

*“Pearls”
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Veterinary Medicine*



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AT A GLANCE

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Gastroenterology – Feline Medicine

Feline Pancreatitis (condensed)

Read the full report here: [Feline Pancreatitis](#).

Feline pancreatitis is typically idiopathic (>95%), presenting as a continuum from acute necrotizing lesions to chronic lymphoplasmacytic inflammation. Clinical signs are nonspecific and commonly include lethargy, hyporexia, vomiting, weight loss, diarrhea, dehydration, hypothermia, icterus, abdominal pain, and behavioral change. However, histopathologic pancreatic inflammation is common, including in apparently healthy cats, raising the question of whether subclinical pancreatitis exists or the current histopathologic definition overdiagnoses it.

Concurrent enteropathy, cholangitis/cholecystitis, hepatic lipidosis, diabetes mellitus, renal disease, and endocrinopathies are frequent. **Triaditis occurred in 57% of cases** versus 2% having isolated pancreatitis. The shared duodenal entry of the pancreatic and common bile ducts may contribute to the association between pancreatic and hepatobiliary disease.

The recommended minimum database includes CBC, serum biochemistry, urinalysis, pancreatic lipase testing, and abdominal ultrasonography. CBC and biochemical abnormalities may include hemoconcentration, inflammatory leukogram, azotemia, hyperbilirubinemia, hepatocellular enzyme elevation, dysglycemia, electrolyte

derangements, and, in severe disease, thrombocytopenia and coagulopathy.

Spec fPL and DGGR lipase (PSL) support but do not independently establish a diagnosis and require correlation with clinical findings, laboratory abnormalities, and imaging. Although Spec fPL is considered the gold standard for diagnosis, it may be increased in asymptomatic patients with obesity, diabetes mellitus, and CKD but may remain normal in early, mild, or chronic pancreatitis (~25% cases missed if only fPL used). Elevated fPL with **abnormal cardiac biomarkers** may reflect secondary myocardial stress, not primary heart disease—cardiovascular workup warranted. Furthermore, marked hyperlipasemia may occur in clinically normal cats and cats with enteropathy. Neither the absolute lipase concentration nor its serial trend consistently correlated with pancreatic ultrasonography, GI signs, appetite, body weight, or overall clinical condition in one small study; interpret isolated hyperlipasemia cautiously.

Recently updated suggested thresholds for **Spec fPL**: equivocal 4.5–8.7 µg/L; **diagnostic ≥8.8 µg/L** for 99% specificity (vs previous cutoff >5.3 µg/L). A **CBC model** (WBC <18 G/L, bands <0.27 G/L, eosinophils >0.3 G/L) **ruled out pancreatitis with 91.8% sensitivity**—better for exclusion than confirmation. **SNAP fPL** suits screening: 54% sensitivity in mild cases, up to 100% in moderate-severe; specificity 67–100%. **Vcheck fPL 2.0** has poor linearity and precision. DGGR lipase (PSL) and Spec fPL generally agree, although DGGR assays may be influenced by extrapancreatic lipases.

Ultrasonography: Sensitivity for feline pancreatitis is variable and operator dependent. Sonographic findings of **acute feline pancreatitis**—which may include pancreatic enlargement, hyperechoic mesentery, focal effusion, or duodenal corrugation—are often equivocal, with a reported

