



**ITBA Veterinary
Lecture Series 2013**

Notes

Lecture Topics

- * **Hoof and Health Care
in Foals**
- * **Lawsonia in Horses**
- * **Identification and
Management of High Risk
Pregnancies in the Mare**
- * **Piroplasmosis:
An Overview for Ireland**
- * **EHV Vaccine**



ITBA

WORKING FOR IRISH BREEDERS

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INTRODUCTION



The notes in this booklet are from the 2013 Autumn Series of lectures hosted by ITBA. As always the lectures were informative for our members and we are very grateful to the speakers who shared their experience and expertise with the attendees. We encourage members to attend these lectures: while the notes are a helpful guide there is no substitute for hearing the information first hand, seeing the visual aids and being part of the question and answer session at the end of the talks. The lectures are also a productive opportunity for thoroughbred breeders to meet and share information with each other.

Breeder education is one of our key roles at ITBA and one we take seriously. If there are topics you would like covered in future lectures please let our Association office know and we will do our best to include them.

We hope that the information in this booklet helps you to produce sound and healthy athletes.

A handwritten signature in black ink, appearing to read 'Joe Osborne', written in a cursive style.

Joe Osborne
ITBA Chairman

HEALTH CARE IN NEWBORN FOALS

by Mariann Klay MRCVS

Start with the Mare

Care of the neo-natal foal (up to 23 days old) begins with the pregnant mare, as the foal spends 11 months within that maternal environment.

The mare is scanned at 42 days and then again 1st October. That is a very important time as it's the last chance to look at the uterine environment. If the vulva is stitched, check that the stitches have not broken, as it can leave the foetus open to infection. It is also important to check the vulva regularly thereafter. The earlier any infection is treated the better. At this stage the mare should be receiving adequate nutrition, exercise and vaccination against EHV, influenza and tetanus. Rotavirus vaccine is expensive and is therefore recommended only when it is a problem. Worming is also important, based upon the individual results of the faecal egg count (FEC).



Check mare for discharge from vulva (placentitis), left or premature udder development, right.

Preparing To Foal

The mare should be moved to her foaling environment two weeks before her due date and her stitches removed. The mare produces specific antibodies in her colostrum and if she is left in a different environment she will produce the wrong antibodies. The foal is most at risk from an unattended foaling, so one of the various foaling aids is well worth having. The foal is usually born at 340 days, plus or minus ten days, although in a prolonged severe winter 378 days is not an exception.



Icteric mucous membranes of a haemolytic foal.



Muzzled foal

The screening test for a haemolytic foal is essential. The disease can be easily screened and prevented. A mare can produce antibodies in the colostrum that destroy the foal's red cells and can kill if not treated. Mares born prior to 2000 have their bloodtype registered with Weatherbys. Younger mares can be bloodtyped for €20. A bloodtype compatibility with the stallion is available from Weatherbys for €15, which identifies the risk of a haemolytic foal as low, moderate or high. If a moderate or high risk is shown, test serum closer to the foaling date for the presence of lytic antibodies.

If identified, the foal should be muzzled for 24-36 hours after birth, to prevent suckling. The mare's milk should be discarded and the foal must be given donor colostrum. Milk out the mare diligently and discard her milk, which is most important.

The foaling time can be predicted by an electrolyte test of the mammary secretion and commercial kits are readily available. The closer to foaling, the more secretion there is and when it is high in potassium and low in sodium it becomes colostrum. If a mare is injured and needs to be induced, the nearer to her colostrum production the better.

HEALTH CARE IN FOALS (CONTD.)

Foaling Stages

It is important that whoever foals the mare is familiar with the normal procedures and is experienced with foaling. Assist the mare, but do not interfere. Check for correct presentation of the foal. When the birth begins, guide, but do not pull. It is important to protect the umbilical cord against an early rupture, so that the maximum blood flow goes from the placenta to the foal. Therefore try to stop the foal from coming out too fast. You will feel the pulsing of blood through the cord and until it stops, don't break the cord. It usually ruptures when the mare stands up. Up to a litre of blood can be lost to the foal if the umbilical cord is broken too soon.

