Prepurchase Examination of Jumpers and Dressage Horses

Daniel Marks, VMD

A rigorous examination aided by a check list, careful recording of findings, knowledge of the horse's discipline and awareness of legal liability are necessary for a satisfactory pre-purchase examination. Clear communications with all parties can help avoid misunderstandings and upsets. Author’s address: 59 Winding Rd., Santa Fe, NM 87505. © 1999 AAEP.

1. Introduction

This presentation focuses on aspects notable to jumpers and dressage horses, with some remarks about show hunters. The author’s experience as a practicing veterinarian and as a legal consultant leads to the following observations.

Today’s pre-purchase examination occurs in a different equestrian milieu from that of 30 years ago. Buyers are more litigious and frequently have less understanding of the uncertainties of horses and the limitations of a pre-purchase examination. The prices of elite competitive jumpers and dressage horses have escalated dramatically. They are often treated more as a business investment than an avocation. Purchasers and their agents expect expertise from the examiners, including familiarity with the horse’s proposed activity and a knowledge of the pertinent veterinary regulations for proposed competitions.

The days of the charming, roguish horse dealer and “caveat emptor” should be behind us. The seller is responsible for furnishing information that in the past would have been considered inappropriate to ask. However, by neglecting to ask these questions, the veterinarian may be placed at a medical disadvantage or even in legal jeopardy.

2. Discussion

The work sheet can serve as a check list of the points to be inspected, a record of all findings, a record of any limitations of the specific examination, a source to compile the report to the buyer and a legal document. This work sheet should not be given to the buyer and is not a pre-purchase report. The form used here (see Appendix) was derived from a much simpler and shorter one. The additions result from mistakes the author has made, situations encountered in doing legal consultation and the experience of others. Check boxes indicate a completed phase of the examination, and places to circle expedite note taking. As stated by Werner and Moyer, “Failure to properly record places the integrity and value of the final report at serious risk.”

The intended use of the horse should be clearly agreed on by both buyer and seller. A horse who could engender reservations for use as a grand prix jumper might be considered acceptable for competition over much lower fences. The focus of the examination and interpretation of the findings

NOTES
may vary depending on the intended use of the horse.

3. History
The answers to these questions can offer indications of serious problems, clues for further investigation, evidence that might qualify clinical findings and information that may be helpful to the buyer if he or she acquires the horse. Work and competitive histories are relevant. Other questions are for general information. Some pertain to problems that the clinician would have no way of ascertaining at the time of the examination, such as bleeding, repeated colic or anhidrosis. The veterinary history is included.

Vices are a vague subject; some can be trainer induced or dependent on heat cycle. What is an acceptable vice in one case may be totally unacceptable in another. A professional might be quite willing to deal with a kicker, but a parent might not want one for a child. I report the history and anything I see.

No questions specifically address suitability, i.e., the horse’s qualifications for doing its job. Medical condition is but one factor. The veterinarian should comment only on the medical aspects, with one exception: safety. I will not be a party to potential injury by omitting information. This position is controversial, with advocates for the veterinarian’s duty on all sides.

The seller or agent is required to sign the history. The seller/agent also should sign a release if the footing is precarious (uneven, slippery, frozen). It is a good policy to have the seller or the seller’s designee lead, longe and ride the horse.

4. Description
The description must be complete in order to verify identification and should be compared with any passport or registration papers.

The people present at the examination can have importance where there is controversy or even litigation, and should be noted.

5. Laboratory Tests
The routine laboratory tests consist of drug testing (both blood and urine), Equine Infectious Anemia, complete blood count, fibrinogen, glucose, and serum proteins. If the horse is a candidate for export, equine viral arteritis (EVA) is also tested. If the horse is being imported, Piroplasmosis, EVA, and Contagious Equine Metritis (except in geldings) are also checked.

