to four fingers as much as a week before calving, but the cervix of the calf usually stays tightly closed until the day before calving when it begins to relax. The extension of the cervix takes place in two stages. At the preliminary stage, the cervix is passively enlarged by reducing the tone of the cervix. Expansion of the inner cervix begins 2-4 hours after the outer wasp reaches a diameter of 6 to 12 cm. The active phase of cervical dilation begins approximately when the outer OS is sufficiently enlarged to allow the introduction of the hand and is initiated by increased concentrations of estradiol, combined with an increase in PGF2 levels. These hormones cause severe contractions of myometrium that pull the cervix open and force the fetus and its membrane into a partially enlarged cervical canal. Complete erasure of the cervix occurs when part of the fetus enters the cervix and applies mechanical pressure inside the canal. Pressure on the cervix is caused by increased myometric contractions and the presence of the fetus activates pressure-sensitive neurons located in the cervix that synapses in the spinal cord and eventually synapses with oxytocin produced by neurons in the hypothalamus. Oxytocin, released into system circulation, acts to facilitate myometric contraction initiated by estradiol and PGF2. As the pressure against the cervix continues to increase, so makes the secretion of oxytocin, and the power of the myometric even muscle contraction begins to peak. When applying this maximum force, the head of the fetus and the redistribution completely fall into the cervical canal, the hoorioallantua is usually torn, and the first stage of the parturation is completed. At the end of the first stage of childbirth, the cervix and vagina are a continuous channel. Sometimes it may be necessary to distinguish between dystocia caused by incomplete cervical dilation and long-term first stage of childbirth. The differential feature of the conditions is that the progressive expansion of the cervical canal can be distinguished between two consecutive examinations in cases of long-term birth of the first stage, while the condition of the cervix remains unchanged in cases of incomplete dilation. Clinical signs associated with the first stage of childbirth are most common in primitive animals; Signs can be minimal or pass unnoticed in old dams. Signs of the first stage of childbirth are usually those that are associated with abdominal discomfort and include a variable degree of anorexia, anxiety, weight shifts from one leg to the other, and the presence of an arched back with an elevated tail. If given the opportunity, most dams will seek privacy away from the rest of the herd. Some dams may soft and intermittent deformation of the abdominal cavity during the late parts of the first stage; thus, the demarcation between the first and second stages is not as clear in cows as in mares. The rupture of the hoorioallantua and the release of the allanote fluid (water disturbance) may be a more accurate attribute by which the end of the first stage of labour can be noted. The average duration of the first stage of childbirth is about 6 hours, but there are significant differences among animals, and the stage can last up to 24 hours in heifers.11 The fruit is delivered during the second stage of childbirth, which is characterized by the use of strong abdominal pressure by the dam. Myometric contractions, stimulated by oxytocin, cause the fetus to retract and stretch the cervical canal. In particular, the conical shape of the head as the nose enters the cervical canal is important because it gradually expands the cervix with mechanical pressure. Stretching stimulates the release of more oxytocin from the maternal pituitary gland, which causes further contractions of the uterus. Oxytocin is also thought to stimulate the release of prostaglandins from the endometrium, which further stimulates myometric contractions.12 This positive forward-feeding system makes it difficult to stop childbirth after it starts. Forms of dystocia, which delay or prevent the penetration of the head or limbs of the fetus into the cervix to stimulate pressure receptors, result in little if any abdominal straining by the cow. A typical example is a cranial view with a full flexion of the hips (a true presentation of the shutter). An undamaged amnion should appear in the vulva in the form of a liquid-filled bag shortly after the rupturain of the hokialantua. After the amnion appears, the dam often alternates between standing and reclining. Amnion is usually torn while the dam is lying down, and the rupture is accompanied by regular bouts of abdominal strain. At the beginning of the second stage of childbirth, each bout of abdominal tension consists of 5 to 7 abdominal contractions, which increases to 8 to 10 contractions as the process progresses. The cow usually lies in the stern recumbent and can eat between bouts of abdominal tension. As the supply continues, the length of the rest periods decreases and the strength of the abdominal cuts increases. As the cramps become more forceful, the dam rolls to the lateral recumbency and lifts the head, backs, and upper limbs and can vocalize with each force. Maximum strength is needed to deliver the head of the fetus through the vulva, and in most cases the rest of the fetal body is followed with little or no effort. In the case of large calves, additional abdominal pressure may be required to