A continuous pattern with 4-0 polypropylene suture with tomosis were performed to remove the rope. The anastomosis was questionable. Intestinal resection and end-to-end anastomosis of a 1.5-inch portion of the intestine at the site was identified in the distal third of the jejunum; viability of a 1.5-inch portion of the intestine was questionable. Results of a CBC and serum biochemical profile were within reference ranges, except for slight monocytosis (1,090 cells/µL; reference range 0 to 840 cells/µL), slightly high serum activity of alkaline phosphatase (157 U/L; reference range, 5 to 131 U/L), and slightly low serum amylase activity (274 U/L; reference range, 290 to 1,125 U/L). Analysis of a free-catch urine sample revealed moderate proteinuria and concentrated urine (specific gravity > 1.040). Survey abdominal radiographs revealed no abnormalities.

Because of a lack of identifiable causes and to further characterize the nature of the gastrointestinal signs and associated pain, a ventral midline exploratory celiotomy was performed. A linear foreign body (rope) was identified in the distal third of the jejunum; viability of a 1.5-inch portion of the intestine was questionable. Intestinal resection and end-to-end anastomosis were performed to remove the rope. The anastomosis was performed by use of a modified simple continuous pattern with 4-0 polypropylene suture with a swaged-on taper-cut needle, as described. Routine 3-layer closure of the abdomen was performed. Recovery from anesthesia and surgery was routine. The dog was fed small amounts of an easily digestible diet starting 2 days postoperatively, had no further signs of gastrointestinal upset, and was discharged from the hospital on the third postoperative day.

Approximately 7 months after surgery, the dog was evaluated because of a 1-week history of vomiting, diarrhea, lethargy, and decreased appetite. A presumptive diagnosis of acute gastroenteritis had been made 2 days earlier, but conservative management, which included withholding food and water for 24 hours, had failed to control clinical signs. On physical examination, the dog had signs of abdominal pain and loose feces in the rectum. Results of a CBC and serum biochemical profile were within reference ranges, except for slight monocytosis (1,090 cells/µL; reference range 0 to 840 cells/µL), slightly high serum activity of alkaline phosphatase (157 U/L; reference range, 5 to 131 U/L), and slightly low serum amylase activity (274 U/L; reference range, 290 to 1,125 U/L). Analysis of a free-catch urine sample revealed moderate proteinuria and concentrated urine (specific gravity > 1.040). Survey abdominal radiographs revealed no abnormalities.

Because of the high index of suspicion for a small intestinal obstruction, a ventral midline exploratory celiotomy was performed. A linear foreign body, starting at the site of previous intestinal resection and anastomosis, was identified. The distal third of the jejunum was hyperemic. An enterotomy was performed to remove a string and piece of plastic that were caught on a portion of polypropylene suture material from the previous surgery, which had been extruded into the lumen of the jejunum. The knot of the polypropylene suture was grossly visible on the serosal surface of the jejunum and, unlike the remainder of the suture, had not moved. The enterotomy site was closed with 4-0 polypropylene suture material in a simple continuous pattern, and a serosal patch was placed over the enterotomy. An enlarged intestinal lymph node was seen, and an incisional biopsy of the node was performed for histopathologic analysis. No other abnormalities were noted. The abdomen was flushed with 1 L of warm saline (0.9% NaCl) solution. Routine 3-layer closure of the abdomen was performed.

Recovery from anesthesia and surgery was routine. The dog was fed small amounts of an easily digestible diet starting 2 days postoperatively, had no further signs of gastrointestinal upset, and was discharged from the hospital on the third postoperative day.
the suture material to close incisions into the lumen of the small intestine, such as during enterotomy or a resection and anastomosis, is a common and accepted practice. In the 3 dogs described here, foreign bodies were caught on a portion of polypropylene suture that had evidently been extruded into the lumen of the small intestine after its use for closure of a previous intestinal surgery. To the authors' knowledge, there are no previous reports of migration of polypropylene suture into the lumen of the intestine or of suture material acting as a catch point for foreign bodies.

Like other nonabsorbable suture materials, polypropylene elicits minimal tissue response characterized by early and rapid proliferation of connective tissue that encapsulates the suture and persists for years. Polypropylene has been compared with other suture materials for closing incisions in the stomach and colon and was the least reactive of the suture materials studied in a report involving 127 dogs. In a study of 27 human patients requiring gastrointestinal surgery, polypropylene was well tolerated, with available autopsy reports indicating clearly visible sutures without gross evidence of tissue reaction and only minimal microscopic evidence of fibrous tissue reaction surrounding the sutures.