6. Clinical Examination
A. Eyes
If eyes must be dilated, the author waits until after the horse is ridden. Dressage and jumping horses are allowed to compete with one eye. Loss of an eye does not usually detract from a horse’s ability as a jumper. This has been substantiated by several successful one-eyed horses, including an Olympic double gold medal winner. Hunters are not allowed to compete with loss of vision in an eye.

Appaloosas have approximately nine times greater predilection for severe recurrent uveitis than other breeds. Therefore, any evidence of previous uveitis is statistically more significant in this breed.

B. Perineum
The temperature is taken, and the tail tone and perineum are checked. Tail blocks are sometimes done on hunters. The perineum and ventral tail of grey horses should be palpated carefully for small melanomas.

C. General Condition
Muscle, fat and coat condition are recorded. These factors can be altered radically by long transportation and quarantine times.

D. Integument
Pin-firing or freeze-firing marks are recorded, as are any active lesions or significant scars.

E. Ears
The ears and hearing are checked. Ticks (Otobius megnini) can cause headshaking, muscle tremors and other neurologic signs.

F. Respiratory System
The respiratory requirements for jumpers and dressage horses are modest compared with those of racehorses or advanced 3-day horses. The larynx is palpated, and surgical scar sites are investigated. The parotid region is checked for melanomas. The neck must be extended and relaxed to detect a scabbard trachea. Lung auscultation at rest is best accomplished with a rebreathing bag. Generally, endoscopy should be performed even if the horse does not make a noise. Ethmoid hematomas, tumors, early arytenoid chondritis, epiglottic entrapments and cysts can all be present without an abnormal noise at exercise. A slap test is performed for neurologic evaluation. If a respiratory noise is not consistent with the endoscopic appearance, treadmill examination is considered. This is the only way to diagnose a displaced soft palate, epiglottic eversion, pharyngeal collapse, intermittent epiglottic entrapment or ary-epiglottic fold intrusion.2

Laryngeal hemiplegia in show jumpers usually is of no consequence, and many successful horses have been untreated roarers. However, it can be psychologically disturbing as well as physiologically limiting, especially if the horse has a flexed, constrained head carriage. The same applies to dressage horses. The American Horse Show Association (AHSA) states that a hunter must be “sound of wind.” Therefore, any abnormal noise could cause disqualification.

Chronic obstructive pulmonary disease (COPD)
can be exacerbated by traveling because of lack of control over shipping, stabling, bedding and feed. If COPD can be managed without use of prohibited medications, horses usually can compete.

Nasal bleeding is usually of three types:

1. Exercise-induced pulmonary hemorrhage (EIPH) is recurrent and precipitated by strenuous exercise. I have not seen EIPH in dressage horses or hunters. Although it is not common, jumpers can have typical “race horse EIPH” that can progress to career-ending severity. A particular indoor show, with very poor ventilation, had many times the usual numbers of EIPH occurrences in jumpers. A one-time episode can be associated with an early viral respiratory infection and usually has no future significance if treated appropriately.

2. Mild epistaxis associated with less strenuous work is usually attributable to an ethmoid hematoma. A tumor can also cause this.

3. Spontaneous severe bleeding, not usually associated with exercise, can result from a mycotic infection invading the internal carotid artery in the wall of the gullet pouch. This necessitates expeditious surgery, which is generally successful.

G. Cardiovascular

Cardiac capacity is rarely a limiting factor in jumpers, dressage horses or hunters. I have seen high-level jumpers compete successfully with atrial fibrillation and aortic or mitral insufficiency. The presence of murmurs (even flow murmurs) and abnormal arrhythmias should be noted. The fear of sudden death from a “heart attack” is prevalent although in horses, unlike in people, most result from aortic rupture. Cardiac disease usually is progressive. Of course, progression to congestive failure can end a horse’s usefulness. An ECG and ultrasonographic examination are worth consideration to document and clarify potentially serious abnormalities.