deliver the fetus to the shoulders or hind parts. Most cows deliver their calves while in lateral recumbency, but some can complete the delivery, Delivery while is more common in pluripara dams than in heifers and may be the result of unintentional cow disturbance caused by handlers. The average duration of the second stage of labour in pluriparal cows is 2 to 4 hours, but this stage is more in the heifers because more effort is required to expand the tissues of the ancestral canal. A healthy erous fetus can survive for 8 hours after the start of the second stage of labour, provided that the umbilicus remains intact; survival longer when uterine contractions are weak or rare. Exhaustion and secondary inertia of the uterus lead to the termination of the contraction of the uterus and abdominal cavity after 8-12 hours of delivery. The third stage of childbirth is characterized by detachment and expulsion of the cotylandendon placenta. The expulsion of fetal membranes requires that the chorionic willies be dislodged from the crypts of the mother side of the placenta. This release of chorionic wheelies is thought to be caused by the powerful vascularization of the arteries in the wheely-related continuation of myometrious contractions. The contractions of the uterus continue after the birth of the fetus and are sometimes strengthened by occasional bouts of abdominal tension. Myometric contractions gradually subside in frequency and amplitude and are not detected 2-4 days after calving. The time it takes to expel the placenta is an average of 8 hours, but can range from a few minutes to 12 hours, not considered abnormal. Most of the dams rise in the third stage of childbirth and begin to care for their cub, licking first its back, and then the head and neck. Dams usually continue to collide and lick their calves after they stand, but soon allow the calf to move nearby, look for a ism, and nurse. The reasons for the dystocia related to management practice are discussed later in the chapter. From a clinical point of view, the etymology of dystocia is multifaceted and includes defects in the dam or fetal and management factors, or combination.13 For the purpose of developing a clinical management plan for an individual animal, it is convenient to divide the causes of dystocia into the causes of maternal origin and the cause of fetal origin. It is important to remember, however, that clinical cases may result from several underlying disorders, and may also require treatment to address related problems, in addition to more traditional mechanical or surgical treatments. Problems with the dam that hinder or hinder delivery include the lack of force and anomalies of the birth canal. In general, the origin of the fetus dystocia in cattle can be divided into those caused by fetal abnormalities (defects in fetal disposition and various forms of development as a result of the development of the fruit monsters) and those caused by excessive foetal size in relation to the maternal pelvic pelvic (fetop pelvic imbalance). Spectrum clinical The veterinarians are huge. Diagnosis of dystocia is usually made by the owner or manager of the animal, who may decide to seek professional help at the beginning of childbirth or not, until the birth is too long. The first step in clinical evaluation of cattle dystocia is to get as much relevant history as possible. While the usefulness and accuracy of the story will vary with the diligence of the manager, the doctor should try to get at least a minimal amount of information before initiating the examination. It is important to know how long the animal has been in labor. Cows and chicks should have enough time to spontaneously deliver their calves. It is common for cows to voice during voltage at the beginning of the second stage parturition. This is due to the stretching of the soft tissues of the birth canal.14 Thus, although clinical judgment is necessary, the amount of vocalization during voltage can be used as a rough guide to the duration of the second stage if the story is unavailable. If sufficient time has been exceeded for the first or second stage of childbirth, the examination indicates. Calves should be allowed longer for spontaneous delivery than required in pluriparal cows. If the intervals between observations are excessive (more than 3 hours), the manager will not be able to accurately determine the time of the birth, and immediate intervention may be justified. Early obstetric care has been shown to improve the subsequent fertility of beef cows.15 The nature of expulsion efforts must be determined by whether they are weak and sporadic or substantial and frequent. In some individual animals, the second stage of labor can manifest itself as just a few weak attempts to deliver the fetus to the secondary inertia of the uterus supervenes. Vigorous and determined attempts must lead to steady progress; If they don't do it, the dam should be investigated. The doctor must determine if the fetal membrane is torn. The rupture of the orioallant membrane and the release of the leading allantic fluid are used to indicate the beginning of the second stage of labour. The rupture of the amnion is accompanied by the release of viscous amniotic fluid. The examination indicates if the delivery is not completed within 2 hours after the amnion appears outside the vulva. It is important to determine whether the patient has been examined or whether any attempts have been made to deliver