A 6-month-old neutered male Dachshund was evaluated because of a 1-month history of persistent flank biting and signs of abdominal discomfort on palpation. The dog's appetite was good, and no vomiting or diarrhea was reported by the owner. Pertinent history included a jejunal resection and anastomosis for a foreign body performed by the referring veterinarian approximately 6 weeks previously. Abdominal radiography and ultrasonography did not identify a reason for the clinical signs. Abdominal exploratory celiotomy revealed a foreign body palpable at the previous jejunal resection and anastomosis. The object was not moveable, and resection and anastomosis were performed to remove a stick entwined in polypropylene suture from the first surgery that had been extruded into the lumen. The anastomosis site was closed with a modified simple continuous pattern with 4-0 polydioxanone in a simple interrupted pattern. The dog recovered routinely and was discharged 2 days postoperatively. Fifteen months after the second surgery, the owner reported that the dog had been free of signs of gastrointestinal upset.

Ten months later, the dog was returned to the hospital for evaluation of signs of gastrointestinal upset, including inappetence, vomiting, and signs of abdominal pain. Abdominal radiographs revealed a large amount of radiodense material in the small intestine and apparent plication of the small intestines in the midabdomen. Abdominal exploratory surgery was performed, and no evidence of obstruction was found. Omental adhesions at the previous resection and anastomosis site were found and broken down, but no polypropylene knots were identified. The radiodense material was moved into the colon and removed through the anus. The dog recovered routinely from surgery and was discharged from the hospital. Approximately 6 months postoperatively, the dog was euthanatized for an unrelated health problem at another veterinary hospital.

The use of polypropylene suture material to close incisions into the lumen of the small intestine, such as during enterotomy or a resection and anastomosis, is a common and accepted practice. In the 3 dogs described here, foreign bodies were caught on a portion of polypropylene suture that had evidently been extruded into the lumen of the small intestine after its use for closure of a previous intestinal surgery. To the authors' knowledge, there are no previous reports of migration of polypropylene suture into the lumen of the intestine or of suture material acting as a catch point for foreign bodies.

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bursting strength, lumen diameter, lumen circumference, and healing characteristics were detected between the 2 techniques. However, staples placed by use of a gastrointestinal anastomosis surgical auto-stapling instrument during intestinal surgery in dogs may come loose and be extruded into the lumen, but only when an inverting serosa-to-serosa anastomosis is performed.19

Although no such data were found for polypropylene in the gastrointestinal tract specifically, it is possible that a similar chronic inflammatory response in conjunction with the normal peristaltic contractions of the small intestines may have contributed to extrusion of the polypropylene suture material into the intestinal lumen of the dogs in this report. We also speculated that the use of polypropylene in an interrupted pattern would not result in the same type of complications because of the short segments of suture that are used. Additionally, the discovery of a foreign body attached to the intraluminal portion of the suture in the dogs reported here underscores the clinical relevance of such suture migration and the need to prevent it.

Because the Dachshund was, chronologically, the first affected dog encountered of these 3 dogs, a trend had not yet been identified and the second intestinal surgery site was closed with polypropylene. The authors have chosen to replace polypropylene with polydioxanone suture material for use in the closure of intestinal surgeries because it is absorbable3 and have not since encountered similar cases. Polypropylene suture was initially selected because of the availability of a swaged-on, taper-cut needle. A similar needle is available swaged on polydioxanone.6

A comparison of stomach and colonic wounds closed with absorbable sutures and those closed with nonabsorbable sutures found no significant differences in breaking strength curves.14 By 14 days postoperatively, the relative contribution in strength from sutures in small intestinal anastomoses is negligible.17 Polydioxanone suture material has a 14% reduction in tensile strength by day 14 with complete resorption by day 180;2 thereby, it should provide adequate time for intestinal healing to occur. Poliglecaprone 25, an absorbable monofilament suture material with a breaking strength retention of approximately 20% to 30% after 2 weeks and complete absorption by 91 to 119 days with minimal tissue reaction,18 could be considered as another alternative to polypropylene for use in closure of small intestinal surgical sites.

References