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Proposal for rational antibacterial use in the diagnosis and treatment of dogs with chronic diarrhoea


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Chronic diarrhoea is a frequent complaint in canine practice and the diagnostic path is often characterised by numerous diagnostic tests and stepwise empirical treatments, often applied before gastrointestinal (GI) endoscopy/mucosal biopsies. These include dietary interventions (novel protein, hydrolysed protein diet), parasiticides and still, in many cases, antibacterials. Indiscriminate use of antibacterial drugs risks detrimental consequences for both the individual patient (antimicrobial resistance, long-term disruption of intestinal bacterial populations, potential worsening of GI signs) and general public. For that reason, in this Perspective essay we advocate use of antibacterials only after histopathologic evaluation of GI biopsies or, for those cases in which endoscopy is not possible, after other therapeutic trials, such as diet/pre-probiotics or anti-inflammatory drugs have proven unsuccessful. They should be reserved, after appropriate dietary trials, for those canine chronic diarrhoeic patients with signs of true primary infection (i.e. signs of systemic inflammatory response syndrome or evidence of adherent-invasive bacteria) that justify antibacterial use.

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The standard diagnostic investigation of chronic diarrhoea usually includes a variety of laboratory investigations, such as complete blood count, serum biochemistry panel, urinalysis, faecal exams, evaluation of pancreatic function and inflammation, endocrine assays (i.e. adrenal gland function), as well as diagnostic imaging procedures (e.g. abdominal radiographs/ultrasound) and GI endoscopy, including mucosal biopsies for histopathological examination. Empirical treatment is often trialled and can include dietary interventions, parasiticides and antibacterials (ABs) such as metronidazole or tylosin (Jergens et al. 2003, Kilpinen et al. 2015, Allenspach et al. 2016). These empirical treatments are often administered before GI endoscopy/muco-osal biopsy because they may represent effective strategies for managing canine chronic enteropathy (Volkmann et al. 2017, Heilmann et al. 2018). Corticosteroids and other immunosuppressants are needed in some cases to control clinical signs, but
are generally recommended after other treatment strategies have been exhausted and after mucosal biopsies have been obtained, which are necessary to diagnose intestinal inflammation and other GI disorders such as (primary) lymphangiectasia, infectious agents (e.g. fungal infections, adherent-invasive *Escherichia coli*) and neoplastic infiltration (e.g. lymphoma).

Antibiotic-responsive diarrhoea is recognised as one form of chronic enteropathy. Its clinical presentation is indistinguishable from other types of chronic enteropathy; it is associated with intestinal microbiota dysbiosis (Hall 2011) and responds exquisitely well to administration of ABs, while it often recurs as soon as they are withdrawn (Hall 2011, Westermarck 2016). Most often, tylosin (tylosin-responsive diarrhoea) (Westermarck et al. 2005), metronidazole (Allenspach et al. 2016) and oxytetracycline (Hall 2011) have been used as therapy. Diagnosis is based on a positive response to ABs after exclusion of other conditions as outlined above. In antibiotic-responsive diarrhoea, histopathology of intestinal biopsies, if acquired, frequently shows no or only mild non-specific inflammatory infiltrates or abnormalities (Hall 2011, Volkmann et al. 2017). However, although ABs constitute an empirical therapy instituted by many clinicians in dogs with chronic diarrhoea, this might lead to unnecessary administration or overuse of ABs, as not all of these dogs will eventually be diagnosed with antibiotic-responsive diarrhoea. This practice is of even greater concern considering recent reports in which antibiotic-responsive diarrhoea was retrospectively reported in only 11 of 136 (8%) (Volkmann et al. 2017) and 33 of 203 (16.2%) (Allenspach et al. 2016) of dogs with chronic diarrhoea, respectively. In addition, a study by Jergens et al. (2010) is noteworthy, because it shows oral prednisone alone to be clinically as effective as prednisone plus metronidazole in dogs suffering from inflammatory bowel disease, suggesting that the use of antibiotics might not always be necessary.

