

# Practical Vehicle Management

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I practice about 40 miles south of Manhattan, Kansas. My type of vehicle might be a bit different, but it seems to work in my practice very well. I have just a one man, general practice. You might say it is the old type, mainly ambulatory, mainly beef cattle. I have used a van for a number of years, fitted with a large box with a lot of drawers. I know different veterinarians have different ideas about what they like for ambulatory vehicles.

I have a lot of pasture work and vans have suited my practice very well. The box sets in the door space with buckets, etc., behind it. There is a lot of

room in the back. I do not do a lot of dispensing in my practice. I also use an apron. It holds approximately 20 blood tubes. This way I can carry everything I need to service a small herd.

Opposite the side door, there is a seat, which also serves as a box. I can carry a lot of stuff in there. I also have a portable table. The back of the seat slips out so you can get in from the other side. I do a lot of bull evaluating in the country. This makes a pretty nice portable laboratory.

That gets everything under one roof. There's also room behind the seat for other things.

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## Surgical Treatment of Urolithiasis

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Suturing the ruptured bladder in a case of urolithiasis has proved to be unfeasible and unsatisfactory in our experience. Our method involves performing a urethrotomy dorsal to the blockage, which is usually in the sigmoid flexure. We also drain urine from the abdominal cavity. Our results have been satisfactory, with the bladder wall healing itself, especially in steers ranging from 200 to 600 pounds body weight.

Unfortunately, this is not true in steers in the 800 to 1200 pound range. Not only does the bladder wall not heal itself but usually the blockage is of the phosphate sludge instead of the silicone stone and may be located for some distance dorsal to the sigmoid flexure and normal urination does not return with the conventional urethrotomy.

About 10 to 12 years ago, we started using a different approach to this problem. We insert a size 24 French human female catheter of woven fiber into the bladder and sutured the same in place. Today, because of the cost of a woven fiber catheter, approximately \$7.00 each, we use a size 24 French, Rusch plastic catheter, costing approximately 85 cents each.

The procedure is performed under an epidural or local anesthesia. A 2 to 3 inch incision is made in the midline between the semi-membranosus muscles approximately 3 inches below the anus. This is the area where the penis tranverses dorsal-ventrally over the pubic arch. It is very important for the incision to be in the midline to find your guidelines to the penis. Fascia is separated and you will be able to pick up the retractor penis muscle and then palpate the bulbus-cavernosus muscle approximately 1 inch thick and covered with a strong aponeurosis. This muscle surrounds the penis in this area. A longitudinal 1 inch incision is made through the muscle and penis into the urethra. The catheter is then inserted into the bladder and sutured to the skin using heavy Vetafil or Supramid suture material. The remaining incision is not sutured but left to heal openly.

In most cases after introduction of the catheter into the bladder you will notice clear or blood tinged urine coming through the catheter. If you do not see this urine coming through the catheter it is wise to rotate or reinsert the catheter as you may have inserted it through the rent in the bladder wall or have plugged it with a blood clot.