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17.15–17.40

Practical corticosteroid use

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Corticosteroids remain one of the most frequently used drugs for the treatment of orthopaedic conditions in competition horses. This presentation will concentrate on the intra-articular use rather than the less frequently employed systemic and topical routes.

Corticosteroids have traditionally received a rather 'bad press' with respect to their potential for causing cartilage damage. Certainly the drugs can be over-used but if the right products are used in appropriate dosages, in horses with actual joint disease they can be most helpful drugs. The majority of research work suggests that triamcinolone is more chondroprotective than betamethasone or methylprednisolone acetate (MPA), and is generally considered the drug of choice in our practice. MPA has been shown to have deleterious effects on cartilage and its use is not encouraged. With appropriate aseptic technique for injection the risk of infection is very low in practical terms. I would not normally administer intra-articular antibiotics as a routine, but would inject 100 mg of amikacin along with corticosteroids if the joint had been blocked in the previous week.

Injection with corticosteroids is often combined with hyaluronic acid. There is no firm evidence that this is beneficial but it may possibly ameliorate some of the deleterious effects of corticosteroids as well as having a beneficial effect in its own right and many clinicians comment that they may get a longer duration of positive effects after medication with steroids if they are combined with hyaluronic acid. Because of the risk of laminitis I would normally use a maximum dose of 20 mg of triamcinolone in a sport horse. Racing Thoroughbreds seem more

resistant to developing laminitis and a dose of up to 40 mg would commonly be used in our practice. A dose of 5–10 mg per joint would be used generally, depending on the number of joints to be treated. Methylprednisolone acetate still tends to be used more in low-motion joints and for infiltration into the back and sacroiliac region. I have used combined injections of up to 200 mg of methylprednisolone acetate with the simultaneous injection of 20 mg of triamcinolone in cases needing medication of multiple regions.

In a retrospective study in our practice, only 3 horses out of 2000 receiving joint injections developed signs of laminitis and 2 of these were transient bouts in ponies which had previously had laminitis. Thus the owners must be warned of the risk of laminitis, albeit a very low risk if the products are used appropriately. The limbs are routinely bandaged for 24 h after injection. My standard routine is to box rest the horse for 48 h from the time of injection, followed by 2 days of box rest and hand walking exercise, followed by a gradual return to exercise, depending upon the degree of lameness and the pathology being treated. I prefer not to treat a joint more than 2–3 times annually and if there is a diminishing response to medication, then the diagnosis should be reviewed and alternative treatments considered.

Withdrawal periods for medication control at competitions may also influence the choice of corticosteroid. MPA has a long and variable detection time, and its use during the competition season is discouraged. I use a withdrawal period of 13 days for triamcinolone and 3 days for dexamethasone.

NOTES
