Case Log Instructions for the CSAVP and CASVM

Internal Medicine

ESAVS
European School for
Advanced Veterinary Studies

Case log explanations and instructions:

The case log for the **ESAVS Certificate / Internal Medicine** shall contain **at least 100** cases mostly compiled in the second half of the program. Among the 100 cases, all shall be internal medicine patients. There shall be a minimum of 25% cats or 25% dogs, the remainder must be dogs or cats.

Each of the following categories shall have at least the following number of cases:

Gastroenterology (incl. hepatology and pancreatology):	20
Nephrology:	14
Respiratory:	11
Infectious diseases:	11
Endocrinology:	9-10
Neurology:	7-8
Immunology and clinical pathology:	7-8
Cardiology:	5
Oncology:	5
Emergency and Critical care:	5
Toxicology:	3-4

For each case, the following information is mandatory:

1. **Date:** give date of first presentation for current complaint
2. **Case identifier:** number in computer system or name of dog and owner
3. **Species:** dog or cat (use drop-down list)
4. **Breed:** …
5. **Age and sex:** in years or months if < 1 year
6. **Primary care / referral:** referral or primary care (use drop-down list)
7. **Emergency / routine:** emergency or routine (use drop down list)
8. **Major complaint / problems:** give all pertinent abnormal findings from history and physical examination
9. **Examinations:** list all tests performed and the pertinent abnormal findings
10. **Final diagnosis:** give all reached diagnoses
11. **Treatment / management**: list drugs (including dose and interval), surgical procedures, dietary and other management recommendations
12. **Outcome:** give follow-up results including time when performed. Depending on problem/diagnosis, reasonable follow-up is required.
13. **Organ system:** use drop-down list to choose appropriate organ system

The case log needs to be compiled as an excel file using the template in the appendix

Abbreviations may be used but must be explained at the beginning of the case log table List the cases in chronological order.

Upon submission of your completed log (100 cases), the evaluator will request detailed **documentation of 6 selected cases**. Please provide the documentation shortly after being prompted as follows:

1. Provide each case in PDF format in reduced file size (15–20 MB for the whole case should be maximum)
2. The PDF shall contain the **complete medical record** of your patient **in chronological order** with all information including history, physical exam findings, all laboratory results, all diagnostic imaging results (for videos, give 1 to 3 relevant still pictures) including the diagnostic imaging report, patient management and discussions with the owner **and all follow-up results** (history, physical exam findings, lab results, diagnostic imaging, management) IN YOUR OWN NATIVE LANGUAGE. This PDF shall be created directly from the patient management system where all relevant patient information is stored.

A case log may not be acceptable and may be rejected in its entirety if critical concerns regarding one or more categories result in a fail, regardless of whether all other required criteria are adequately met.

EXAMPLE OF CASE LOG (please be aware that also this case log may have minor irregularities)

Major complaint/ problems	Examinations (Laboratory results, diagnostic imaging, etc.)	Diagnosis	Management	Outcome	Organ system
longstanding pu/pd with incontinence, no pronounced polyphagia as per owner. Had been treated for incontinence with moderate success (ephedrine 10mg sid).	PE: Thin skin and coat with pyoderma (also known atopy). Hypertension (200mmHg syst BP), CBC unremarkable. BC mildly elevated ALP. UA density 1.011. RX thorax normal. Abdominal ultrasound non-invasive right adrenal gland mass measuring 2.1-2.4cm. Left adrenal gland very small, measuring 0.3cm at caudal pole. LDDST positive for Cushings disease. metanephrines and normetanephrines normal	Adrenal-dependent Cushing's disease	Adrenalectomy vs medical treatment was discussed. Start treatment with trilostane 1mg/kg bid. Spectacular response after start vetoryl.	Spectacular response noted at 14d recheck: symptoms resolved completely. Pre-trilostane blood check at 28d post treatment. Stayed on 1mg/kg bid. Owner often did not follow the follow-up instructions but was stable. Dosage unchanged. Was euthanasied 2 years after diagnosis due to uncontrollable osteoartitis pain	Endocrinology