Have equipment ready at each foaling to save time. An oxygen cylinder and sterile nasal tube are essential, as well as thermometer, obstetrical lubricant, clean towels and resuscitation equipment.

The first stage of foaling can be similar to colic. As the mare suffers uterine contractions she will become restless, paw, lick and roll, to position the foetus. The second stage is the expulsion of the foetus. The allantoic sac ruptures and her waters break. As the amnion appears it sets off the foaling alert if one has been inserted, at which point you should proceed quickly to the box and check the foal's presentation. If you feel the fore feet and a little muzzle, then relax. The birthing process should take only 20 minutes. Be very careful with maiden mares after foaling and keep them under observation. Never leave a maiden mare alone through the night, even if she has suckled her foal. They can often fall asleep, get unnerved by the movement of the foal and kick.



Good quality colostrums can be frozen for at least one year.

Colostrum Banking

The udder should be cleaned prior to foaling with chlorhexidine. A refractometer is not cheap, but is well worth the investment and measures the quality of colostrum. Less than 10-15 is poor and substitute colostrum should be given; 15-20 is borderline and 20-30 is good. Older mares sometimes have poor quality colostrum and it may need substituting. Colostrum is like gold dust and very difficult to get, so don't waste it – bank it. 250ml-300ml can be collected in a sterile container and frozen, in a home freezer, for up to three years. Label it with the mare's identity and quality details. Cellular immunity develops slowly in the first six months, so colostrum is very valuable. Always wash your hands carefully, to prevent mastitis, and take a little to bank, save 300ml from every mare. A milk pump, like a breast pump, is a very handy thing to have.

The third stage of the foaling is the expulsion of the placenta, which should be less than an hour after foaling. Tie up the placenta and membranes, to make it more comfortable for the mare, and make sure she doesn't stand on it. If not tied up, maiden mares may become scared and kick. Simply wait for the placenta to pass. If it hasn't been passed in two hours a vet should be called and oxytocin administered. Retaining placenta can lead to laminitis.



Normal Placenta

Placenta

Keep the placenta for the vet to see. It should weigh 10% of the foal's body weight, so around 4.5kg on average. Look at it from both sides. Are the tips of the horns intact? If a tip is broken off and has been left in the mare, there is some danger to the mare. A swab is also useful, allowing you a head start before the foal shows signs of infection. The swab will identify the type of infection. If there is any suspicion of the Equine Herpes Virus the placenta is highly contagious.

HEALTH CARE IN FOALS (CONTD.)



"Red bag" presentation or premature placental separation.

Abnormal Foalings

Most importantly, if anything during the foaling process is not normal, act quickly. In mares, you have no time and death can be the result of not acting quickly.

In the case of a 'red bag' delivery – premature placental separation – it's an emergency. The foal is detached from its oxygen supply and is suffocating. First, check by pressing into the red bag to make sure the foetus is in there. In very rare cases it could be the bladder. Cut open the bag and extract the foal immediately.

A Healthy Foal

After a normal birth, the foal should show the sucking reflex within 15 minutes. It should take up to one hour for the foal to stand. It should have suckled between one to two hours from birth. If it has not suckled after 90 minutes, it requires help and if it has not suckled after two hours there is a problem.



Healthy Newborn

The normal temperature of a foal is 37.2-38.9°C. Its respiratory rate should be 30-60 bpm. Observe the newborn foal from a distance to see it 'blow'. Be absolutely sure the foal swallows. Even put your hand on its neck to feel it swallow. Some foals make the sucking noises, but are getting no milk. After 24 hours a foal can no longer absorb colostrum. If bottle-feeding, be very careful, as it is easy for a foal to ingest milk into the lungs and get aspiration-pneumonia. It is often better to have a vet use a stomach tube than to bottle-feed.



