SIGNALMENT: "Catcher" is a 17-yr-old gelding

HISTORY: This gelding was presented for evaluation of a right-sided corneal ulcer and facial paralysis on 2/25. He had an episode of 'choke' in October that spontaneously resolved. On 1/20, he had another episode of 'choke' that was resolved by the rDVM. Approximately 3 days later, the owner noted right-sided muzzle and ear deviation and an eyelid droop OD. The rDVM diagnosed facial nerve paresis/paralysis and a corneal ulcer. Systemic treatment with phenylbutazone and topical atropine and terramycin was initiated. The corneal did not respond and a temporary tarsorraphy was placed on 2/10.

A second veterinarian performed acupuncture twice. A subpalpebral lavage system was placed and ocular treatment with atropine, Neo-Poly-Gram ophthalmic solution, serum, and oral flunixin meglumine was initiated. On 2/24, the rDVM noted the ulcer size had decreased and improved movement of the eyelid but recommended further evaluation by an ophthalmologist.

PHYSICAL EXAMINATION: On presentation, the horse was mildly ataxic. Body weight was 1164 pounds. Rectal temperature was 98.9^{o}F, heart rate 28 beats/min, respiratory rate 8 breaths/min, and mucous membranes were pink and moist with a capillary refill time of less than 2 seconds. The horse had a head tilt to the right, right ear directed laterally, right eyelid drooping, and muzzle deviated to the left. The horse resented removal of the eyemask. The horse had a fixed lingual process.

DIFFERENTIAL DIAGNOSES:

DIAGNOSTIC TESTING:

RESULTS AND DISCUSSION:

AUREO

Signalment

12 year old PRE Andalusian gelding

History

Owner purchased the horse 9 months previously. At the time of pre-purchase examination several small masses were noted over the peri-anal region and along the ventral base of the tail. No other abnormalities were reported and the horse has been healthy since purchase. The owner does not report any change in the number or size of the masses.

Initial Physical Examination

Attitude: Bright, alert, and responsive

T: 100.2 F Pulse: 36/min Resp: 16/min BCS 7/9

Integument: Multiple small masses (1-3 cm diameter) present on peri-anal region; encircling anus but not obstructing defecation. Multiple nodular cutaneous masses of various sizes along the ventral tail from base to tip. Small mass (1.5 cm diameter) noted on the inner surface of the left bottom lip near commissure. Oval, well circumscribed and freely moveable mass (5 cm x 4 cm) over right scrotal region.

All other physical examination parameters normal

Diagnosis

Treatment & Outcome

Notes

DUNCAN

Signalment

23 YO Welsh Cob gelding (450 kg)
Use: pleasure/dressage. Currently worked 5 days/week with 25 minutes in saddle – walk/trot primarily.

History

Owner purchased the horse 7 years previously. Five-year history of cyclic and vague neurologic signs, mild and intermittent lameness, and mild anemia. At the onset of these clinical signs multiple other horses on the property also demonstrated neurologic signs of varied severity. Suspected either rickettsial disease (not specified) or water contamination. Farm borders heavily wooded area. Owner has since changed water source; however, horse's clinical signs persist. "Episodes" occur on average every 6 – 8 weeks.

Up to date on vaccinations and deworming
Medications: Adequan, Vit E (1,000 IU/day), phenylbutazone (as needed)
Acupuncture x 8 months

Lameness history: Limited to back and neck stiffness (coincides with neurologic episodes) and intermittent bilateral hind limb lameness.

Diagnostics:

2009 PPE radiographs – bilateral hock osteoarthritis (L > R)
2013 lameness examinations x 3 - sound
April 2015 lameness evaluation – mild positive response to flexion at hock; not sensitive to palpation along thoracolumbar spine or SI joint.

Neurologic history: Clinical signs involve mild and nonspecific ataxia and hypersensitivity to sound and touch. These signs often progress to those of progression and lethargy over a period of a few days and frequently coincide with perceived back soreness and mild sheath edema.

Diagnostics:

January 2013 neurologic examination – mild (?) ataxia
January 2013 Serum Vitamin E – normal
January 2013 CSF tap – EPM negative (IFAT); CSF cytologically unremarkable
March 2013 serology tick panel – negative for all (*Borrelia, Anaplasma, Babesia, Ehrlichia, Rickettsia*).