Chronic incontinence only during sleeping as per owner, no pu/pd. In consultation room mild dribbling of urine was also noted while walking. UA and further workup was advised, but owners did not follow advise. Seen again 4 months later with same complaint: same advise was provided, but again was not followed. Patient was not seen until 7 months later: now sleeps outdoors due to severe incontinence. Has received ephedrine po from colleague without improvement.	PE: Obesity. UA: wnl, culture negative. CBC wnl, BC with SDMA wnl. AUS moderate hydronephros right kidney with normal kidney size and shape, with dilated right ureter. Very caudal implantation (exact site not seen with ultrasound) suggestive of right ectopic ureter. Left kidney normal, left ureter was not detected on AUS. Interventional endoscopy at referral center confirmed ectopic ureter (right)	Ectopic ureter with hydronephrosis right kidney. Obesity.	Was sent to referral center due to strong suspicion of ectopic ureter. Was confirmed and corrected (laser ablation, perineal approach). Recheck AUS was advised multiple times but owner did not follow postoperative advise. Dietary advise to loose weight (metabolic diet advised)	Patient is clinically better with less incontinence, but communication with owner was/is challenging and follow up advise was never followed. It took almost a year before owner was willing to do workup, and after presumed diagnosis, it took owner another 3 months to go to referral center for interventional surgery. Unfortunately, we were not able to do the planned AUS recheck to see if hydronephrosis had changed.	Nephrology
pu/pd, weight loss, weakness, acute circular motion to the right, subtle heart murmur. Blindness.	CBC pseudothrombocytopenia (aggregates) rest wnl, BC mildly elevated ALT, mildly elevated SDMA without azotemia and normal urinary density, severe hypokalemia. UA e/c mildly elevated (0,42), rest wnl. Toxoplasmosis negative. Protein electrophoresis normal. RX thorax normal. Abdominal ultrasound bilateral renal infarcts, non invasive large right adrenal gland mass (1,3x1,4cm). Aldosterone measurement >2770 pmol/l. Repeated BP 130mmHg systolic (unexpectedly)	Hyperaldosteronism due to adrenal gland mass with severe hypokalemia. Concurrent CKD iris1	Initial fluid therapy with potassium supplementation and follow up blood measurement (potassium). Maropitant 2mg/kg. Mirtazapine aural gel sid. After stabilization, patient was discharged with spironolactone 1,5mg/kg bid and Kaminox orally 2ml bid. Hills k/d early stage wet + dry food was initiated once good appetite.	Recheck after 4 days: good response to medication: weakness disappeared, potassium levels normalized with treatment. Neurological signs, however, did not disappear. Since stable, CT scan to rule out intracranial disease, and adrenalectomy were discussed. Owners decided to wait. 3 weeks later, patient rapidly declined neurologically, owner declined further diagnostics and patient was euthanised	Endocrinology

Episodic hematuria since 1month, no other complaints	CBC mild polycythemic, rest wnl. BC mildly elevated DGGR-Lipase, mildly elevated bile acids (but not sober), rest unremarkable. UA density 1.022, hematuria, rest wnl. Abdominal radiograph large urolith within bladder. Abdominal ultrasound urinary tract: large urolith within bladder, mildly enlarged prostate. Urolith analysis: cystine. Urine for first sample COLA analysis was obtained pre-castration but the test was declined by owner.	Urolithiasis: cystine	Cystotomy. Routine castration was concurrently performed due to mildly enlarged prostate and predisposition for cystine urolithiasis (later confirmed). COLA analysis was discussed but not performed. Postoperative meloxicam 0,1mg/kg sid for 5 days. Was fed urinary diet pre-castration.	Uneventful recovery from castration. Since COLA analysis declined, no further dietary advise was given. Owner chose follow up with own vet.	Nephrology
Gradual excercise intolerance, decreased appetite, mild weight loss. No travelling abroad, UTD with antiparasitics.	PE overall alert, pale mucous membranes, strong pulse; CBC severe non-regenerative normocytic normochromic anemia, mild neutropenia. CBC wnl, T4 normal. Thoracic radiograph wnl. AUS small nodule visible on spleen, rest wnl. UA wnl. Blood smear: multiple atypical lymphocytes seen, with few LGL. Serum electrophoresis normal. CRP normal. FNAB splenic nodule: reactive hyperplasia and extramedullary hematopoesis. PARR test: no clonal T-cell or B-cell population detected. Bone marrow aspirated declined by owner	Marked non-regenerative anemia, etiology unknown (possibly neoplasia)	Doxycycline 10mg/kg sid po while awaiting test results. Prednisolone 1mg/kg po bid was started after test results were know. Tried to motivate owner to perform bone marrow aspiration, but was declined. Since etiology could not be defined, doxycycline was continued for 4 weeks, and prednisolone dosage unchanged	Owner visited for follow up every 1 - 3 weeks. Hematocrit gradually increased from 12% to 20% after 4 months. After start of prednisolone, neutropenia disappeared and mild neutrophilia was noted. Hematocrit started to gradually decrease again after 5 months of therapy. Doxycycline 10mg/kg was restarted for 4 weeks, but did not alter test results. Was still seen monthly and experienced fatigue but was comfortable. Owner did not wish to add any more medication. Patient was euthanised 10 months after presentation	Immunology and clinical pathology