Based on our experience and on the evidence in the literature reported here, the aim of this report is to make a strong argument against the empirical use of ABs when routinely managing dogs with suspected chronic enteropathy. The use of ABs should be reserved for patients in which all other conditions are excluded and other empirical treatments have been exhausted. The following paragraphs will elucidate potential detrimental effects of ABs on individual gut health and public health.

**EFFECTS OF ANTIBACTERIALS ON GI MICROBIOTA**

Although the effect of AB administration on the faecal microbiota still needs to be defined further, some aspects have been investigated in humans (Rizzatti et al. 2018) and both healthy and diseased animals. It is known that AB administration causes changes in the composition and richness of the intestinal microbiota in dogs and cats and that this dysbiosis can be detrimental to overall host health (Suchodolski 2016), similarly to those presenting with inflammatory bowel disease (Minamoto et al. 2015). Specifically, the administration of oral tylosin (20 to 22 mg/kg SID for 14 days) to healthy dogs was associated with changes in the proportions of jejunal bacteria (e.g. increases in *Enterococcus*-like organisms and *Pasteurella* spp.). Microbiota alterations (i.e. increase of *Escherichia coli*-like organisms) were still observed 14 days after withdrawal of tylosin (Suchodolski et al. 2009). The phylogenetic composition of the microbiota following tylosin withdrawal was comparable to day 0 in only two of five dogs, while bacterial diversity was similar in three of five dogs, suggesting a possible long-term adverse effect in some animals (Suchodolski et al. 2009). Very recently, as found in healthy dogs, it was shown that the administration of tylosin (20 mg/kg PO BID) induced dysbiosis- and eubiosis was not restored by 56 days following tylosin discontinuation, leading the authors to conclude that in these patients “… reestablishment of the native microbiota is possible but not guaranteed.” (Manchester et al. 2019). Faecal bacterial diversity was also reduced when administering oral metronidazole for 14 days (12.5 mg/kg BID) to healthy dogs (Igarashi et al. 2014). Similarly, oral administration of amoxicillin (10 mg/kg BID for 7 days) to healthy dogs resulted in differences in faecal bacterial composition before and after administration, with many faecal *E. coli* isolates showing increased resistance to multiple ABs during and after treatment (Grønvold et al. 2010). Interestingly, in dogs with tylosin-responsive diarrhoea, there were increases in faecal *Enterococcus* spp. and other potentially probiotic bacteria (including lactic acid bacteria) (Kilpinen et al. 2015). It was speculated that there could be a possible indirect probiotic effect of tylosin by exerting a selection pressure, resulting in a relative increase in tylosin-resistant enterococci (Kilpinen et al. 2015). Although these results are interesting, there are still concerns that antibacterial resistance could be passed horizontally from commensal bacteria or alleged probiotics to pathogenic bacteria sharing the same intestinal environment (von Wintersdorff et al. 2016).

Furthermore, the metabolic pathways through which ABs may alter gut homeostasis are still under investigation. For example, a recent paper suggests that the administration of a cocktail of antibiotics in mice (antibiotic-induced microbiome depletion) in addition to modifying the abundance of some bacterial species, also altered glucose homeostasis and luminal short-chain fatty acid concentration (enterocytes use glucose instead of butyrate, which is reduced in the intestinal lumen) and bile acid metabolism (Zarrinpar et al. 2018).

Additionally, it is anecdotally reported that select antimicrobials may have immunomodulatory or anti-inflammatory actions in treating chronic enteropathy; in particular, metronidazole has recognised immunosuppressive and anti-inflammatory properties (Shakir et al. 2011). In one small pilot study, the effects of metronidazole, tylosin and conjugated linoleic acid on immune function were evaluated in healthy dogs (Jergens et al. 2007). In this study, peripheral blood mononuclear cells were isolated, incubated with graded doses of the antibiotics and conjugated linoleic acid, and immune responses were investigated using MTT cytotoxicity assay, immunostaining and flow cytometry of B and T lymphocyte subpopulations and *in vitro* mitogen-induced lymphocyte proliferation (*4H*-thymidine incorporation). Results indicated that metronidazole and tylosin, at different dosages, were not successful in arresting mitogen-stimulated proliferation of lymphocytes; in contrast, conjugated linoleic acid was shown to directly inhibit peripheral blood mononuclear cell blastogenesis. Moreover, it must also be
reminded that the use of antimicrobials for non-antimicrobial effects is questionable and discouraged (Weese et al. 2015).