** owner treated for EPM 2013 and Borrelia (etc) in 2014

May 2013 hospitalization for observation x 7 days – no abnormalities noted, normal neurologic examination, normal CBC & chemistry

Presented March 2016 for lameness evaluation

Initial Physical Examination

Attitude: QAR, basic physical examination normal
Lameness evaluation: no obvious lameness; toe-dragging hind limbs when circled

Neurologic examination:
Mentation - quiet, alert and responsive. Subjectively inappropriately quiet.
Cranial nerves - intact. Direct and consensual PLRs intact.
Palpation - Inappropriately hypersensitive to focal areas on the lumbar muscles and on the left side of the neck (approximately level of C6).
Other: Toe-dragging bilaterally in the hind limbs noted on the straightaway, during circling and backing up. While circling (both ways), mild circumduction was noted in the hind limbs. Occasional mistakes were made with both hind limbs. When stopped, placement of the hind legs was abnormal and replacement into normal position was prolonged. When stepping up and down curbs the primary abnormality was dragging toes. No neurologic abnormalities were noted in the front limbs. The abnormalities were not exacerbated by lifting the head. Appropriate range of motion of the neck was noted.
Grade 1/5 ataxia and 2/5 weakness in the hind limbs bilaterally.
Neuroanatomical localization: Ataxia/weakness - C1-L2; Mentation - Forebrain or reticular-activating system

Differentials

Additional Diagnostics

Diagnosis, Treatment & Outcome

Notes

SIGNALMENT: "Max," a 3-year-old, Quarter horse, gelding presented for chronic diarrhea

HISTORY: This gelding was presented with a 3.5-month history of chronic, intermittent diarrhea. The initial episode occurred at the trainers and responded to Biosponge® administration and a switch to grass hay. Later he was returned home to the owner and developed watery diarrhea while fed alfalfa hay and a commercial fat supplement. He became dull and depressed, necessitating fluid therapy. Resuming a restricted grass hay appeared to improve manure consistency, but each attempt to re-introduce grain resulted in a return of the diarrhea.

PHYSICAL EXAMINATION: BAR, with normal mentation. Weight is 1100 with a body condition score of 6/9. Temperature is 99.3°F, heart rate is 40 BPM with a normal rhythm, respiration rate is 24 breaths per minute without abnormal lung sounds, and mucous membranes are pink, moist, with a CRT < 2 seconds. Gastrointestinal sounds are present in all quadrants, and a small amount of soft, watery manure is noted adhered to the tail. Digital pulses are within normal limits, and the horse moves without obvious lameness.

DIFFERENTIAL DIAGNOSES:

DIAGNOSTIC TESTING:

RESULTS AND DISCUSSION:

SIGNALMENT: "Molly", a 15-year-old, Missouri Fox Trotter mare estimated at 950 pounds, BCS 4/9

HISTORY: Initial visit was to investigate anorexia of 4 to 5 days duration and low grade colic. Molly is current on vaccinations and is on a twice yearly deworming program. Trainer had treated with intermittent doses of flunixin meglumine (5 to 10 ml up to BID).

PHYSICAL EXAMINATION: Initial physical examination revealed temperature 100°F, heart rate 36 BPM, respirations 28 breaths/min, mucous membranes were moist, pink with a normal CRT. No murmurs or arrhythmias were heard upon auscultation of her heart. Pulmonary auscultation revealed mildly increased respiratory sounds, more readily heard on the right, but no wheezes or crackles were appreciated. Borborygmi were present and normal within all abdominal quadrants. Digital pulses were within normal limits in all limbs. Mild discomfort was appreciated during palpation of the temporomandibular joints. Her teeth had hooks and roughened edges, and her tongue had mild abrasions from her sharp teeth.

How would you proceed at this point?

RECHECK PHYSICAL EXAMINATION: "Molly" continues to suffer from anorexia over the next three weeks. She will eat grass but not hay or concentrate. Her bouts of anorexia appear to resolve if on 1 gram phenylbutazone, PO, BID. Repeat examination reveals temperature of 99.6°F, heart rate 40 BPM, and respirations at 20 breaths per minute. Mucous membranes are pink, moist, and have a normal CRT. Lymph nodes appear normal. Manure consistency is normal with a reduction in volume. Mare resists downward pressure on the spine.

DIAGNOSTIC TESTING:

RESULTS AND DISCUSSION:

SIGNALMENT: "Star", a 22 yr-year-old, Quarter horse, gelding presented for chronic weight loss and hypercalcemia.

HISTORY: "Star" presented for evaluation of chronic weight loss, increased heart rate, mild discomfort (pawing), and a right hind limb lameness. The referring veterinarian had been treating "Star" for over a week for diarrhea and suspected liver/kidney disease based on serial chemistry profiles. The gelding was treated with trimethoprim sulfadiazine (TMS) and metronidazole. The day prior to presentation the gelding was noted to be pawing with a heart rate of 70 beats per minute.

PHYSICAL EXAMINATION: On presentation, the gelding was quiet but responsive. Rectal temperature was 97.8 °F. The gelding weighed 1230 pounds with a body condition score of 3/9. Heart rate was 68 beats per minute with a normal rhythm, and no murmurs heard. Respiratory rate was 12 breathes per minute with no crackles or wheezes auscultated. Mucous membranes were light pink with a capillary refill time of 3 seconds. Jugular refill time was noted at 1 second. Normal gastrointestinal sounds in all quadrants. There was marked ventral edema along the gelding's belly, and the sheath was swollen. The right hind leg was diffusely swollen from the coronet band to the stifle. The gelding walked in soundly, but after being stalled was noted to be lame on the right hind limb. Normal digital pulses were palpable.