the calf before the attendants have sought professional assistance. Managers' ability to determine the cause of dystocia varies, but the results of an experimental examination can be useful to the clinician. Information about futile attempts to deliver attendants can be difficult to obtain, but damage to the birth canal or fetus caused by good intentions, but inappropriate efforts must be detected before so that the veterinarian is not brought to justice. Available means and behavior of the patient often dictate the restraint used to examine and facilitate dystocia. Amenities and conditions are often less optimal. Ideally, however, the conclusion of the part-part dam should be in a dry, well-laid hull of generous size and with sufficient lighting. Complex vaginal delivery often helps if the dam can be placed in a side recumbent place; so it's a perfect place to cast and contain recumbent animals. Access to clean water is also desirable. Squeezing the gutter may be appropriate for the initial survey, but the propensity of most cows to become recumbent during cravings makes this choice undesirable in all but the simplest supplies. Although fetal extraction is better performed with a dam in the lateral recumbent, the initial examination is more readily performed with the animal standing because the pressure in the abdominal cavity is reduced in this posture. Thus, the patient is most conveniently restrained with the halter, but stanchion or head collateral can be used if caution is exercised to prevent suffocation or excessive pressure on the carotid arteries if the animal has become recumbent during the examination. During childbirth, enough space should be available behind the patient to allow the manipulation of the fetus extractor or fetata. The position of the side recumbent can be achieved with a combination of rope and sedation. Figure 42-2 shows ropes mounted on a heifer in preparation for casting in the side of the reclining after a diagnostic craving confirmed that vaginal delivery is possible. Administration of epidural anesthesia is usually not performed if vaginal delivery should be used, because in most cases the pushing forces of the dam are useful in assisting delivery. The desensitization of the birth canal and perineum is usually reserved for cases that require moderate to extensive fetal manipulation prior to extraction, fetotomy or surgical delivery. Vaginal examination in dystocia almost always implies manual entry into the birth canal. In rare cases, however, speculum expertise may be more appropriate than manual methods. Such cases include cases where the tension is minimal and the timing of conception is only approximate. The two main requirements for effective obstetric intervention with minimal postoperative complications are cleanliness and lubrication. Before invading the ancestral canal, vulva and promenade area and any protruding parts of the fetus are washed with surgical soap and water. The operator's hands and hands are also cleaned. Some doctors prefer to wear plastic shoulder length sleeves, while others believe that wearing these sleeves reduces sensitivity and interferes with thorough examination. should be familiar with zoonous diseases in the geographical area and take appropriate precautions. Hands and hands should be covered with a generous amount of untested obstetric lubricant before entering the vaginal canal. It is often useful to pump 3 to 5 liters of lubricant into the generic channel, in addition to applying lubricant to the hands of the operator. Note that despite the long-standing doctrine of using warm soap water during obstetric intervention, soap is not an ideal product for work. While they may provide some short-term lubricant, they quickly increase the friction they encounter due to their propensity to reduce fats and oils from contact surfaces. In long-term cases with autolytic changes in the fetus, some doctors choose to apply a generous amount of lanolin or barrier cream to the hands to reduce skin irritation and folliculitis, which can result from prolonged exposure to foul-smelling tissues and fluids. The birth canal and the fetus are first considered for lesions or hemorrhages that may have been caused by previous birth attempts, and the caretaker is informed of their presence. The operator then determines as accurately as possible the representation, position and posture of the fetus and the presence, if any, of congenital abnormalities. In some cases, it is difficult to determine whether the limbs or posteriities of the fetus are present in the birth canal; Fetal elbow and fetal hock can have similar characteristics on palpation that can confuse even an experienced operator. Limbs can be differentiated, ranging from hooves and counting joints from dystal to proximal to limb. Forelimb has a carpal joint between the fetlock joint and the elbow, while on the back, the hock joint is palpable immediately proximal to the fetal joint. Ears, eyes and jaws can be used to identify the head, while the presence of the tail indicates the tail of the presentation. If the fetus is in a dorsal position and the soles of the foetus' hooves are sent ventralized, the limbs represented by the birth canal are limbs, while if the soles are directed to the dorsal, the posteriments are represented first. The location of the fruit in cross presentations is sometimes difficult to establish and a thorough examination is required. Fortunately, cross-view is rare