DIAGNOSIS AND TREATMENT OF CHRONIC NASAL DISEASE IN DOGS AND CATS

Philip Padrid DVM
Associate Professor of Molecular Medicine (adj)
The University of Chicago Pritzker School of Medicine
Associate Professor of Small Animal Medicine (adj)
The Ohio State University
USA
ppadrid@aol.comi

Chronic rhinitis is a common finding in small animal companion animal practice. The signs are usually obvious and include all or some combination of sneezing, nasal discharge and noisy breathing. We make the assumption that chronic signs are NEVER caused PRIMARILY from bacteria, but instead are caused by foreign bodies, masses, tooth root infections or immune mediated, non-infectious inflammation with lymphocytes and plasma cells. In these cases, routine immunologic defenses within the nasal cavity are altered and commensal bacterial species can "infect" the nasal cavity to cause secondary signs of green/yellow nasal discharge and congestion.

Cats with chronic rhinitis have a single significant different etiology compared with dogs, and that is Feline Herpes Virus –1 (FHV-1).

A thorough workup for both species includes nasal radiographs, endoscopic evaluation of the caudal nasopharynx and right/left nasal cavities, appropriate biopsies, and an aggressive nasal flush. Typical microscopic findings include; "Rhinitis, lymphoplasmacytic, neutrophilic, segmental, moderate to severe, with turbinate remodeling and multi-focal intra-epithelial intranuclear eosinophilic inclusions". Our therapeutic strategy is to clear the opportunistic bacterial infection, evaluate the efficacy of corticosteroids, and facilitate patient comfort with nasal decongestants. Once you have turbinate destruction / remodeling and denuding of the epithelium, it becomes a disorder we can only hope to manage, but never cure.

The following protocol is meant as a guideline, not as a definitive treatment for every patient.

1. *Antibiotics*: A 3-6 week course of enrofloxacin and clindamycin to clear up bacterial infection. If patient has been on multiple antibiotics previously, marbofloxacin is recommended for resistant pseudomonads in place of the enrofloxacin.*

2. *Corticosteroids*: Once the nasal discharge is serous in nature (vs. mucopurulent), a 5-day trial of prednisilone @ 0.25mg/kg po bid is recommended. If the clinical signs are steroid-responsive, then Flovent therapy bid is recommended for chronic management. Flovent will be discussed in more detail during the lecture on feline bronchial disease.

3. *Decongestants*: "Little Noses" (phenylephrine HCL ¼%) nasal decongestant drops are rotated on a 3-day cycle with saline drops (i.e. 3 days decongestant then 3 days saline). This facilitates drainage from the sinuses, resulting in greater patient comfort. When administering the decongestant, the patient's nose is pointed up and one drop is given in each nostril. The saline drops would be rotated to prevent a significant "rebound effect" of nasal congestion.

* In patients with severe turbinate destruction, chronic antibiotic therapy may be needed to adequately manage the patient. A suggested regime would include marbofloxacin, azithromycin and minocycline, for weeks 1, 2 and 3 followed by a rest week. This cycle is repeated on a monthly basis.