H. Gastrointestinal

The mouth is important because of the bit. Surgical shortening is used to correct tongue protrusion (“tongue lolling”). The condition of the tongue, teeth, bars and commissures of the lips affect the ridability of the horse if a bit is used—as it must be in all horses except jumpers.

The abdomen is examined for surgery scars. Surgery confers a six times greater risk for fatal colic, depending on the type of surgery, the length of time since the surgery and the history during this time. I am familiar with a dressage horse and a jumper who competed with large, healed postsurgical hernias with no untoward disabilities.

Gastric ulcers are sometimes clinically benign or can cause varying degrees of anorexia, repeated colic and a decline in condition and performance. A long gastroscope is necessary for definitive diagnosis. More than 90% of race horses in training have been reported to have ulcers. Although the number in show horses is probably less, this seems to be an underdiagnosed condition.

I. Conformation

Any obvious conformation abnormalities are recorded, as well as movement and shoe wear. In the report to the buyer, the following are deemed worthy of mention:

1. a strong probability that a defect will impact the eventual soundness, e.g., short upright pasterns in a grand prix jumper;

2. a particular conformation that might accentuate a clinical or radiographic finding, e.g., front toed-in conformation accompanying a lateral suspensory branch lesion; and

3. an obvious conformation defect that is unlikely to have an impact on future soundness, e.g., over at the knee. This should be noted to dispel any qualms.

J. Musculoskeletal

This segment also incorporates parts of the neurologic assessment. It includes observing the horse being led from its stall, at rest; and in hand on a hard surface—backing up, walking and trotting straight lines and circles. Results of front and hind flexion tests and others, e.g., hind retraction tests, are recorded. A positive response to front fetlock and pastern flexion, with no other signs of lameness or pathology, is found in sound horses and should not be used as a sole criterion for evidence of a problem. Positive results of hind flexion tests, supporting the leg above the fetlock, are usually a source of concern. The horse must be relaxed and go with its head free to move. If this cannot be accomplished by horsemanship, 25 to 100 mg of xylazine or 5 to 10 mg of acetylpromazine can be used without masking lameness. Very small walk circles are performed to evaluate neurologic function. If possible, the horse is walked and trotted up and down hill normally and with the head elevated and also backed uphill. Next is longing at all three gaits on soft, deep footing. The horse is ridden in its normal competition balance. Along with normal gaits, I like to observe a reinback, changing diagonals every 10 steps on a straight line and in both circles, small figure eights at the trot with an abrupt change of bend, extended trot, tight canter circles, flying changes and galloping on both leads. The heart and lungs are then ausculted. Other movements can be observed. The horse is not jumped unless it is requested by the buyer or there is a question that might be elucidated by jumping. Generally a horse jumps away from a sore front leg and
lands going at an angle rather than straight ahead. Hind-leg lameness customarily causes it to jump toward the sore limb.

Jumping and dressage prepurchase examinations should focus on the front feet and pasterns, hocks, front and hind suspensory ligaments, axial skeleton, locomotor muscles, and stifles. Less commonly a source of problems, but also important, are the fetlock joints, front superficial flexor tendons, splints, bicipital bursae, and check ligaments.