Entropion sutures with stained corneal ulcer

Meconium must be evacuated from the foal within 24 hours. To prevent meconium retention give a phosphate enema when the foal starts to strain. Watch also for the foal to urinate, within eight to ten hours. The urine should be pale or clear if the foal is well hydrated. A ruptured bladder doesn't present for up to three days.

Treat the umbilicus to prevent infection. Check the eyes – in-growing lashes can scratch the cornea. Always handle newborns with care as their ribs are very easy to fracture and a quarter of foals have compromised ribs. Foals from maiden mares are more prone to rib fractures due to a harder foaling.

Observe all the time and recognise changes in behaviour. The change from good to bad can be very quick in foals and a quick referral increases the chances of a positive outcome. Small amounts of regular exercise are very important.

HOOF CARE IN FOALS

by Jeremy Stanley Dip.WCF, Chairman Irish Master Farriers Association

The Mare

The feet of the mare are equally important to the health of the foal and the foal's care always begins with the care of the mare. Look at her carefully – is she correct? Are her faults hereditary? Her limb conformation and hoof conformation will determine her long-term soundness and her ability to carry a pregnancy full-term.

A great deal can be learned from hoof growth – nutrition, environment. Moisture can lead to soft feet and thrush problems and cause abscesses. White legs can also be more prone to skin problems. The growth rate of the hoof wall is dependent upon the seasons, genetics, age and health. Long pasterns often lead to longer toes and a predisposition to cracks.

The front and hind feet face different issues – the front feet carry 60% of the horse's weight and the foal adds to that weight in a pregnant mare. When it comes to the care of both foal and mare the farrier is an important factor.

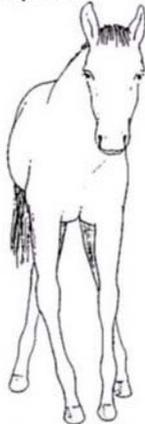
Chronic bad feet lead to stresses in the hoof capsule, resulting in fracture lines. Personally I don't like to shoe mares and prefer to keep the feet as simple as possible. Longstanding imbalances require a farriery programme and it's important to stick to it.

Look at the mare's feet and ask – a full-term foal weighs 50kg: will the hoof capsule carry that weight? The hoof is the most important aspect in the long-term career of the mare. Lots of ligament issues and tendon problems, which can lead to navicular disease, originate in the hoof capsule. Simple things such as re-using shoes can cause damage to the pastern, if the shoe has worn to a wedge.

Carpus Valgus



Carpus Varus



Foals – When and How to Assess

I like to see the foal at a week old. If the foal has weak tendons, keep it in for four or five days. Allow it a little exercise, five minutes of hand-walking, and it should improve.

Angular limb deformities show at a week old. Flexural deformities are very common and can be congenital or acquired. There are higher instances in colts than in fillies. In such cases the farrier will work with the vet from the start. It's all about keeping the weight of the foal correctly aligned on all four limbs. With 'ballerina syndrome' and laxity, where muscles are pulling up the tendons, the weight of the foal's body on the limb is causing the problem, so the farrier has to provide some sort of support for that limb.

The lower down the limb the problem, the quicker it needs to be addressed. The fetlock must be corrected within two to three months.