**ANTIBACTERIAL RESISTANCE**

Antibiotic resistance represents one of the most serious and imminent health-related problems worldwide (WHO 2017); the last joint EFSA/ECDC report Antimicrobial resistance in Europe, (http://www.efsa.europa.eu/it/interactive_pages/AMR_Report_2016) based on 2016 data reflects on this alarming situation. The problem is also recognised in companion animals (Peter et al. 2017), with serious potential concerns for human health associated with methicillin-resistant *Staphylococcus aureus* (MRSA) (Rossi et al. 2017). More specifically, for complaints related to the digestive tract, the gut microbiota has been considered as a dynamic reservoir of antibiotic resistance, termed the (“gut resistome”), which can be affected by the administration of ABs (Rizzatti et al. 2018). A recent report showed that 54% of isolates of *Clostridium perfringens* from dogs with acute diarrhoea, which had not been treated with antibiotics, presented with a decreased susceptibility to metronidazole (Gobeli et al. 2012). Moreover, dogs are also considered a possible reservoir of antibiotic resistant strains potentially dangerous for human patients. This includes the discovery of epidemic ribotypes of multiresistant *Clostridoides* (*Clostridium*) difficile (Nagy 2018) in dogs with GI disorders (Orden et al. 2017).

**ALTERNATIVE INTESTINAL MICROBIOTA MODULATION**

There is growing interest and clinical evidence supporting alternative treatments to modulate bacterial populations, which could include the administration of prebiotics, probiotics or synbiotics. Several studies show that probiotics are likely beneficial in cases of diarrhoea, even in dogs suffering from inflammatory bowel disease (Rossi et al. 2014, White et al. 2017, Rossi et al. 2018). Another promising modality is faecal microbiota transplantation. It has been recommended for recurrent *Clostridoides* (*Clostridium*) difficile infections in humans, a hospital-acquired infection that usually develops after extensive AB treatment (Cammarota et al. 2018).

**DIAGNOSTIC ALGORITHM FOR THE CHRONIC DIARRHOEIC DOG**

![Diagram](image_url)

**FIG 1.** Diagnostic algorithm for the diarrhoeic dog. This algorithm is suggested by our combined clinical experience, but different parts are also variably widely reported in literature, including (but not limited to): Jergens et al. 2003, Allenspach et al. 2007, Cerquetella et al. 2010, Washabau et al. 2010, Allenspach et al. 2016, Westermarck et al. Westermarck 2016, Erdmann & Heilmann 2017, Volkman et al. 2017, Cerquetella et al. 2018, Heilmann et al. 2018. It is recommended to use (targeted, not broad spectrum) ABs in the chronic diarrhoeic dog (when there is no clinical evidence of a medical *rationale* for their immediate use), only at the end of the diagnostic protocol, once GI biopsies are performed, and with evidence of infectious causes. *In some cases more than one diet change may be needed, and for this reason duration of diet trial may vary. Depending on the severity of clinical condition, these trials can be postponed going forward with the algorithm. FRD Food-responsive diarrhoea, IBD Inflammatory bowel disease, SRD Immunosuppressive/steroid-responsive diarrhoea.
that there are few indications for using ABs in chronic diarrhoea, because primary bacterial agents causing non-self-limiting disease are rare (Marks et al. 2011), it means that these treatments should be reserved for specific diseases and in accordance with appropriate AB resistance testing panels, avoiding the empirical use of broad spectrum ABs such as amoxicillin/clavulanic acid or fluoroquinolones.

**Conflict of interest**

None of the authors of this article has a financial or personal relationship with other people or organisations that could inappropriately influence or bias the content of the paper.

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Antibacterials use in dogs with chronic diarrhoea


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