The front legs and feet are examined. The type and quality of shoeing is noted, as is shoe wear. An example of the many factors the veterinarian must consider before reaching a conclusion is demonstrated by an oddly shaped or small foot. In this case, the following factors are relevant: history of previous lameness; conformation that may relate to the foot; musculoskeletal pathology in the leg; shape and quality of the hoof; wear of the shoe or foot; shoeing; response to hoof testers and percussion; the flight of the leg and the foot landing and breaking over; evidence of lameness (especially in small circles on hard going, preferably on a slight incline); other tests (such as toe elevation prior to trotting); radiographic findings; the veterinarian’s knowledge of the intended discipline; and consideration of the buyer’s circumstances, e.g., quality of the farrier (a good farrier might be needed to maintain difficult feet), schooling surface, probable show schedule and show footing. Slight differences in size and shape of the feet are common and not necessarily abnormal. Some variation may result from the left handedness of most horses. An upright foot (“club foot”) can be functional depending on radiographic changes and shoeing. Foot lameness is usually more apparent on hard going and frequently accentuated by circling. This ranges from a minor sole bruise to irreversible “navicular disease.” International regulations prohibit any sort of nerving. Navicular disease includes several variants. Radiographs do not always correlate with clinical signs, but certain lesions are cause for concern to the author; i.e., multiple large lollipops, central radiolucent areas, radiolucencies that can be shown on the skyline view to break through the cortex, and large well-defined cysts. Many horses with mild navicular disease, if shod and managed well, are acceptable for pleasure riding and easy competition, but jumping big jumps is not compatible with navicular sensitivity. Dressage riding surfaces are forgiving of foot problems, but a tendency to shorten stride is not a good thing in a dressage horse. Corners, zig zags, extended trot, and tempo changes are movements in which navicular disease may degrade performance. Hunters can compete with mild navicular disease provided that the gallop stride is naturally long and the going is forgiving. Some horses with caudal hoof pain have a laminar tearing rather than an internal foot problem. Pedal osteitis and deep bruising may sometimes reside in the subchondral bone of the third phalanx (P-3). Ossification of the collateral cartilages (sidebones) is frequent, especially in horses with draft blood. It is rarely associated with lameness; nor do asymmetrical ossifications relate to uneven foot loading. However, navicular spurs can result from extremely uneven hoof loading. Laminitis/founder have so many variables that each case must be evaluated on its own merit.

The front and hind proximal interphalangeal joints frequently show slight radiographic remodeling of the dorsoproximal articulation of P-2 as well as changes of shape of the hind pastern bones. This seems to be more frequent in warmbloods. Although these changes are usually of no clinical significance, proximal interphalangeal degenerative joint disease (DJD) develops occasionally. Distal interphalangeal DJD that is demonstrated radiographically, is quite serious. Short, upright pasterns predispose to interphalangeal joint disease. A small, smooth, radio-opaque density at the apex of the extensor process is, by itself, usually benign.

Suspensory apparatus disorders include high suspensory disease (HSD), suspensory body and branch desmitis, lesions of the sesamoid bone, and distal sesamoidian ligament injuries. Front-leg HSD—which the author suggests is primarily an attachment desmopathy with or without significant desmitis—is very common in sport horses. Horses with mild lameness from front-leg HSD, surprisingly, can compete satisfactorily over big fences, frequently with little or no increase in lameness. Once the lameness has resolved, about 20% of jumpers have a recurrence. It is a late-bearing lameness that is most easily observed with the horse circling at the trot in deep going, with the affected leg on the outside of the circle, or trotting down a slight grade. Work tends to decrease the lameness. Proximal suspensory ligament involvement of the hind leg behaves clinically and therapeutically quite differently from front-leg HSD, and it is one of the most serious and difficult conditions with which to contend. Chronicity and recurrence are frequent and are exacerbated by collection. This lameness is characterized by limited protraction at the trot and may first be evident in the extended trot, especially when the horse is turning. Unlike front HSD, in hind HSD the lameness usually increases during a riding session and seriously detracts from jumping and dressage. Grand Prix dressage horses may have to be retired. This condition tends to be associated with a straight hock, but it is found in other conformations. Dr. Sue Dyson has suggested that the lameness is the result of a chronic neuritis, which would explain the clinical signs better than a desmitis.9 Front or hind suspensory body and branch lesions are frequent in athletic horses and are the most common cause of athletic retirement in jumpers. Ultrasonographic evidence of fibrosis between the hind branches connotes a poor prognosis.9 Stretching of the suspensory ligament, which permits greater pastern translation, can lead to a

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progressive debility and loss of athletic use. Straight hocks and sloping pasterns are associated with branch and body stretching. While this usually develops in old mares, it can affect horses in their prime as well. Radiographic evidence of sesamoiditis does not seem to influence soundness. Sesamoid fractures are rare, except in ex-racehorses, but can be significant. Only severe radiographic sesamoiditis is usually associated with lameness.