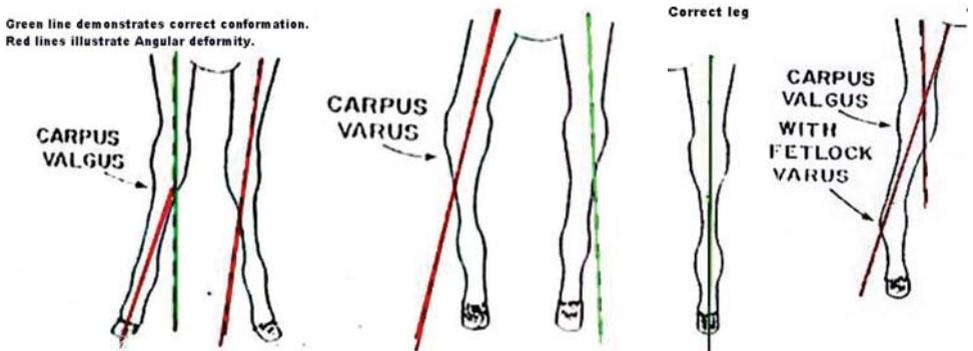
Foal Conformation

Most foals have a narrow chest and their feet are slightly turned out at seven to ten months. As the foal matures it will straighten, but thoroughbred breeders want their foal straight as a yearling. If it is overly-corrected too early in life it will start to get deviations as it gets older. As the chest widens, the feet will start to turn, instead of becoming correct.

HOOF CARE IN FOALS (CONTD.)

The hoof capsule is a very dynamic thing and within a shoeing cycle problems can be corrected. The hoof capsule conformation is constantly evolving and the opportunity to correct limb conformation is over after 18 months.

Every foal is different and requires different farriery management. If it is up on its toes (ballerina syndrome) it will require trimming every two to three weeks. A foal with normal conformation will require trimming every five to six weeks. It's preferable for a farrier to see a foal every month, unless interim treatment is required.



A farrier will recognise a problem quicker than someone who is seeing the horse every day and will see the changes over each month. Most foals correct themselves naturally, without intervention, after the first two weeks.

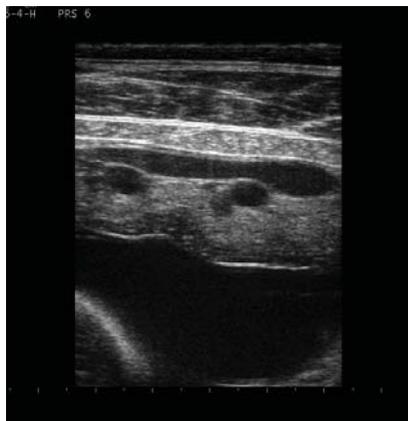
It's important to remember the hoof care of the foal, when it is turned out at grass with the mare. Commonly, they will graze with one foot forward, and that can cause an imbalance, so regular monthly checks by the farrier are essential.



IDENTIFICATION AND MANAGEMENT OF HIGH RISK PREGNANCY IN THE MARE

*by Kevin Corley BVM&S PhD DACVIM DACVECC DECEIM MRCVS
of Anglesey Lodge Equine Hospital, Co. Kildare*

Monitoring of a pregnancy is recommended if there are cases of abortion in herd mates, a history of previous problems in the individual, a vulval discharge (brown, and especially if yellow), premature udder development, unusual increase in abdominal size, or acute abdominal pain (lip curling being a particular sign of this in broodmares).



Thickened separating placenta oedema

Monitoring is best done through ultrasound. The combined uterine wall and placenta is measured, which in normal cases should be less than 1cm, usually 0.6cm or less, and any thickening is an indication of infection and problem. The foetal fluid seen on the ultrasound should be clear and black and a 'snowstorm' of specs indicates infection and poses a severe risk to the foal. Because a foal is too big for a scan, its aortic measurement is taken by ultrasound. By measuring the aorta the size of the foal can be ascertained.

The thickening of the placenta is caused by inflammation or infection and increases the distance between the blood vessels of the mare and the blood vessels of the foal, thereby limiting oxygen supply to the foal. The presence of an oedema on the placenta is very worrying and causes increased foetal fluid. A

separating placenta can also be seen in ultrasound and if a section of placenta is not properly stuck to the wall of the womb it is not supplying nutrients and oxygen to the foal and increases the risk of a 'red bag' delivery.

Foetal heart rate can also be measured, via ECG connected to the mare for a constant measurement, and should be 120 at seven to eight months, dropping to 70 just before birth. Foals can 'gallop' within the womb and high heart rates can be okay if brief, but a prolonged high heart rate is a sign of something wrong. Too low a heart rate indicates not enough oxygen. The ultrasound also shows the heart and provides a temporary measurement.

