Feline Nasal Disease
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"Allergic" rhinitis is a difficult and frustrating clinical condition in cats. Because of the relatively young age at which many cats are afflicted, we assume that Feline Herpes Virus-1 (FHV-1) is part of the pathophysiology. A thorough workup 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 prednisolone @ 5 mg/cat po bid is recommended. If the clinical signs are steroid-responsive, then Flovent therapy bid is recommended for chronic management.

3. **Decongestants:** "Little Noses" 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.

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