Fetlock DJD is more prevalent in warmbloods than in Thoroughbreds (except for racehorses) and can involve the hind joints as well. Small, smooth “chips” associated with dorsoproximal P-1 are usually unimportant if the joint is otherwise not remarkable. Larger and multiple lesions are cause for concern. Even without obvious lameness, metatarsophalangeal joint disease can affect jumping.

Healed superficial digital flexor tendinitis (bowed tendon) is usually well tolerated by sport horses, except for elite jumpers competing over large fences (World Championship, Olympic Games). In the 1960s and 1970s, when the jumps were considerably larger, the incidence of bows and rebows approached that of race horses. However, most affected horses were able to compete again. Palpable, nonsensitive thickening of the distal check ligament is occasionally felt. Usually this has not caused past lameness, nor is it necessarily a cause for concern.

Digital sheath enlargement (“windgalls”) usually is reasonably symmetrical and benign. Extreme distention also involving the distal pouch can result from chronic inflammation. If synovial proliferation and adhesions develop, they may cause lameness that is difficult to treat. Palmar annular ligament constriction usually is multifactorial and may include thickening of the subcutaneous tissue, annular ligament thickening, chronic synovitis, superficial or deep digital tendinitis or involvement of the encircling ring of the superficial tendon. Although these structures all can be involved, proliferative synovitis is the most frequent. Thickening or stretching of the digital annular ligaments has similar causes, and thickening of distal ligament is an indication of deep digital flexor (DDF) tendinitis. The most frequent location for pathologic DDF changes, including longitudinal tears, in both front and hind legs is within the digital sheath. Therefore, healing is slow and there is a tendency to develop adhesions, which are serious. An ultrasound examination is necessary for accurate diagnosis in annular ligament and digital sheath conditions.

Splints are customary but usually of no clinical significance. Some, especially lateral splints, heal slowly and can occasion protracted lameness. A large splint detracts from a conformation hunter.

Axial skeletal soundness is very important for jumping and dressage but not as important in hunters. Mild back soreness may be acceptable for low-level jumpers and equitation horses, because limitation of back movement can make them easier for less skilled riders to sit on in the air. With higher jumps, sore backs may manifest by flat jumping, inadequate use of the hind end, inability to shorten to oxers, bucking and anxiety leading to disobedience. Dressage horses with thoracolumbar pain have difficulty with zig zags, circles and piaffe. The universal complaint is that a horse will not “come through,” i.e., educated riders feel a lack of connection between the forehand and hindquarters.

I examine the temporomanidular joints, neck, forehand muscles, withers and back, including the area around the tuber sacrale, sacrum, pelvis, gluteal and hamstring muscles and the tail. The neck is manipulated to evaluate flexibility and pain. Cervical muscle soreness is the most common condition, but facet joint arthritis, equine protozoal myeloencephalitis (EPM), vertebral stenosis and spinal root nerve impingement all can cause neck pain and in some cases changes in cutaneous sensation. Healed fractured withers usually are of little significance except for saddle fit. Back flexibility and pain are evaluated visually by palpation of both the muscles and the vertebral processes and by incorporation of various maneuvers. An effort is made to distinguish between muscular and skeletal pain.

Radiography (and nuclear scans) can be helpful if the latter is suspected. Palpable pain in the lumbo-sacral space and lateral to the tuber sacrale (but not of the tubera) may indicate “sacroiliac” soreness. It will cause reduced power pushing off and may also be evidenced by difficulty resisting with the hind legs in abrupt halts. In more severe cases it causes mild lameness. If the condition is chronic, it tends to recur with increased work and will degrade jumping and dressage. Gluteal and hamstring soreness are common in athletic horses and, although usually transient, can be chronic. This is especially true of gluteal myositis/tendinitis, first described by Dr. Edwin Churchill. Even without demonstrable lameness, gluteal soreness is likely to degrade jumping and extreme collection significantly. Coincident with examination of the axial skeleton, acupuncture points relative to the musculoskeletal system are palpated.

