Date: June 21, 2022
Owner: Susanna Eriksson
Horse: Donna Tess – 14 Year Old Warmblood
Patient ID: 1604411
Ref Vet: Dr. Elin Skärlina

CLINICAL HISTORY:
Trauma to the left front limb yesterday with severe lameness and several wounds; medially to the cannon bone, dorsally over P1, dorsally and medially in the coronary band. Lameness blocks to a ASNB. Radiographs reveals comminuted fracture of the coffin bone and substantial gas suspectedly localised in the coffin joint. Ultrasonography reveals ecogenic spots in the coffin joint fluid and suspected trauma to the medial collateral ligament. Synovial tap is blood contaminated and difficult to interpret. CT performed to get more information about the extent of the fracture and the extent of joint involvement. We also highly suspect that the wound has penetrated the joint capsule and/or that the fracture is open, but we have not been able to confirm this. New tap during CT exam is also sanginous, pressure test of the coffin joint is negative.

COMPUTED TOMOGRAPHY FINDINGS:
LEFT FRONT DISTAL LIMB:
There is a moderately sized wound along the dorsal aspect of the proximal pastern that does not extend to the margin of the proximal phalanx. A small amount of gas is present in the medial and lateral, palmar soft tissues of the pastern region that may be iatrogenic or traumatic. The subcutaneous tissues of the pastern are moderately, circumferentially thickened.

There is a complex, comminuted articular fracture of the distal phalanx. There are multiple fracture lines that extend in multiple directions:

- "Y" configuration fracture that extends in a dorsal-lateral to palmar-medial direction with branching of the medial, palmar component of the fracture
    - One branch of the Y extends through the medial compact bone of the distal phalanx and communicates with the fossa of insertion of the medial collateral ligament of the distal interphalangeal joint
    - The substance of the MCL is normal in attenuation
- Transverse fracture line at the junction of the body of the distal phalanx with the medial wing with small, comminuted fragments in the axial aspect of the fracture
- Oblique fracture extending from the dorsal fracture margin in a curvilinear, palmar-lateral direction into the lateral wing
    - Short oblique fracture line extending distally and towards midline from this fracture
- Solar margin fracture of the toe of the distal phalanx

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There is a wound along the medial aspect of the limb at the level of the coronary band. A small gas focus is present in the navicular bursa.

There is a small, curvilinear mineral attenuating focus along the distal margin of the navicular bone, slightly lateral of midline.

There is a small amount of granular mineral attenuating material in the scutum arising from the palmar, proximal, medial margin of the middle phalanx. The dorsal, proximal margin of the middle phalanx is mildly roughened.

A small to moderate volume of effusion is present in the fetlock joint and digital flexor tendon sheath.

There is a moderate amount of well-defined, mineral attenuating material in the region of the intersesamoidean ligament.

IMPRESSIONS:
Complex, comminuted, articular fractures of the distal phalanx as described above. Multiple wounds are present along the limb, consistent with the history of trauma. Gas is present within the navicular bursa on the pre-contrast images, which is concerning for a septic process though a communication between a wound and the navicular bursa is not identified. Gas is not identified within the distal interphalangeal joint and a clear communication between the distal wounds and the joint are not identified. Effusion of the fetlock joint and digital flexor tendon sheath is likely reactive.

Mineral focus along the distal margin of the navicular bone is likely traumatic though it is unclear if it is arising from the distal phalanx or navicular bone.

Mineral foci in the region of the attachment of the scutum on the middle phalanx may be secondary to chronic enthesopathy or acute avulsion.

Chronic dystrophic mineralization of the intersesamoidean ligament.

