already at a show or sale and are tied to a fence or partition and it is very simple to administer this drug via the oral route. I use a 3 cc disposable plastic syringe, pull the Acepromazine into the syringe, remove the needle, grasp the steer or heifer by the nose or the upper lip, place the syringe in the corner of the mouth and eject the Acepromazine. The animal will not spit the tranquilizer out because of the small quantity of fluid even though it has a bitter taste.

Third is that by using this drug orally I don't seem to get the drooped ears and eyelids that I get when I use the same dose intramuscularly and this is a tremendous advantage on show cattle. The thumb rule I base my dosage on is 10 mg or 1 cc Acepromazine per 500 lb. of body weight. Now, this dosage will vary with the animal and the state of excitability of the animal, but I have never had to use over 30 mg when using the oral route. I have had a couple of 1200 to 1300 lb. steers that I have used 3 cc or 30 mg on and this is the maximum. These steers were of the exotic breeds. I have had some very excitable heifers at sales that I have used 20 mg on and it seems to work well enough to quiet the animal so that the person can get it through the sale ring without any injury or without the animal becoming too excitable. I administer the drug one hour prior to the time when the animal is going to be shown or sold.

Another way this can be used, which I find very easy, is for working a bunch of cattle or weaning calves that are going to be moved to another farm. We administer the drug when we have them in the head gate, castrating, vaccinating or whatever we might be doing to the animal. By using a dosage of 10 mg, I find that it cuts down the possibility of shipping fever, becasue we are cutting down on the stress factor.

I have taken steers of my own that were going to slaughter, given them 30 mg 48 hours prior to slaughter, taken them to the slaughterhouse, told the inspector what I've done and that this meat is for my use, and we have never come up with a trace of the tranquilizer in the carcass. So I feel we are very safe along this route.

In summary: my basic dose is 10 mg or 1 cc per 500 lb. body weight one hour prior to the time desired. No possibility of staining a carcass, easy to administer, and less chance of injury to you.

Diagnosis and Correction of Some Intestinal Obstructions

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There are three types of obstructions that I most often encounter. These are intussusception, torsion, and strangulation. These obstructions have several similar clinical signs. If the owner observes the animal early, he notes signs of colic. The animal will kick at its abdomen, stamp its feet, switch its tail and be restless. These signs will progress to stasis of the digestive tract and beginning toxemia. After two or three days the abdomen becomes somewhat distended and there will be little or no feces passed. The animal stops eating and drinking.

Rectal examination is a must when you see the animal. Many times you will be able to palpate an intussusception just anterior to the brim of the pelvis. Almost always you can palpate loops of intestine distended with gas, whether you have intussusception, torsion or strangulation. With an intussusception, the small amount of fecal material present will be blackish, fetid smelling, and of a tar-like consistency. With torsion or strangulation there will also be a small amount of fecal material present, but it may be of normal consistency or have mucus present. The odor will be somewhat sour as is characteristic of a static intestine in the cow. Many times you cannot find enough clinical evidence of obstruction to be sure of your diagnosis. I like to treat these cases with mineral oil and a mild laxative, wait twenty-four hours, and if no improvement is noted, do a laparotomy. If the cow is extremely toxic, you cannot afford to wait. Do surgery immediately.

Surgery in these obstruction cases is usually successful if there is no peritonitis. I prefer to have the animal standing and do a right flank laparotomy using only local anesthesia. In cases where the animal will not stand quietly, I use tranquilization, cast the animal and use local anesthesia. In most of these cases resection and anastomosis is necessary to correct the condition.

Most intussusceptions and torsions can be exteriorized through the right flank laparotomy. I like to use intestinal forceps to clamp healthy intestine on either side of the affected portion. Then the diseased portion is removed along with enough mesentery to allow the healthy ends to be brought together for end-to-end anastomosis. The suture pattern is a continuous mattress that everts the ends of the intestine. Then the everted ends are brought together with a simple continuous pattern. The mesentery is then sutured and routine closure of the laparotomy made. I like to leave some type of antibiotic or antibacterial agent in the peritoneal cavity.

In some early torsion and strangulation cases, before devitalization of tissue occurs, it is possible to reduce the torsion or strangulation and not have to do resection and anastomosis.

Postoperative therapy includes antibiotics for four or five days, corticosteroids, if needed, and supportive treatment as indicated. Diet consists of moderate amounts of good roughage and small amounts of grain concentrates. Most successful cases are passing feces in six to eight hours.

This is not what would be considered everyday surgery, but it is not rare. I average about two cases per year. To me it is rewarding surgery, not in the monetary sense, but in my feeling of accomplishment. Clients are favorably impressed by this type of surgery and it always benefits your practice.