Diarrhea, sporadic vomiting and decreased appetite since 4 days. Vaccination and deworming up-to-date; last vaccinations 4months prior. Owners children had had contact with other dog with severe hemorrhagic diarrhea (etiology not known) week before	. PE mild discomfort abdomen, no fever, no other abnormalities. Fecal examination: no parasites found, positive for parvovirus, weak positive for C difficile (GDH) and C difficile toxine (A+B)	Gastro-enteritis: parvovirosis (weak positive for C difficile)	Supportive treatment with maropitant 2mg/kg sid, protecdiar® supplementation 1 tablet bid, Fortiflora® probiotica one sachet sid. Hills i/d biome was combined with i/d stew. Strict hygiene was demanded from household, temporarily no more dog parks for patient	As patient was writer's own dog, a very close monitoring and follow-up was possible. Patient already improved significantly by the time parvo test came back positive. Supportive treatment was sufficient. No further blood tests or hospitalisation was needed. It is suspected that the presence of Clostridium was not very relevant in this case so was not further addressed. It is suspected that patient might have come in contact with the virus through the children, even though strict hand hygiene and changing of clothes was demanded (and followed)	Infectious diseases
Hematuria and stranguria. Own vet started treatment with meloxicam po and enrofloxacine po 10days prior but clinical signs did not resolve. PE unremarkable.	UA hematuria, no pyuria or bacteriuria (patient is already receiving enrofloxacine). AUS thickened bladder wall cranially. Cystoscopy foreign object in distal vagina (grass awn), polypoid lesions trigonum. Endoscopic biopsy: mild chronic neutrophilic, plasmacytic and lymphocytic cystitis with mild hyperplasia	Foreign object vagina (grass awn), mild polypoid cystitis	Grass awn was endoscopically removed, which improved symptoms significantly. Piroxicam 0,3mg/kg was started while awaiting biopsy results. Bacterial culture negative and no bacteria seen on histology, so enrofloxacine discontinued.	Clinical signs improved significantly and piroxicam was discontinued after 2 weeks. However, patient developed very rapidly growing mammary masses within a month after initial presentation, which ultimately led to euthanasia shortly after	Nephrology

Dog broke into closet and ate 700gr dark chocolate (70%) a few hours prior. PE weakness and altered mentation, pronounced tremors, temp 39,3, extreme tachycardia (300bpm) with single VPC's	CBC mild neutrophilia, rest wnl. BC unremarkable	Theobromine intoxication	Apomorphine 0,1mg/kg: successful emesis induction. Start fluid therapy. IV diazepam 0,5mg/kg, propofol (effect). Intubation. Lidocaine bolus and CRI. Gastric lavage and colonic lavage. Copious amount of activated charcoal given through gastric tube.	Initially, anesthesia had to be continued to suppress tremors. After 3 hours patient was weaned off anesthesia, but required additional boli diazepam 0,5mg/kg. Charcoal-rich bowel movements 4 hours post admission. Heart rate slowly dropped to normal. Patient was fully awake and had normal mentation 8 hours post admission. Heart rate normalized 10 hours post admission and was sent home (initial plan was to monitor until next day, but patient was stable and became uncooperative in hospitalization)	Toxicology
Recent pu/pd, weight loss, polyphagia. PE unremarkable	CBC wnl, BC hyperglycemia, very high fructosamine level. T4 low-end. UA significant glucosuria.	Diabetes mellitus	Prozinc was initially started at 0,25IU/kg bid. Diabetes education with demonstration of injection technique, importance of routine and feeding regime was discussed. Still pu/pd one week later; glucose monitoring in clinic showed hyperglycemic nadir at 5,5hours post injection. Effect of insulin visible but not enough: dosage was adjusted to 0,5IU/kg bid. Freestyle placement was advised, but owner declined. Week later still not enough clinical effect, so Freestyle libre monitoring was accepted and placed. Curves show many 'high' readings; glycemic control far from sufficient: dosage adjusted to 0,75IU/kg bid after a week. Now much better glycemic control week after dose adjustment. Advised to stay on this dosage. Was seen again week later: gained weight, no pu/pd, glucose at nadir was high normal range.	Is seen regularly (with gaps since owner often travels abroad): good glycemic control, weight stable, no further complaints. Was advised to repeat full blood work, but owner hasn't followed through.	Endocrinology

