The most recent outbreak of Equine Herpesvirus myeloencephalopathy has finally subsided. Once again this outbreak served to alert horse owners and veterinarians of how prevalent and devastating EHM can be and how rapidly it can spread across state and even country borders. Work by Allen et al has shown that this Herpesvirus mutant has established a well-entrenched reservoir of latently infected horses. Outbreaks of EHM have been observed since 1966 but appear to be increasing in frequency along with significant patient morbidity and mortality. Horses demonstrating neurological signs associated with outbreaks of EHV-1 were more sporadic prior to 2000. (Allen AAEP white paper and GP Allen AJVR 2007).

The principal mode of transmission is horse to horse via the mucosal epithelium of the upper respiratory tract. Recent episodes in the United States are the result of a mutant strain of the Herpesvirus, however it is important to remember that both wild-type and mutant strain of EHV-1 can cause neurological disease. Nasal shedding may last up to 14 days with clinical signs observed within 3 to 6 days after exposure. To prevent disease in naïve animal’s best practices should include vaccine maintenance, although existing vaccines may not provide sufficient protection. Vaccine ineffectiveness may be a result of exposure to a large quantity of virus or exposure to a particularly aggressive strain of virus or suboptimal performance of currently available vaccines.

How do we know it’s EHM? Typical clinical signs may be very helpful with identification of infection by this virus. These clinical signs include ascending neurological deficits such as poor tail tone, urinary incontinence, weakness and ataxia beginning in the pelvic limbs. Identifying a significant rise in complement fixing or virus neutralization antibodies in acute and convalescent serum titers collected 7 to 21 days apart is useful. Tests such as PCR on nasal swabs or blood samples, viral culture, and immunohistochemistry may be used to establish a definitive diagnosis, although in some cases a post-mortem examination is required.

The management of horses with suspected EHM should be directed at achieving a safe environment and providing excellent nursing care. Isolation of horses which are suspected or known to have EHM is critical to help prevent spread from horse to horse. The individual horse with obvious bladder dysfunction should quickly and as frequently as possible have aseptic evacuation of the bladder. Administration of anti-viral agents such as use of valacyclovir has been quite positive recommending doses of 27 mg/Kg three times a day orally for one week followed by 18mg/Kg twice daily for 14 days.
To reduce the risk of large-scale, farm wide outbreaks of EHM herd management procedures should be employed. The procedures considered to be the most effective are dividing the at-risk population of horses on the premises into smaller groups; keeping those sub-groups in closed, physically isolated units; and minimizing the stress caused to horses by crowding, poor nutritional state, heavy parasite infestation, lengthy transport, disruption of established social groups, inclement weather, *en masse* weaning, etc. Smaller group sizes with each group maintained under conditions that limit the transmission between the groups helps to maximize effectiveness. Management should restrict moving horses in and out of each established group and avoid any contact with transient horses. Adding a new horse to a closed group should be preceded by a 21 day isolation period.

Understanding the disease, following proper vaccination protocols along with best herd health practices are important factors for the horse owner to reduce the threat of EHM. In addition, employing good biosecurity practices at home and away at competitions and knowing how to respond when outbreaks occur is critical in safeguarding your horse from the devastating impact of EHM.