Both discharge and premature mammary development are also signs of infection. It is recommended taking culture samples in order to target the infection with the appropriate antibiotic. Premature udder development can also be associated with twins.

Any unusual increase in abdominal size could indicate a pre-pubic tendon rupture. In such cases the mare will find it very hard to move and will often lie down. Her tail will also be raised. Colic in the mare can be a real challenge for the vet and again ultrasound is used to detect the cause.

Swellings can cause tears in the abdominal wall and a condition known as hydrops increases foetal fluid. This can start in the seventh month, with an increase in outer fluid around the foal, or an increase in the inner fluid later in pregnancy. The tradition has been to induce these mares, but treatment for pain and with Regumate has proven successful and in recent cases both mare and foal have survived. Hydrops can also cause dystocia, whereby the foal gets stuck.

IDENTIFICATION AND MANAGEMENT OF HIGH RISK PREGNANCY IN THE MARE (CONTD.)

Early intervention is the key to a successful outcome. By administering Regumate, Aspirin and Clexane to mares the problems that happen later aren't set up. Early intervention is essential and the need to get everything right, before it is too late.

Farm managers should always investigate the cause of an abortion in order to allow the correct treatment of the remaining mares. Any in-contact mares should never be mixed with those that have not been in contact with the aborting mare. Success has been seen when immediately vaccinating any in-contact mares with Valacyclovir, but at around €800 it isn't cheap. If a farm has seen the Herpes Virus in its herd it is recommended vaccinating valuable mares as soon as possible. Above all, adherence to the Code Of Practice is essential and the mixing of new horses and the in-foal band should never be allowed to happen.



Pregnant mare with a massive ventral oedema - prepubic tendon

LAWSONIA IN HORSES

*by Kevin Corley BVM&S PhD DACVIM DACVECC DECEIM MRCVS
of Anglesey Lodge Equine Hospital, Co. Kildare*

Lawsonia is a fairly new disease which was first described in pigs in 1931. It was first diagnosed in a foal in 1982, in Canada. Although originally associated with pigs, it has been found in a variety of mammals and birds, including cats, rabbits, ostriches and game fowl and it is suspected that it can be spread via these other species as well as by infected horses.

Lawsonia is a bug that lives in the cells of the lining of the intestines and causes an increase in cell mass. The wall of the intestine should be paper thin, less than 0.3cm in normal cases, but Lawsonia can cause a thickening of several millimetres. The excessive thickening of the intestine prevents it from properly absorbing fluid and nutrients, causing the foal to waste away. Studies have found that the significant growth check leads to a reduction of 32% in sales price for foals clinically affected, but racecourse performance is not affected.

Symptoms may include colic, lethargy, depression, loss of appetite, diarrhoea and weight loss, often dramatic. It can also commonly cause peripheral oedema, most frequently visible on the brisket, between the forelegs. Early cases of Lawsonia can sometimes be mistaken for Rhodococcus Equi and the antibiotics used against Rhodococcus are often effective against Lawsonia.



Ventral Oedema

Lawsonia can be precipitated by stress and is associated with weaning, a heavy worm burden, or other stressful events. It is a seasonal disease and in the Northern Hemisphere occurs mainly between August and January each year. Foals that have had a previous, unrelated, illness are more prone to Lawsonia. As weaning is one of the most stressful events a foal undergoes Lawsonia is at its peak a month or two after weaning and a foal that has been sick prior to weaning is more likely to be infected. Other foals can also be infected and shed it in their faeces, but not show any signs of infection or be affected themselves. They amplify the bacteria and act as a reservoir. Older horses rarely get Lawsonia and are unlikely to spread it, and a study in Louisiana found no evidence of spreading by mares.

LAWSONIA IN HORSES (CONTD.)