in cattle, which is commonly associated with fetal deformations or fetal monsters such as schistosomiasis reflex. Although cattle are generally considered single-paired, twins and large multiples are not uncommon; thus, it is necessary to determine the number of fruits and to determine their appendages. The location of the inner septum between the two uterine horns is identified so that it is not accidentally damaged by a wire saw if the fetotomy is chosen as a method by which dystocia can be alleviated. After the location of the fetus, the doctor must If it is alive or dead, before choosing the appropriate method to complete delivery.24 In cranial presentation, the intercythal claw reflex can be caused by pinching the tissue cobwebs between the claws. The energetic fetus reacts by removing the leg. A false result can occur if the operator is mistaken in the movement caused by the maternal abdominal press for the fetus. False negative results can occur in living calves if the head and limbs are wedged into the birth canal. The swallowing reflex is caused by applying pressure at the base of the tongue, to which the normal calf reacts by swallowing or sucking. Slow or exaggerated reactions may be associated with hypoxia or may be agonized. A little pressure on the eyeball causes the movement of the eyeball or eyelid. The eye reflex persists even in highly acidotic calves. Reflexes disappear in the peripheral to central progression as the fetal condition deteriorates. That is, the reflexes requiring the longest neural pathways disappear before those with shorter nerve pathways as acidosis increases. Thus, the interdegial claw reflex disappears in the first place, and the eye reflex persists the longest. This differential loss of peripheral compared to central reflexes can help assess the physiological condition of the calf. In the caudal presentation, the interdigenital reflex of the claws is similar to the reflex in the limbs; however, it becomes negative earlier during delivery than does the reflex in forelimbs. Thus, the intercythic claw reflex can be negative in a viable calf, and causing this reflex is a good prognostic sign. reflex is sometimes used to assess the condition of the fetus in the caudal presentation. This reflex is triggered by pressing the expert's finger against or in the anus. Evaluation of the reaction is subjective, however, and the reflex may be absent in a viable fetus. If the reflexes of the fetus are ambiguous or absent, the obstetrician should examine the fetal heartbeat or pulse of the umbilical cord. The heartbeat can be palpable by transferring the hand between the limbs of the fetus along the abdominal aspect of the neck to the sternum. The fetal heartbeat is then palpable with the expert's fingers placed on the left side of the fetus' chest. Palpation of the heartbeat in the fruit presented caudally difficult. The normal intrauterine rate of heart rate in calfs evades from 70 to 120 beats per minute increases to 90-120 beats per minute during childbirth. The heart rate can drop to 40 to 60 beats per minute during the contraction of the uterus. Dam hypoxia, caused by excitement or tension, can lead to a more serious drop in the heart rate of the fetus. Prolonged or

excessive extractive force can cause the pulse of the fetus to drop to almost zero. As the calf becomes acidotic as a result of delayed delivery, the pulse first increases 140 beats per minute and then falls falls becomes irregular as his condition worsens. The umbilical cord of the fetus in the cranial view is located by palping it between the last rib and the abdomen. In the caudal presentation the umbilical cord is easily accessible. The pulsation of the umbilical cord vessels can be felt by applying a little pressure on the umbilical cord. The cord can be wrapped around the abdomen or limbs of the fetus or can enter the birth canal next to the fetus. Although not usually required, the location of the cord can be installed and the cord moves if necessary. Pressure on the cord should be avoided during mutation malpostures and during extraction. Severe congestion of the head, tongue and alterations is the result of long-term exposure of the fetus in the birth canal. The condition may occur in energetic or dying calves and does not offer a prognosis. If delivered alive, the affected calves are experiencing difficulty caring and may need help plus administration of anti-inflammatory drugs. Frequent or violent spontaneous fetal movements can sometimes be seen or felt. Exaggerated movements can be agonial, indicating impending death due to hypoxia. Once the condition of the fetus has been determined, the operator must estimate the size of the fetus relative to the size of the maternal pelvic input and birth canal. Traction delivery leads to fetal respiratory acidosis, and the operator must determine whether the risks of damage to the dam and the fetus during extraction are justified. Effective guidelines have been developed for inexperienced obstetricians to assist in decision-making to determine the possibility of vaginal delivery.14 The basis for these guidelines is sometimes referred to as diagnostic cravings. When the fetus is in a cranial presentation, dorsosacral position, and normal posture, if one person can pull fetlocks from 10 to 15 cm per vulva (approximately one arm width), the shoulder point will pass the maternal iliac and the calf can be delivered vaginally if the correct delivery methods