Acute lethargy, weakness and vomiting.	PE abdominal pain and significant fever, mild tachycardia, moderate pulse; CBC neutrophilia with non-degenerative left shift. BC ALT moderately elevated, CRP significantly elevated. DGGR normal, bile acids normal. UA normal. AUS right caudal liver lobe large irregular shaped heterogeneous mass. Mild lymphadenopathy cranial abdomen. FNA of large mass: large amount of neutrophils with intracellular coccae. Culture: Enterofoccus faecalis. FNA liver: relatively normal hepatocytes, significant predominantly neutrophilic infiltrate, some lymphocytes	Cholangiohepatitis with hepatic abscess *(E. faecalis*)	Patient admitted for fluid resuscitation. Amoxicillin-clavulanic acid 20mg/kg tid iv. Maropitant 2mg/kg sid iv. Metoclopramide 0,2mg/kg was added iv tid. Methadone 0,2mg/kg iv qid (switched to buprenorphine 10µg/kg tid iv after 1 day) Laparotomy with abscess drainage and liver biopsy was discussed with owner, but owner declined and opted medicinal treatment (In case of decline, owner would rather euthanize). Stabilized and fever under control after 2 days. was discharged with amoxicillin-clavulanic acid 20mg/kg tid po, metoclopramide 0,25mg/kg po tid, tramadol 4mg/kg tid po, Ursodeoxycholinic acid was added at 13,6mg/kg sid po	Recheck 7 days after discharge: clinically better, CRP drastically lower, ALT lower. AUS abcess same size, but better defined/organised. Antibiotics and ursodeoxycholinic acid were continued. Recheck after 14 days: doing very well, AUS abcess resolved, CRP normalised, ALT normal. All medication continued. Recheck after 14 days with FNA liver: blood normal, AUS normal, FNA: no inflammatory infiltration seen on cytology. Antibiotics discontinued. Ursodeocycholinic acid was continued for life.	Gastroenterology
Productive coughing and exercise intolerance since a few months. Episodic vomiting. Has always had a congenital heart murmur, was never checked with cardiac ultrasound. Blood exam from referring vet showed mild thrombocytopenia and severely elevated DGGR and had already switched to low fat intestinal diet. Referred for workup of coughing. PE grade 1/6 right sided systolic murmur without pulse deficit. Tachypnea.	Complete CBC and BC was very recently done at own vet. Control DGGR: only mildly elevated. CRP normal. Thoracic Xray: normal cardiac silhouette (VHS = 10,8), marked diffuse bronchial pattern. Given pattern and complaints, a direct fecal smear was examined: loaded with alive roundworm L1 larvae. Angiodetect: strong positive	*Angiostrongylus vasorum* Pancreatitis (already improved)	Milbemycime oxime 12,5mg + praziquantel 125mg 2 tablets once a week for one month po. Prednisolone 0,5mg/kg sid po for one week. Since marked improvement of DGGR, advised to continue low fat diet. Recheck advised after one week: significant improvement; no more labored breathing, no more coughing, no more vomiting. Thoracic Xray: bronchial pattern still present but improved. Prednisolone tapered to 0,3mg/kg sid po 7 days, and then 0,15mg/kg sid po 7 days and then stop.	Complete recovery. Stressed importance of regular deworming. Cardia ultrasound strongly advised	Infectious diseases