Lawsonia is difficult to diagnose, but affected foals often have a decrease in protein levels, so blood profiles showing very low albumin, at concentrations less than 20g/L, are a big sign of infection, coupled with ultrasound of the intestine wall. It can be confirmed by PCR, which identifies DNA from the Lawsonia organism. The problem for vets is that the DNA is only identifiable in the early stages of the disease. If the foal is not shedding bacteria when tested it won't be shown. Shedding does not occur in the first 10-14 days of infection, then occurs for 17-27 days, after which it stops. This very narrow window for diagnosis leads to many false negatives.

Once identified, Lawsonia can be treated with antibiotics, Engemycin, Doxyseptin, Clorom and Zithromax. No other commonly used antibiotics are effective. No foals have recovered without treatment, but there is a 93% success rate for treated animals. They need to be given a three-week course of antibiotic and if treatment is started early, within the first two weeks of infection, it is more effective. Sometimes, due to the inability to absorb fluids and nutrients, the foal requires antibiotics intravenously.

Because the spread of the disease might possibly be caused via other mammals and birds it is important to prevent other animals from gaining access to feeding areas, paying particular attention to the cleanliness of water troughs. Foals shed the Lawsonia bacteria five to seven days prior to showing clinical signs, so by the time the disease is identified in an individual the farm already has an infestation. Monitoring faeces for the Lawsonia bacteria is not cost effective and not recommended.

A vaccine (Lawsonia Intracellularis and Enterisol Zleitis), not yet licensed for horses, is available for pigs and is proving affective in foals during trials. The current protocol is to give the vaccine twice: at two months, and one month, prior to weaning.



Lawsonia emaciation in a seven month old foal

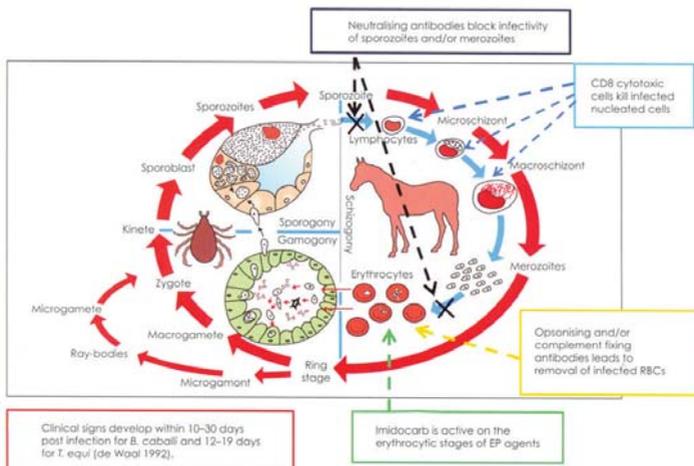
PIROPLASMOSIS – AN OVERVIEW FOR IRELAND

by Dr Des Leadon MA, MVB, MSc, FRCVS, Dip ECEIM

Piroplasmosis is an acute haemolytic disease that infects red blood cells and can infect all equines. It can be sub-clinical and therefore be hard to detect and those horses not showing signs of infection, or horses that have recovered from infection, can act as a reservoir for the transmission of the disease to uninfected horses.

It occurs in Southern Europe, the Middle East, Asia and Latin America, but there is also a trend of it moving from endemic regions to non-endemic regions, where outbreaks have occurred in Belgium, Switzerland, the Netherlands and in North America, where it spread from Mexico to Texas.

Piroplasmosis is caused by two different types of organism, the *T. equi*, which is the most serious of the two and causes lifelong infection, and the *B. Caballi*. Both strains can occur in the same horse. It is transmitted by the tick and more than 15 different types of tick can transmit the disease, none of which are thought to be currently present in Ireland, but which are present in the South East of Britain. Ticks are the main reservoir for the *B. Caballi* strain, while horses are the main reservoir for *T. equi*.



A potential threat is the risk of iatrogenic spread, which is the spread by human-aid via lack of stringent hygiene, such as the re-using of needles or through plasma. While veterinarians are aware of such risks and the precautions necessary, it is possible that other professionals with less awareness can also inject animals and therefore unwittingly spread disease.

