VET 433B: Feline Chronic Enteropathy

Feline Chronic Enteropathy

- Food-responsive enteropathy
- Idiopathic inflammatory bowel disease
- Low-grade intestinal T-cell lymphoma

Most common clinical signs

- **Weight loss** (60-90%) *most common!
- Vomiting (25-65%)
- Hyporexia or polyphagia (20-40%)
- Diarrhea (12-75%)

Laboratory Findings

- Hypoalbuminemia (mild) PLE is extremely rare in cats
- Globulins may be normal or mildly decreased/increased
- Increased liver enzyme activity (ALT)
- fPLI increase without clinical signs is likely insignificant
- fTLI EPI is rate in cats but possible with chronic pancreatitis
- Decreased cobalamin and folate
- Iron deficiency anemia
- Hypophosphatemia
- Hypovitaminosis D
- Cats may also not have any laboratory abnormalities

Abdominal Ultrasound

- Diffuse thickening of the muscularis propria, submucosa, or mucosal layer
- Muscularis to submucosa ratio of >1 is indicative of an abnormal bowel
- Cats with thickened muscularis and abdominal lymphadenopathy are more likely to have LGITL than IBD

Comorbidities

- Pancreatitis
- Cholangitis
- Chronic kidney disease
- Hyperthyroidism
- EPI – RARE and often secondary to chronic pancreatitis

What are the components of triaditis and why does this occur in cats?

- Pancreatitis
    - Often chronic or acute on chronic
    - Ultrasound usually shows a pancreas with hyperechoic or mixed texture with irregular margins
    - Diagnosed based on clinical signs and fPL/imaging
- Chronic enteropathy
- Hepatopathy
    - Reactive
    - Chronic hepatitis
    - Bacterial cholangiohepatitis
    - Characterized by increased liver enzyme activity
    - Hepatic lipidosis +/- liver dysfunction

- The common bile duct and pancreatic duct merge before opening at the major duodenal papilla. About 20% of cats have an accessory pancreatic duct
- In dogs, the common bile duct and pancreatic duct enter in close proximity but do not merge at the duodenal papilla. Most dogs have an accessory pancreatic duct opening at the minor duodenal papilla

IBD in cats

- Lymphocytic, plasmacytic *most common
- Eosinophilic > rule out parasites and hypersensitivity
- Granulomatous > rule out fungi and *E. coli*
- Neutrophilic > rule out bacteria

LGITL	IBD
Mature, small lymphocytes +/- Inflammation Uniform Infiltrate	Mature, small lymphocytes +/- Plasma Cells Mixed infiltrate

Differentiating between LGITL and IBD is challenging, the use of PARR or clonality testing can help us make that differentiation. Neoplasia is usually from a clonal population of cells (all the same T-Cell receptors, whereas inflammation will have a non-clonal or mixed population of T-Cell receptors.

Small cell, low grade lymphoma	Large cell, high grade lymphoma
Most common form >80% T-cell lymphoma, diffuse Small intestines (jejunum) Slow progression > low grade Good prognosis MST 1.5-3 yrs	Less common Mostly B-cell, localized Stomach, ileocolic junction Fast progression > high grade Prognosis is variable but the MST is less than SCL

Basic Work-Up for Cats with GI Disease

- First Tier
    - Take a good history!
    - Monitor body weight
    - CBC, Chem, UA, tT4, +/- fecal
    - Cobalamin, Folate (fPLI, FTLI)
- Second Tier
    - Abdominal Ultrasound
    - FNA
- Third/Fourth Tier
    - Biopsies
    - Histopathology
    - IHC
    - Clonality

Treatment

- Start with diet
    - Hydrolyzed
    - Novel Protein
    - Home-cooked
    - Multiple trials may be necessary
- Microbiome
    - Pre and probiotics may be necessary
    - +/- Antibiotics if severe
- Immune System
    - Steroids
    - Chlorambucil
        - 2mg TOTAL dose PO q 48-72h (M, W, F)
        - If fractious can give 20mg/m^2 every 2 weeks
        - Most common side effects include myelosuppression and hepatoxicity
        - CBC, Chemistry panel every 2 weeks
    - Cyclosporine