Progressive nasal stridor with purulent discharge for 2 months. Known with HCM but stable disease. Now presents with severe nasal stridor and unilateral nasal discharge (right), and inspiratory /expiratory dyspnea	CBC mild leucocytosis, BC mild hyperglobulinemia. Thoracic Xray mild to moderate bronchial pattern. Retrograde rhinoscopy: white tissue visible from right nasal passage. Antegade rhinoscopy obstructive effect with same tissue on right side. Cytology of biopsy (obtained with nasal flush): large cell lymphoma	Nasal lymphoma with severe nasal stridor an dyspnea	Histopath and oncologic consult were discussed with owner, as was palliative treatment with prednisolone. But since severe respiratory distress, owners opted not to proceed with therapy	Was euthanized same day after diagnostics	Respiratory
Severe perianal wounds and abscesses since nearly a year. Had been treated as anal gland abscesses by own vet but keeps reoccurring. Dyschezia.	PE severe malodorous exudate in perianal fur, wounds visible. Patient too painful to manipulate perianal region awake; Sedated exam: complete clipping of perianal region. Skin severely inflamed, with large perianal fistulae and a large open, infected chronic wound on left side of anus. Ulcerative vulvar lesions	Severe chronic perianal fistulae/furunculosis	Repeated surgical debridement of wounds, followed by Phovia® light therapy twice a week under sedation. Diet switched to hypoallergenc diet with fiber supplement added (Fibor®). Tacrolimus ointment (protopic®) sid locally. Cyclosporine 5mg/kg sid po. Tramadol 2mg/kg tid po. Initially amoxicillin-clavulanic acid 12,5mg/kg bid po was added.	Patient was seen very frequently to assess perianal wounds, followed by Phovia light therapy, with spectacular improvement after each session. Hypoallergenic diet, fiber supplement, cyclosporine and tacrolimus ointment was continued; amoxicillin-clavulanic acid was discontinued 3 weeks after presentation. Wounds were completely healed after 2 months. Cyclosporine was tapered down to 5mg/kg q48h po combined with 2,5mg/kg q48h for one month. Check-up no reoccurrence and cyclosporine tolerated well; tapered further down to 2,5mg/kg sid po. Stayed on this dosage without relapse; visits every 6 months for checkup and monitoring cyclosporine.	Gastroenterology

Per-acute (1 hour) discomfort, nausea, sphynx posture, panting.	PE abdominal pain, very tense but non-dilated stomach. Tachycardia. BP subtle hypotensive; CBC wnl, BC wnl, lactate pre-op high normal. Abdominal Xray double-bubble stomach, no significant dilatation. ECG no VPC's. Lactate post-op mid range normal.	Gastric volvulus	Shock boli fluids iv pre- and peroperative. Methadone 0,5mg/kg iv qid. Fentanyl cri. Maropitant 2mg/kg iv sid. Swift surgical correction with gastropexie. As owner caught it very early, patient stabilized quickly. Discharged same day with maropitant 2mg/kg sid 4 days, tramadol 2mg/kg tid po 2 days, and paracetamol 15mg/kg bid po 5 days. Advised small portions of intestinal diet.	Checkup advised after 2 days (came 5 days postop): PE normal, patient doing very well. No further follow-ups needed.	Emergency and Critical care
Chronic and progressive nasopharyngeal stridor and stertor since 2 years. Own vet did repetitive and very recent bloodwork (CBC occasionally mild neutropenia, BC incl T4 unremarkable), Thoracic Xray unremarkable. PCR Herpes negative. Treated with prednisolone 1mg/kg sid without significant improvement.	Additional serology: FeLV negative, FIV negative. Retrograde rhinoscopy: retrograde very large obstructive mass effect retronasally. Antegrade rhinoscopy: bilateral normal architecture, with mild hyperemic mucosa and purulent discharge caudal right ventral meatus. Nasal polyp due to chronic inflammation was confirmed histopathologically.	Nasopharyngeal polyp, chronic rhinitis	A very large polyp was uneventfully removed from nasopharynx after rhinoscopy. Treated postoperatively with dexamethasone 0,01mg/kg IM. Treatment at home with dexamethasone drops one drop bid in both nostrils. No Horner syndrome was seen post removal.	Patient recovered almost instantly after polyp removal and no more nasopharyngeal complaints were seen. Continuation of dexamethasone drops in nose was advised. Was euthanised at emergency clinic a few months later due to unrelated disease.	Respiratory

