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ECTOPIC PREGNANCY IN A PERUVIAN GUINEA PIG

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Submitted by Jan Tibbetts, Washington.

Breeder's note: This is a medical report done by my veterinarian, Dr. Stacy Pritt, on one of my Peruvian sows. The sow "Cinnamon" had been bred on 7/8/00 in a breeding pen with one boar and 2 other sows. All 3 sows became pregnant right away, 2 sows delivering healthy litters around the end of September, 2000. Cinnamon, however, continued carrying her baby until January, 2001. I would show her to people who came over and say, "See my sow that has been pregnant for 6 months!" Cinnamon was healthy, eating well, and acting normally. I took her in to be X-rayed on January 31, 2001 and it was indeed a fetus lying directly across Cinnamon's spine. Dr. Pritt offered to do a C-section on her because this was intriguing. The report follows:

A two-year old, female, pedigreed, Peruvian guinea pig was presented for a suspected abnormal pregnancy. The sow successfully delivered a litter of three young in March, 2000. The next breeding took place in early July. The guinea pig presented 7 months later with the complaint that she had not given birth (normal gestation is 63-70 days).

The guinea pig was outwardly healthy but overweight at 1322 grams. Appetite, activity and vital signs were all within normal limits. Two to three large, firm, irregular masses were easily palpated within the abdomen. The owner stated that the masses had been present since late July and were progressively getting larger.

Radiographs revealed one large, fully formed fetus lying horizontally in the cranial abdominal cavity. An exploratory laparotomy was scheduled to evaluate for a possible ovariohysterectomy.

SURGERY AND FINDINGS

The guinea pig was started on enrofloxacin (2.5mg/kg SC q12h) the day before surgery. The patient was fasted for 3 hours and then premedated with atropine (0.05mg/kg) and torbugesic (0.2 mg/kg) given in separate SC injections. Anesthesia was induced via face mask with 6% sevoflurane and 3 LO2. A surgical plane of anesthesia was maintained with 4.5-5.0% sevoflurane and 1 LO2. The abdomen was clipped and surgically prepped in a routine manner.

A routine ventral midline incision was made. The ventral abdominal musculature was thickened and fibrosed. It appeared that the incision was going directly into the uterus from which drained a small amount of red-tinged amniotic fluid. A dead fetus was then visualized. After probing the area around the fetus, it was determined that the uterus was adherent to the abdominal wall. The fetus was extracted after breaking down the adhesions to the inner lining of what was believed to be the uterus. Due to the significant amount of blood loss, the decision was made to euthanize the sow while under anesthesia (0.5 ml Euthasol IC).

The dead fetus was 5 inches long and 2 inches in diameter, weighing 151grams (normal is 50-100 g). The fetus was sent intact for histopathology and necropsy. (Gross and Microscopic Pathologic Findings, Discussion and References can be found at www.exoticdvm.com).

CONCLUSIONS

While no scar tissue was found in the right uterine horn, expulsion of the fetus through a thin-walled diverticulum into the abdominal cavity is theorized to have occurred during the March, 2000 parturition. The large fetal size could account for severe stretching and subsequent compromise of the uterine horn wall after which the fully developed fetus was expelled into the abdominal cavity. The fetus was most likely in the abdominal cavity for 4 months beyond the typical guinea pig gestation time. Implantation of the fetus within the abdominal cavity did not occur.

The presence of acute adrenal necrosis and erosive gastritis reflected significant stress in the sow. Hepatic lipidosis suggested that she may have been anorexic for some time. Although the sow showed no evidence of bacterial sepsis, the areas of inflammation within the necrotic fetus suggested bacterial sepsis arising from the fetus may have occurred subsequent to expulsion.

The guinea pig was presented and treated while Dr. Pritt was a Banfield, The Pet Hospital, 7603 NE Vancouver Plaza Dr., Vancouver, WA 98662.

Dr. Pritt has since moved to Manchester, NH to further her career.

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