Clinical Piroplasmosis ranges from chronic and mild, to acute and severe, which can be fatal. It can be identified by such signs as loss of appetite, poor performance, weight loss, anaemia and limb oedema, and can cause fever, colic, liver problems, kidney failure and affect the central nervous system, leading to an uneven gait and even collapse. Many of these symptoms are identifiable with other diseases, which must first be eliminated when diagnosing.

Piroplasmosis can also exist in asymptomatic carriers, those who carry the disease, but display no symptoms. Carrier mares may transmit the organism to their offspring, which may result in abortion or neonatal Piroplasmosis. The transplacental transmission occurs very early in the foetal development and foals may be born as carriers yet remain apparently healthy.

PIROPLASMOSIS – AN OVERVIEW FOR IRELAND (CONTD.)



It is currently considered to be impossible to prevent foetuses from becoming infected in utero and congenital *T. equi* infection in the foals of carrier mares is a relatively normal occurrence. The outcome of such infection is influenced by the number of parasites infecting the foetus. In naturally occurring *T. equi* abortions and neonatal Piroplasmosis cases, parasitaemias of more than 50% are frequently observed. It is thought possible that maternal antibodies ingested with colostrum, together with innate immune responses, may act to control levels of parasitaemias during the foal's early months of life.



Clinical disease ranges from acute and severe and in some cases can be fatal including Anaemia, bilirubinaemia and haemoglobinuria

Laboratory diagnosis can often be difficult. The OIE approved test for international trade since 2004 has been the cELISA, which can identify inapparent carriers, but may also produce false negatives. The IFAT can detect antibodies between three and 20 days after infection, but can also be difficult to standardise and interpret. The PCR is useful in conjunction with both tests and all three tests are recommended to ensure a correct result. However, in a test case of 25 horses who were found by PCR to be negative, 24 of those same horses returned positive by cELISA, which is the internationally approved test, and those horses are therefore unable to be transported or traded in countries such as USA and Australia, due to restriction of movement.

In endemic regions, horses develop life-long immunity and are resistant to the clinical disease. Immunity is for *T. equi* or for *B. Caballi* and there is no cross immunity. A horse immune to *T. equi* is not immune to *B. Caballi*, and vice versa. It is important to note that there is no vaccine for either strain. Endemic regions do not aim to clear the infection, but simply to control it and preserve immunity.

Treatment is available to sterilise Piroplasmosis but it causes severe local reactions, colic and can often be fatal. It is therefore considered better to leave infected horses untreated. Piroplasmosis is a notifiable disease in Ireland, but not in Britain. In the EU, there are no movement controls between endemic and non-endemic Member States. It is endemic in France.

The outbreak in the USA illustrates the necessity for careful control and adhering to the Code of Practice. In August 2008 a horse in Florida tested positive for Piroplasmosis. Several horses had been imported from Mexico and two tested positive. The transmission of the disease from these two animals was by the re-use of needles and a practice called 'blood doping'. All of the positive horses were involved in non-sanctioned horseracing. The Florida outbreak was well-controlled and the final quarantines were lifted in February 2009, but we must consider the implications for our own industry and how catastrophic a six-month quarantine could be.

A similar outbreak later occurred in Missouri in June 2009, transmitted by a Quarter Horse that participated in non-sanctioned racing. Eight horses sharing the same trainer were found to have been infected, again from the re-using of needles and less than optimal hygiene practices. Extensive tick surveillance was carried out on the premises, but only a few ticks were found and none were species capable of transmitting Paraplasmosis. Only one outbreak in the USA, at a Texas ranch producing horses for working cattle, was found to have been spread by natural means.

PIROPLASMOSIS – AN OVERVIEW FOR IRELAND (CONTD.)

An outbreak occurred in Ireland in 2009, when clinical signs were seen in a horse in June. Sampling of all horses in the same stable showed 28 of the 60 samples were positive on cELISA, but as many horses naturally carry *T. equi* or *B. Caballi* this is not a true reflection of the percentages involved.

