Diagnosing and Treating Gingivostomatitis in Cats

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One of the most frustrating oral diseases in feline patients - for the practitioner, the patient and the client - is gingivostomatitis. Gingivostomatitis (or caudal stomatitis) is chronic proliferation and inflammation of the gingiva and oral mucosa. All areas of the mouth may be affected, and the disease can range from mild to very severe, sometimes becoming so inflamed that the pharyngeal area is almost completely blocked.

Etiology and pathology

Lymphocytic-plasmacytic stomatitis is often a histological diagnosis reflective of plasma cells and lymphocytes found in oral tissue biopsies, but this does not indicate an etiology. This, along with increased serum immunoglobulin levels indicate an immunological basis for the disease – suggesting that some cats may have an exaggerated immune inflammatory response to plaque bacteria.

Numerous etiologies may exist that result in gingivostomatitis, although none have proved to be a singular causative agent. While some patients test positive for various viral and/or bacterial infections (FeLV, FIV, FCV, B. henselae), these diseases may affect the severity of the disease instead of being a direct cause.

Clinical signs and diagnosis

Clinical signs in cats with gingivostomatitis include: anorexia, weight loss, unkempt appearance, ptyalism, halitosis, and purulent discharge from mouth. Dysphagia, dropping food, swallowing without chewing, growling or crying while eating, running from food dish and reluctance to eat are also signs. Temperament changes may include hiding, unexplained aggression, not wanting attention/affection, or biting may be seen.

Although painful, cats may allow examination if the mouth is opened very slowly and gently. It will be easy to differentiate between periodontal disease and gingivostomatitis by the presence of caudal stomatitis. Depending on the severity of the disease, oral tissues bleed easily, will be swollen and friable, and have a "cobblestone" texture. Inflamed tissue is usually symmetric on both sides of the mouth. A complete oral examination (possibly requiring chemical restraint) should include hard and soft palates, tonsillar regions, all gingival and oral mucosa, tongue, teeth, salivary glands, and pharynx. One should rule out periodontal disease, squamous cell carcinoma or other neoplasia, or eosinophilic granuloma complex and assess the patient's FeLV and FIV status before moving ahead with treatment.

Treatment

Since caudal stomatitis is associated with increased immune response to plaque bacteria, basic oral hygiene is the logical first step for treatment. However, cats are notoriously hard to convince to brush their teeth. Couple that with the extremely painful nature of this condition and reluctance to try on the owner's part, and we can quickly understand why other medical treatments should be considered. Immunosuppressive treatment using cyclosporine or high-dose glucocorticoids (only if patient is FeLV and FIV negative), anti-inflammatory treatments with NSAIDs or glucocorticoids, antibiotic therapy, and laser therapy to remove inflamed tissue have all been suggested to deal with gingivostomatitis. These treatments, especially long term treatment with glucocorticoids, are not especially recommended due to significant side effects.

The most efficacious treatment for cats with chronic caudal stomatitis is full mouth extractions (+/- canines and incisors). The earlier the teeth are extracted, the better the outcome in most cases. Full mouth intra-oral radiographs should be obtained prior to and after completing all extractions. This is essential to check for ankylosis, tooth resorption, root abnormalities, and periodontal disease prior to extraction, and to serve as documented proof of complete extractions. All of the tooth structures, including the periodontal ligament, must be removed and the alveoli debrided to ensure removal of the site of attachment of bacterial plaque. The decision to remove canine and incisor teeth should be made on a case by case basis and is based on the evidence of any inflammation around these teeth. On a personal note, I do not extract mandibular canine teeth unless there is significant inflammation around them, as these teeth are notoriously difficult to extract and also provide stability to the jaw. If no significant improvement is made in the patient's oral health within four to eight weeks following extractions, it may be because not all roots were extracted or continued plaque formation on remaining canine and incisor teeth is causing "flare-ups." In this case, extracting remaining teeth should be beneficial. Supportive medical management may be indicated after extractions to decrease bacterial load, reduce remaining inflammation and deal with refractory pain. Proper nutrition also plays a very important role in the healing process after full mouth extractions. This may be provided with enteral feedings through an esophageal tube in cases of prolonged inappetance.



References

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