ABSTRACTS

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LAPAROSCOPIC SURGICAL CONTRACEPTION IN BITCHES

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Several surgical contraception methods are been described in the bitch. Those include traditional midline ovariohysterectomy, lateral flank ovariohysterectomy, ovaricectomy and laparoscopic procedures (3). Laparoscopic sterilizations by means of laparoscopic and laparoscopic assisted ovariohysterectomy and ovariecctomy have been well developed in the last ten years in several centers. Technical variables include: number and position of ports, means to perform haemostasis and ligaments resection. The current advantages of minimally invasive surgical contraception are: magnification (excellent visualization of the genitourinary tract) and reduction of incomplete ovary resection risk (8), minimal tissue trauma and therefore slight adherence formation, reduction of postoperative pain, recovery time, risk of infection and postoperative wound complications (1,2,5,6). Currently claimed disadvantages are related to the hight costs of the equipment, the need of an assistant surgeon, operating time, morbidity (viscera injuries and bleeding), and specific anaesthetic protocol and need for a specific training (1,5,7,8,9). However currently performed studies show that, under appropriate guidance, the learning curve is steady (Fiorbianco, Findik, Dupré, unpublished data). Since the first description of the techniques many progresses have been accomplished due to development of new instruments and better training of the surgeons (4,5,7,8,9,10). Besides, morbidity has dramatically decreased and rare secondary organs injuries, as spleen and liver; caused by trocars and Veress needle insertion, are self-limiting (1,4,5,6). Operation duration is in most of cases less than 60 minutes (2,4,7,8,9) but is still slightly superior to traditional surgery if performed by non-trained surgeons (1,2,6,7). Operation duration has proven to be influenced by the technique, the instruments, the surgeon and the patients characteristics. Nowadays, the use of a limited numbers of portals (ovariectomy is currently performed through one 12 mm hole) as well as the use of feed-back control haemostatic devices enable (1,2,4,8,9,10) to compare favourably the duration of laparoscopic ovariecctomy with standard ovariecctomy.

In conclusion, the entire view of the abdominal cavity, the magnification, the very limited morbidity, the decreased per-operative and postoperative pain, the better recovery period, the little incisions sizes and numbers, the feasibility of laparoscopic ovario-hysterectomy instead of ovariecctomy if needed, the steady learning curve of non-experimented surgeons make laparoscopic ovariecctomy or ovario-hysterectomy the method of choice for surgical sterilization of the bitch.

References