Stacie Aarsvold, DVM, DACVR, DACVR-EDI

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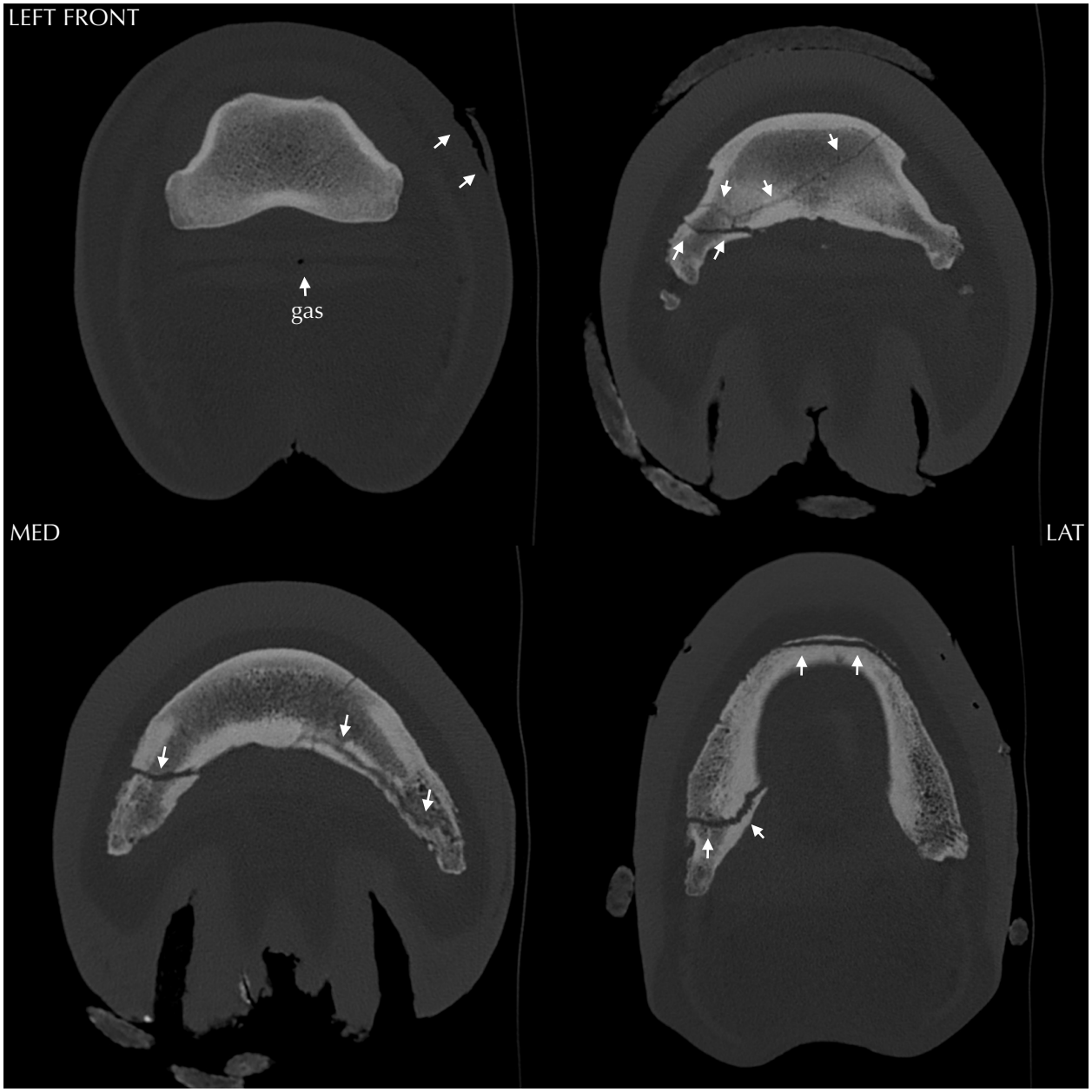

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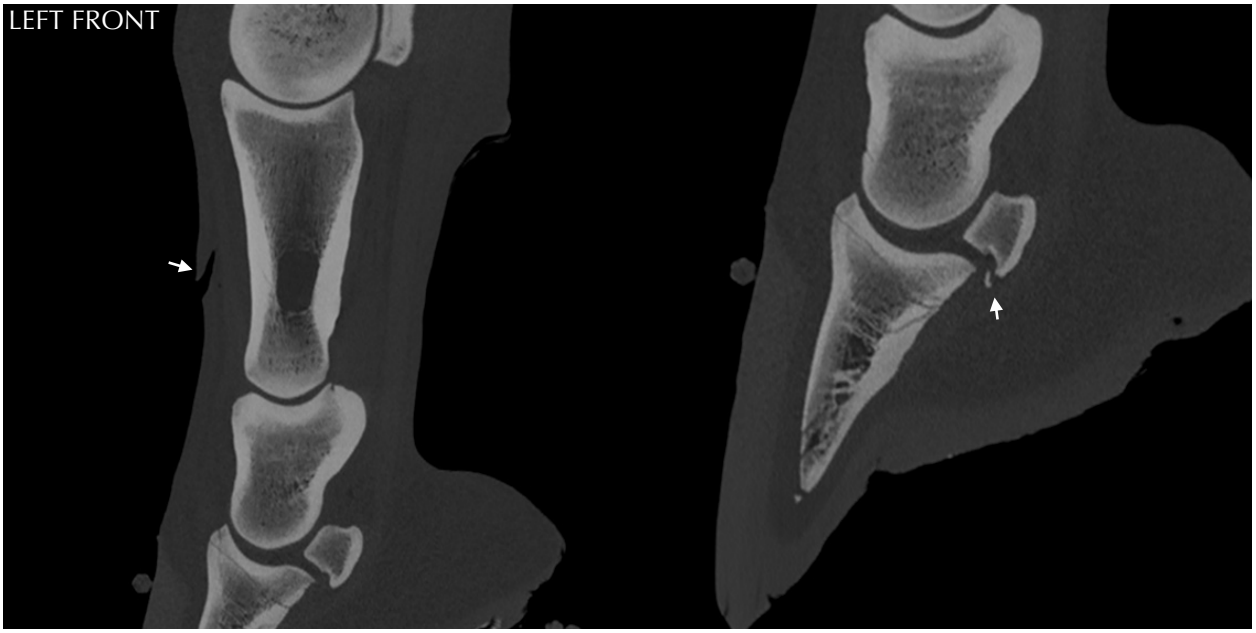

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