Post-operative care for patients after a tie-back

In this procedure one of the cartilages in the larynx (the "voice box") is permanently drawn to the side ("lateralised") with sutures to permanently hold the air-way partly open. These patients are usually larger breed dogs and typically have a history of collapse when they are excited or exercised, and stress in hot weather. They have obvious loud breathing sounds (predominantly as they breath in) and they often have a chronic low grade cough. After the procedure the cough and breathing noises often persist. The goal of the surgery is to improve the patient's tolerance of exercise and excitement. These dogs are usually geriatric. Laryngeal paralysis is sometimes a component of a wider degenerative neurological syndrome and these patients may develop other neurological abnormalities including clinically significant megaoesophagus in the months and years after surgery.

Medication:

Antibiotics: Antibiotics like claviseptin are usually given for a few days (usually tablets given twice daily).

Anti-inflammatories: Non-steroidal anti-inflammatory drugs usually start/resume the morning after surgery. These are tablets (eg carprofen, Onsior or Previcox), or liquid (meloxicam). They should be given with food. If vomiting or diarrhoea is noted, stop this medication and seek prompt advice.

Analgesics: We may have dispensed tramadol (tablets given twice daily).

Rechecks a few days after discharge may be with your own vet to save un-necessary travelling. We can do this check-up where travelling is not an issue. All our post-op check-ups are free under our "fixed price" schemes. Please contact us to book an appointment for us to see the case back 2-3 weeks post-operatively when we can remove sutures/staples and check that all is going to plan.

Immediately post op
Your pet can eat (see feeding below) and drink on the evening after surgery. Eating, drinking and urination should have been seen on the morning after surgery, and at least once daily thereafter – if not, please call us without delay. Defaecation sometimes isn't seen for several days post-op.

Strict rest is enforced for one month to avoid over exertion and heavy breathing while scar tissue establishes and matures in the larynx. A harness is used rather than a collar. Five minutes walking exercise on a lead a few times a day is allowed.

Excitement and barking should be avoided wherever possible during first month or two

Hot weather which can cause stress and panting should be avoided

Feeding. Try to get your pet to eat slowly and steadily rather than gorging. Consider limiting the amount available at one time. Food with the consistency of meatballs that stays in a lump when squeezed without exuding liquid is easiest for these patients to swallow. Dry food is an alternative but liquid food should be avoided at all costs (eg gravy). It is a good idea to be present during feeding, especially if using dry food in the unlikely event of some lodging in the airway. For many cases it can be a good idea to feed smaller quantities over several meals per day, to feed the dog from a height (eg sitting down and with the food bowl raised), and to feed the dog without the competition of other dogs nearby (which encourages gulping food down too fast).

Water may need to be given in limited volumes initially to prevent excess coughing in some dogs.

Coughing can continue post-operatively. It may change in character, it may be chronic and low grade, or it might flare up at intervals. It can result from the inhalation of food particles. Antibiotics may be required from your vet periodically.

Complications and possible future developments
Seroma, the accumulation of tissue fluid under the skin, is not uncommon with this surgery. This usually resolves over a few weeks without any intervention.

Wound infection is uncommon, but it does occasionally happen. If ooze is evident from wounds, seek prompt advice.

The inhalation of food particles can cause aspiration pneumonia which is potentially fatal. The risk is minimised with careful attention to feeding.

Failure of the tie back is possible with recurrence of signs. The risk is minimised by keeping the patient calm in the first month or two post-operatively while fibrosis matures to make the lateralisation permanent. If recurrence occurs the other side may need to be "tied back", although this carries increased risk of aspiration.

Our fixed prices include any follow up consults with us, but don't include further medication or revision surgery. For further details please see www.wm-referrals.com**, "about us", "FAQs".**

For further advice please contact us by phone on 07944 105501 or at enquiries@wm-referrals.com**. Consider texting/emailing pictures.**