A healed, fractured tuber coxae (“knocked down hip”) usually has no effect. Mechanical lameness results infrequently. This does not usually impair jumping but may make the jog at international shows a sticking point. Dressage judging penalizes any gait unevenness.

Inflammation of the distal intertarsal and tarsometatarsal joints affects more than 50% of all jumpers and grand prix dressage horses and requires treatment for maintenance of peak performance. Usually the condition is bilateral but not symmetrical. A combination of shoeing, management and medication generally is successful. Many horses will require intra-articular injections. Defective flying changes are one of the first signs of a problem. The correlation between radiographic appearance...
IN DEPTH: PURCHASE EXAMINATION

and clinical findings is not good except with severe changes. Angulated hocks (curby) with a narrow lateral dimension and a suggestion that the bend of the hock is carried through the distal joints are unsuitable for demanding collection. The extreme of this is a collapsed central tarsal bone. Small figure eights at a trot, flexion and splint manipulative tests and sensitive acupuncture points may provide diagnostic information. Distention of the tibial tarsal joint (bog spavin) usually results from an osteochondrosis dissecans (OCD), customarily situated on the intermediate ridge of the tibia. Most cases do not affect performance, but large pieces can cause lameness and require removal. Avulsion of the hind superficial digital flexor tendon from the top of the tuber calcis occasionally occurs in jumpers and cross-country horses. The tendon tends to form a fibrous track, and the horse will continue to have a slight mechanical lameness; in one case the condition was bilateral and the gait symmetrical. Some horses have returned to compete successfully in jumping and 3-day eventing. Permanent lameness ensues when the tendon continually slips on and off the tuber calcis. An achilles tendon strain heals slowly and may recur in jumpers. Warmbloods tend to have enlargement of the lateral digital extensor tendon sheath just distal to the hock that is functionally insignificant.

Stifle soreness is common in sport horses. Although it usually is radiographically and scintigraphically negative, the lameness responds to local anesthesia or intra-articular anti-inflammatory medication. OCD of the lateral femoral trochlea may or may not cause dysfunction, depending on the size, number, and location of defects. Palpable synovial distention or manipulative sensitivity is cause for concern. Cysts of the medial femoral condyle (especially if they are close to the joint), DJD and cruciate ligament rupture constitute serious pathologic stifle changes. DJD localized to one joint can cause the horse to load the foot unevenly, and lameness is especially evident in lateral work. Patella fractures are rare in jumpers but happen with 3-day event and timber horses.

Carpal joint disease is uncommon in sport horses. Fractures or conformation that would preclude racing may be inconsequential for dressage, jumping, or hunting. Actually, hunters that are back at the knee tend to move in a way that judges favor. Healed accessory carpal fractures usually are insignificant unless there are signs of carpal tunnel distension. This fracture rarely occurs in sport horses; rather, it happens in the horses that race over fences. Jumpers incur direct trauma to the extensor carpi radialis tendon, which can also tear the retinaculum and cause bursal enlargement. This is only cosmetic if there is no limitation to range of movement or sensitivity with flexion. In the latter case, tendinitis of the common or lateral digital extensor tendons and their sheaths should be investigated.15,16 Stringhalt is not compatible with dressage performance, but I have seen several effected jumpers perform successfully.

Shivers or shivering is another idiopathic condition that has more than one form and occurs in halfbreds. Several top-class jumpers with this condition have competed for years with no obvious progression of signs. It may be genetic, principally attributable to draft blood, which causes a polysaccharide storage disease. A muscle biopsy is required for diagnosis. In such cases a high-fat diet is the treatment.17,18

Bucked shins and healed cortical fractures are not a problem in sport horses. Coxofemoral, elbow joint and scapulohumeral lameness, except for OCD in warmbloods, are seldom seen. Bicipital bursitis is common.