The OIE Code of 2013 denies export certification for “An individual animal infected by a pathological agent, with or without clinical signs” and it is therefore vital to trade and competition within the thoroughbred industry that Piroplasmosis is not allowed to spread. The take home messages are:

- ✓ Ticks can survive for up to four years without feeding, so check all imported hay for ticks
- ✓ Remove all ticks and check horses diligently
- ✓ Test all blood or plasma donors
- ✓ Test your horse before entering for sales that require Piroplasmosis Negative certification
- ✓ Check Piroplasmosis certification when considering purchases
- ✓ Make full use of RESPE and IEC statistics



EHV VACCINE – EFFICACY AND AVAILABILITY

Vaccine Efficacy and Availability: ITBA Meeting December 13th, 2013

There is a shortage of vaccines available due to production issues. There is concern about the limited availability of the vaccine over the past two years and the imminent exhaustion of existing stock.

The issue was discussed by a panel, chaired by ITBA President John O'Connor, which included Lesley Hobson and Eamonn O'Sullivan of Zoetis (Ireland) Ltd, currently the sole supplier of EHV vaccines in Ireland; Dr Gabriel Beechinor, Director of Veterinary Sciences at the Irish Medicine Board (IMB); Breda Meehan, Department of Agriculture, responsible for the control and distribution of veterinary medicines; and Ann Cullinane, Head of Virology at the Irish Equine Centre (IEC).

Vaccines such as Equip® EHV (currently replaced by Pneumabort-K® due to lack of availability) reduce the incidence of abortion but do not prevent individual instances of abortion. John O'Connor pointed out that vaccinating mares against EHV was essential in protecting against abortion storms, which could wipe out entire crops with catastrophic affects for breeders. Not only is vaccinating at five, seven and nine months of pregnancy essential, but increased instances of abortion have been found on farms which failed to carry out twice yearly boosters.

Ann Cullinane gave a comprehensive overview of the disease and vigilance was called for among breeders in ensuring that pregnant mares never come in contact with potential EHV carriers. EHV can also be carried as a latent virus, reactivated by stress. Lengthy transportation, pain, isolation or bullying can reactivate EHV in a mare after a period of many years. Cullinane reminded breeders that it is essential to send all aborted foetuses to the IEC for post mortem -- a service provided free of charge thanks to the support of the ITBA.

Breda Meehan and Gabriel Beechinor spoke about the stringent process of licensing and authorising the marketing of drugs in Ireland. There is a dependence on the Zoetis Equip® EHV vaccine which, through no fault of Zoetis, is now in critically short supply. Eamonn O'Sullivan explained how a change of ownership at the Netherlands production plant and the necessary upgrading of an American plant contracted by Zoetis as a result has affected the stringent testing process and decreased manufacture of the vaccine, one that is notoriously difficult and expensive to produce.

While Zoetis expect production to be back to levels that will match demand by the end of February 2014, O'Sullivan confirmed that only 1,200 doses of Pneumabort-K® (the current stand-in for Equip® EHV) remained in stock, while he estimated only a further 500 doses were possibly still held in stock by wholesalers, a figure refuted by several vets present who had been unable to order stocks from wholesalers.

O'Sullivan recommended vets and breeders place orders for the vaccine immediately, direct through Zoetis if necessary, in order for special licenses to be granted for the importation of alternative vaccines. Both Meehan and Beechinor gave assurances that special licenses could be authorised within a very short time frame.

With a thoroughbred broodmare population of 12,000, the essential nine-month vaccination now due and the current movement of mares, from sales and for coverings, the situation is critical and 1,200 doses clearly insufficient. Des Leadon urged breeders to refer to the Code of Practise and to put in place bio-security measures that can be used in the absence of vaccine. Shane O'Dwyer also promised the ITBA would monitor compliance of the Code of Practise on stallion farms.

Tell us!

If you have any suggestions for topics for the 2014 Evening Lecture Series, we'd love to hear them.

Contact us at the details below.



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