are used. When the fetus is in the tail presentation, dorsosacral position, and normal posture, if one person pulling on each leg can make the hocks appear in the vulva, the more trochanters will pass the sub-ram and the calf can be delivered vaginally. Other factors may be included in decision-making as experience is gained. For example, the probability of successful traction delivery increases under the following circumstances14: On the contrary, the probability of successful delivery by traction is reduced under the existing following conditions: the vaginal examination is by assessing the degree of dilatation of the vagina, vestibulovaginal sphincter and vulva. Most vaginal, vulva and intermediate brain ruptures occur during obstetric intervention and should be prevented by manual dilation channel before the traction. Manual dilating of the caudal reproductive tract is an extremely important part of the method of delivery, with many doctors suggesting that the need for episiotomy can be significantly reduced if time is needed to ensure that effective dilation is achieved before the use of traction. In addition, stress and associated acidosis in the calf are reduced, as resistance to head and chest delivery is less. After the use of obstetric lubricant, the birth canal can be stretched by putting hands together and inserting both hands. External pressure with forearms is placed in a diagonal direction with one forearm at 2 o'clock and the other forearm at 8 o'clock. Constant pressure is applied as a wedge as long as the operator can control; then the hands move on the other diagonal at 4 hours and 11 hours, and the procedure is repeated. Perseverance is important because 10 to 20 minutes may be required to expand the birth canal enough to prevent soft tissue damage. Upon completion of the examination and assessment of the condition of the fetus, the dam and the birth canal, the doctor must formulate a plan to resolve the dystocia. Available options in cattle are a mutation of abnormal presentation, position or posture; Forced mining; fetotomy; pelvic symphysiotomy; and C-section.16 Euthanasia can be shown in situations where the value of an animal is limited and the prognosis is poor. When developing a fetal delivery plan, the doctor must consider the cost of the dam and the potential value of its offspring, the cost of the procedure and postoperative care, as well as the prognosis for the life of the dam and fetus and for the future reproductive performance of the dam. Often the decision will be influenced by the available means and assistance, as well as personal preferences of the owner of the animal and the doctor. Figure 42-3 is a diagram of the flow of the decision-making process that can be used by a doctor in the clinical management of dystocia. In order to effectively communicate the details of the case of dystocia, it is important to standardize the terminology. This book uses the following definitions. Mutation is defined as the process by which the fetus is restored to normal presentation, position and posture by repulsion, rotation, version or enlargement of limbs. Fetal posture abnormalities are usually easier to correct when the dam is standing. However, in specific circumstances, placing a dam in side lying conditions can be beneficial, especially if there are objects such as a hydraulic sloping table or even a sloping loading ramp. For example, when the head of the fetus is held, if the cow can be placed in a side position with the upper head of the fetus and Cows elevated a bit, head mutations in normal posture can be eased. If the mutation cannot be completed within 15 to 30 minutes, you should choose an alternative delivery method. Mutation of foal limb defects usually requires that the fetus be recaptured from the mother's pelvis before trying to correct. As a rule, the correction of limb flexion is achieved by reflecting the proximal end, rotation of the middle part of the lateral and the application of thrust to the distal end. Repulsive and rotating forces can be used by the operator's hand. The traction can be applied by the operator if there is enough space in the birth canal to allow the introduction of both hands, or an assistant using an obstetric chain or trap. In cattle, the head is most often deflected to the left side of the fetus and lies on the chest wall. Malposture is adjusted by grabbing orbital grooves with the thumb and middle finger (clutching the grip of force) and carrying the head into the mother's pelvis. Rope traps placed behind insorth teeth can be useful in complex cases. The head redirection pull can be applied with a trap operator or assistant, while on the other hand the operator directs the head and protects the uterine wall from carved teeth, covering the mouth of the fetus. The head can be glowed with ventrals between the limbs, with the jaw resting on the sternum. The examination may not reveal the presence of the head, and the defect may be mistaken for a case of caudal representation. In some cases, malposture can be corrected by reflecting the fetus's forehead with your thumbs while lifting the jaw with your fingers. Correction in more severe cases requires that one or both limbs be beaten and bent on the carpus, elbow and shoulder joints. The space is then available to convert the abdominal shift of the head into a lateral shift, which is then adjusted by drawing the head into the pelvis. Induced malposture forelimb is then adjusted