Traumatic incomplete fractures can be caused by a fall. These may become catastrophic complete fractures a week or two later.

K. Neurologic

It is essential to perform a neurological examination to detect mild problems that may not be evident without specific tests. Most of the cranial nerves have already been assessed. When crossed front leg proprioceptive tests are being performed, the crossing leg should stand reasonably flat on the foot. I consider replacement that takes more than 3 seconds abnormal. The walk circles should be small enough to cause consistent crossing of the hind legs, but with enough foreword motion to allow this. Excessive abduction of the outside hind leg, failure to cross consistently behind, striking of the other hind leg and pivoting on the front feet should be noted. Sway tests are routinely performed at rest and in motion. Observation in motion in the musculoskeletal examination is necessary for neurologic evaluation, especially head elevation, longing canter circles and observation of the horse for sway and the gait for hypermetria or hypometria—toe dragging is best noticed in a deeper surface and can cause polishing of the dorsal hoof wall. One of the qualities of spinal disease is inconsistency in gait patterns. This can be seen by noting the relationship of the hind foot imprint to the front imprint. Cutaneous sensation, blindfolding, leading over raised rails, hopping tests and observation of the horse running free (having to make abrupt stops and turns) all are useful to further confirm neurologic status. Tired horses are more likely to show neurologic deficiencies.

Dressage horses and hunters with mild “wobbler” syndrome actually can compete at a top class. Jumpers and 3-day horses are unlikely to do so. Unless there are signs of neurologic disease, I do not test serum for EPM.
L. Reproduction

A visual examination is made of the external genitalia. Mares are examined rectally and with a vaginal speculum. Cultures also may be performed. Many warmblood mares are bred at 2 years and then trained at 3. If an in-depth reproductive evaluation is requested, I engage a specialist to supplement my limited skills.

M. Radiography and Other Imaging

The front shoes are removed before radiography. The sole and white line are inspected, and the horse is jogged barefoot.

The following radiographs are routinely taken as survey films for superior dressage and jumping horses and may be modified according to clinical findings: front foot, 5 views (the dorsal wall should have a marker on the lateral view to show any rotation and to measure the wall thickness); fetlock, 3–5 views; front third metatarsal bone, AP exposed to visualize proximal sclerosis that may suggest a high suspensory desmopathy; carpus, usually not viewed unless the horse has recently raced or clinical signs warrant it; hind fetlock and pastern, 2–5 views; hock, 4 views AP, slightly overexposed to evaluate any sclerosis of the metatarsal bone; and stifle, 2 or 3 views. Ultrasonography, scintigraphy, and thermography, may be illuminating, but the purchaser should be consulted if there is significant additional expense.

N. Video

At times it is useful to document some parts of the examination with a still camera, or better yet a video camera. Gait abnormalities can be studied in slow motion, and lameness, neurologic deficits and conformation can be appraised by colleagues for additional opinions. These findings are also memorialized for legal purposes, and the tape can serve as a baseline to compare future findings.

7. Summary

The purpose of the examination is to furnish the prospective buyer with medical information germane to the decision whether or not to buy the horse. It is not to certify soundness, nor to guarantee the horse.19

Clear findings usually are not a problem, but in interpretation of the grey areas, the experienced practitioner can make an informed appraisal of the current medical status and the probable implications of these findings relevant to the horse’s intended occupation.

Following are my personal forms for your reference and use.

8. Appendix
Please Return To: Don Marks, VMD 59 Winding Rd. Siena, NY, US. 518-873-0013
Name: __________________________

Scar. No.

Subcutaneous Neur.

"Efferent" Neur.

"Afferent" Neur.

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References and Footnotes


*Dyson SJ. Personal communication.