

GI Endoscopy

GI endoscopy allows direct visual examination of the GI tract luminal surface and tissue biopsy. This review article summarized the indications, optimal instrumentation for greatest diagnostic utility, limitations, and correlations between clinical and histopathology findings for GI endoscopy. The procedure is useful for detecting morphologic or infiltrative disease; however, it is not helpful for diagnosing functional disorders and some chronic enteropathies.

GI endoscopy should always be accompanied by tissue biopsy and histopathologic evaluation. Although it varies by location in the GI tract, ≈6 adequate samples should be obtained from each region. Care should be taken to preserve tissue architecture and thus improve the

pathologist's ability to make a definitive diagnosis.

The decision to perform endoscopic biopsy vs surgical biopsy depends on the clinical situation, including the most likely differential diagnoses and patient stability. Similarly, the decision to perform upper vs lower GI assessment or both is based on relevant clinical signs. Careful specimen handling, avoidance and recognition of routine tissue artifacts, and consideration of tissue fixative options to facilitate special testing optimize the diagnostic utility of endoscopic biopsy.

Because there can be disagreement among pathologists—and there are no standards for histopathologic assessment of GI inflammation—the authors concluded that it remains difficult to correlate histopathology from GI endoscopic biopsy with clinical disease activity.

Commentary

It is important to take into account individual patient indications when considering endoscopic exploration and biopsy. GI endoscopy and biopsy collection are valuable diagnostic tools and are less invasive than open surgical biopsy. However, the procedures can only sample mucosa and are limited to regions accessible with a scope. Although histopathologic evaluation may be considered the gold standard in many cases, lack of uniform criteria for assessment of GI inflammation may limit utility. Ultimately, a collaborative approach between endoscopist and pathologist is important to glean feedback regarding samples and inform clinical decision-making for each patient.—*Jason Bleedorn, DVM, MS, DACVS*

Source

Jergens AE, Willard MD, Allenspach K. Maximizing the diagnostic utility of endoscopic biopsy in dogs and cats with gastrointestinal disease. *Vet J*. 2016; 214:50-60.

Feline Sebaceous Adenitis

This report reviewed a feline case of sebaceous adenitis, a rare dermatosis in cats, and its treatment with a topical fatty acid supplement. A 5-year-old neutered male Norwegian forest cat was presented for a 5-month history of progressive scaling, which began on the face and neck. Initial diagnostics failed to identify a cause; over the next 12 months, clinical signs worsened.

Histopathology revealed multifocal, lymphocytic mural folliculitis, perifollicular dermatitis, moderate hyperkeratosis, and sebaceous glands that were either absent or effaced by lymphocytic infiltrates. Sebaceous adenitis with concurrent mural folliculitis was diagnosed, and

cyclosporine therapy was recommended. The owners declined because of difficulty with oral administration and concerns about potential side effects. Trial therapy with a topical application containing fatty acids, essential oils, and other ingredients was initiated. Clinical response to therapy was excellent but incomplete. When therapy lapsed, there was a severe relapse of clinical signs along with fever and lethargy. Treatment for clinical signs resolved the fever and anorexia, and reinstatement of the topical essential fatty acid resulted in a good but incomplete response. Persistent mild periorcular and perinasal adherent and mild generalized surface scaling persisted through the last follow-up.

Commentary

This is an interesting case report from several perspectives. First, sebaceous adenitis is uncommon in cats, and facial and nasal crusting is not usually a sign of this disease. Second, the treatment of

choice for sebaceous adenitis is cyclosporine, which the owners declined. Interestingly, the cat responded to a commercial topical treatment. The case report did not specify the frequency of application, but this commentator recommends using it q1-2wk. Third, this treatment was proven beneficial by the relapse of clinical signs when treatment was stopped.

Although cyclosporine is the treatment of choice, complete resolution of clinical signs is uncommon. This topical treatment may be an alternative and/or adjunct treatment for sebaceous adenitis in other animals.—*Karen A. Moriello, DVM, DACVD*

Source

Glos K, von Bomhard W, Bettenay S, Mueller RS. Sebaceous adenitis and mural folliculitis in a cat responsive to topical fatty acid supplementation. *Vet Dermatol*. 2016;27(1):57-e18.