after the head is in the correct position. If attempts to change the position of the head by these methods are not successful, the dam can be cut, cast and rolled into a dorsal recumbent. The fetus then falls to the maternal spine and from the narrow abdominal part of the pelvis, allowing the head to more easily navigate the pelvic canal. Unilateral or bilateral wrist flexion may be responsible for the dystocia in cattle. If the bent carp together with the head of the fetus is inside the mother's pelvis, the situation is described as involving carpal flexion, while if the bent carp is cranial to the mother's pelvis, it is described as a stepped-off cystic flexion. Correction requires that the fetus and bent limb be recaptured from the pelvic floor to enlarge available for correction. The operator inserts a hand corresponding to the side of the shift in the birth canal, and immediately captures the metacarpus, proximal to the fetlock. Then the limb rises dorsally and the shoulder and elbow joints bend. When the fetlock is above the pubic, the hooves are placed in the arm and pulled into the pelvis. If necessary, the thrust can be applied with a trap placed proximal to the fetlock joint. When lifting and repelling the carpus on one side, the operator uses gentle traction to attract the hooves to the pelvis on the other. Shoulder joints can also be unilaterally or bilaterally bent and forelimb located near or under the fetal abdomen. The correction is achieved by capturing the radius and pulling it towards the mother's pelvis. The flexion of the shoulder is thus converted into carpal flexion, which is then adjusted by the methods described earlier. If a traction trap can be placed on a distal carpal joint, it can be used to apply extractive force on one side and the other repels the shoulder joint. Shoulder-elbow flexion or elbow lock posture is the most common in heifers and results in the effects of elbow joints on the pelvic gray. The condition is recognized when the fetal snout lies directly above the hooves, rather than in a normal position around the middle of the metacarpus. Malposture is corrected by first repelling the fetal body into the birth canal and then applying cravings to the affected limbs, one at a time, until the elbow and shoulder joints are fully enlarged. Leg-nape posture is not common for cattle, but occurs when one or both limbs are shifted up to lie on top of the head and neck. The defective posture is corrected by grabbing the fetlock of the affected limb and forcing it down and laterally, while lifting and repelling the head with the other hand until the limbs are in a normal position. In protracted cases, ongoing attempts to deliver the fetus can force the hooves through the dorsal wall of the vestibule, resulting in the formation of fistulas or an intermediate lace wound. Moving the hind limbs is rarely a problem if the foe is in the tail presentation. Incidence of caudal representation in cattle can vary depending on management conditions and genetics, and such movements are often complicated by dystocia. One or both hind limbs can be preserved and bent on the horse race or on the hip. To correct the flexing posture, the limb is grabbed on the metatarsal bone and repelled by the cranial and lateral until there is enough space to draw the hoof in the tail and medial direction in the pelvic canal. The operator must cover the hoof with one hand to protect the uterine wall as it rotates medially. In some cases, the use of snare distal to the fetlock joint may Correction. The cord is placed between the numbers of the affected hoof, and the thrust is applied. The operator then applies the opposite forces, repelling the hock while applying the thrust to the trap. This action causes the fetlock and pasteur joints to bend while the hoof turns to the pelvic sulfur. Bilateral hip flexion (colloquially referred to as a true reclusive presentation) prevents the fetus from entering the cervix; thus, there is no abdominal stimulus and signs of the second stage of labour may be minimal or absent. The hip flexion is corrected by grabbing the lateral aspect of the shin as close as possible to the jump. Hock and smother the joints bend, drawing a hock to the mother's pelvis. Once the joints are galloping and choking completely bent, the malposture becomes a hock flexion, which is subsequently adjusted as previously described. Ventrovertical, or dog-sitting, position causes dystocia in the fetuses represented cranially due to the flexion of the hind limbs on the hips. The hooves can have an effect on the mother's pelvis or lie in the vagina next to the limbs. The cranial part of the fetus is delivered as usual, but the obstacle is detected when the birth cannot be completed. The condition is diagnosed through a thorough examination, which can be difficult if the cranial parts of the fetus occupy the pelvic canal. An attempt can be made to correct the malposture by reflecting the hind limbs as deep as possible into the uterus. The correction is likely to be successful only when the fetus is small. Delivery by caesarean section or fetotomy may be preferable in many cases. Only golden members can continue reading. Sign in or sign up to continue working dystocia in animals ppt. dystocia in animals pdf. dystocia in animals definition. types of dystocia in animals. causes of dystocia in animals. treatment of dystocia in animals. signs of dystocia in animals. prevention of dystocia in animals