DIFFERENTIAL DIAGNOSES:

DIAGNOSTIC TESTING:

RESULTS AND DISCUSSION:

SIGNALMENT: “Scout”, a 14-year-old, Quarter Horse, gelding

HISTORY: This gelding presented with a 1.5-year history of watery diarrhea. Horse was purchased in January. He was mildly thin with normal manure and appetite. In the spring of the year of purchase, the horse developed watery diarrhea and lost weight. Pasture turnout resulted in some weight gain, but no improvement in diarrhea was evident. During the winter months, the horse lost a substantial amount of weight and has not regained weight this spring as was observed the previous year. The winter haircoat has not been shed. Appetite is variable and stools remain watery. Recent bloodwork by rDVM revealed mild neutrophilia, and mild to moderate hypoproteinemia. Fecal egg counts were negative. There may have been some improvement in clinical signs after a dexamethasone trial the previous summer.

PHYSICAL EXAMINATION: Weight is 700 pounds, and body condition score is 2/9. The horse is BAR with a subnormal temperature (96.3^{o}F). Pulse is 44 bpm, and respiratory rate is 24/min with normal hydration, perfusion, and digital pulses. Gastrointestinal sounds are increased in all quadrants. Fluid feces are seen staining the hind limbs and in the hairs of the tail.

DIFFERENTIAL DIAGNOSES:

DIAGNOSTIC TESTING:

RESULTS AND DISCUSSION:

RECHECK HISTORY AND PHYSICAL EXAMINATION:

One year after initial presentation, “Scout” presented for colic. The horse has gained 100 pounds and at least 1 body condition score since last visit. Manure was formed after the initiation of treatment, but diarrhea returned 2 weeks ago and mild abdominal discomfort manifest 8 hours ago. Exam by rDVM identified increased heart rate, no net nasogastric reflux, and thickened colon on rectal examination. Flunixin meglumine did not abolish signs of pain, and “Scout” was referred for further evaluation.

Heart rate was 48 BPM, respiratory rate was 12/minute, hydration/perfusion were normal, and digital pulses were within normal limits. Gastrointestinal sounds were normal on the left and decreased on the right side of the abdomen. Watery diarrhea is observed in the trailer. Lymph nodes were small and soft. Rectal examination revealed a thickened colon wall and thickened rectal mucosa. The examiners sleeve had a small amount of blood from the caudal rectum.

RESULTS AND DISCUSSION:

SIGNALMENT: 9 year Friesian gelding presented for endoscopic examination of the esophagus post esophageal obstruction.

HISTORY: Three esophageal obstructions in the past year that required veterinarian treatment. The most recent esophageal obstruction was the evening prior to presentation. Owner noted difficulty maintaining weight and muscling on the gelding over the 6 years of ownership. Gelding is up to date on vaccinations. The gelding was currently receiving trimethoprim-sulfamethoxazole for an abscess on the mandible.

PHYSICAL EXAMINATION: BCS 3.5/9. T: 101.1^{o}F, HR: 56 bpm no arrhythmia or murmurs noted, RR: 16 bpm with a rattle auscultated in the ventral trachea. Lungs were clear on auscultation with no wheezes or crackles noted. A cough was noted during examination. Mucous membranes were pink and moist with a capillary refill time of less than 2 seconds. Normal borborgymi was auscultated in all quadrants. Normal digital pulses were palpable in all 4 distal limbs. A ruptured abscess was noted on the right caudal mandible.

What diagnostic tests would you perform on this patient?

After watching endoscopy video and viewing the barium study, what's your diagnosis?

Prognosis?

Treatment options?

What would you expect to find on post-mortem?

Why is this abnormality over represented in the Friesian breed?

SIGNALMENT: 26-year-old Appaloosa gelding presented for evaluation of leaking urine.

HISTORY: Drainage from prepuce and scalding to the cranial aspect of hind cannon bones in excess of 18 months duration. Veterinarian performed rectal palpation and ultrasonography and submitted urinalysis, fluid analysis, bacteria cultures, and fungal cultures. Suspected a UTI and treated appropriately. The gelding improved, but the problem did not resolve completely. The veterinarian recommended referral to the University of Illinois early on, but the owner declined multiple times. Bladder lavages were performed which seemed to help. However, a year and a half into this there was concern of a bladder tumor, and the owner finally agreed to referral for further diagnostics. Owner had a restricted budget.

What diagnostics would you like to perform?

What's your diagnosis?

How would treat and manage this case?