Involuntary dribbling of urine with urine scald. Patient is known with lumbal spondylosis and spondylolythesis lumbosacral (CT scan 2 years prior), uses wheelchair and receives meloxicam and/or gabapentin periodically. Recent course of antibiotics for possible UTI (no diagnostics). PE paraparesis with absent proprioception and weak withdrawal reflex hind limbs, and prolonged proprioception front limbs. Large, flaccid bladder, easily manually emptied	RX abdomen: spondylosis visible. Bladder overfilled. No other significant findings. AUS normal kidneys, large bladder with normal wall and anechogenous urine. Initial UA normal density, no pyuria, no bacteria.	Incontinence: LMN bladder. UTI (known spondylolythesis LS with paraparesis)	Was initially advised to manually empty bladder multiple times a day. QOL discussed. Recheck one month later: initially manageable, but then progressive incontinence and more difficult to empty. Repeated cystocentesis: now obvious UTI, treated with amoxicillin-clavulanic acid 12,5mg/kg bid 3 weeks. Bethanechol discussed but not started yet due to UTI.	Plan was to add bethanechol once UTI stable, but owners decided not to proceed as QOL was insufficient. Patient was euthananised 2 days after UTI as diagnosed.	Neurology
Episodic and chronic nasal discharge and sneezing. No further complaints. On PE narrowed nostrils with nasal stridor, mild nasal discharge. Had been treated with local diluted maropitant droplets bid with limited success	Xray skull and nasal passage (no CT available in practice) no significant findings. Rhinoscopy bilateral in all 3 meati erythematous and swollen mucosa. Purulent discharge PCR eye/airway profile negative for herpes, calici and chlamydia, but positive for mycoplasma. Culture of deep nasal swab negative.	Chronic rhinitis, BOAS	Thorough nasal flushing. Instilled dexamethasone intranasally after procedure. Started patient on drops with dexamethasone 1 drop bid locally in both nostrils. Education of owner on the nature of chronic rhinitis. Many possible therapeutic options discussed: nasal flushing bid with NaCl 0,9% drops, inhalation therapy with flixotide 250µg bid vs aerosol therapy with corticosteroids, surgical treatment of BOAS was not done.	Owner noted improvement with dexamethasone local therapy but patient had a few relapsed in the following years. Owner was hesitant to try other options (puffer, aerosolinhalation). Even though the relevance of the positive mycoplasma PCR is questionable, a trial of doxycycline 10mg/kg sid was given for 4 weeks, with no effect (this step was in agreement with ophtalmologist, since patient also developed conjunctivitis). Patients upper airway is overall stable with dexamethasone instilment through nasal drops	Respiratory

Mild chronic diarrhea and weight loss with normal appetite. Panting more recently. Very recent bloodwork from own vet showed marked leucocytosis with marked neutrophilia, vitB12 normal; referred for AUS. PE alert, BCS 2/5, large palpable spleen, no fever, pannus cornea right eye	CBC mild non-regenerative normochromic normocytic anemia. Marked leucocytosis (69.000) with significant neutrophilia without left shift (60.000). Mild eosinophilia, monocytosis and basophilia. Moderate thrombocytopenia. BC screening wnl, CRP mildly elevated, TLI low normal (grey zone). AUS significant splenomegaly, mild ascites. Abdominal effusion: modified transudate. FNAB spleen: nonspecific inflammation/reactive. Repeated bloodwork 2 weeks later: CBC extreme leucocytosis (240.000) with severe neutrophilia (180.000) and mild left shift. Moderate lymphocytosis, moderate eosinophilia. Anemia unchanged, thrombocytopenia unchanged. Returned half day later due to sudden collapse: thoracic Xray generalized very mild bronchial pattern. AUS hemo-abdomen, mass-effect on already severely enlarged spleen. PT/aPTT normal. Direct fecal smear: roundworm larvae visible. Angiodetect positive. Laparotomy showed splenic rupture with hematoma. Histology spleen: myeloid metaplasia spleen. Intestinal biopsies: chronic mild to moderate lymphoplasmacytic eosinophilic neutrophilic enteritis (duodenum / jejunum / ileum).	Leukemoid reaction. Myeloid metaplasia spleen. Angiostrongylus vasorum infection. Chronic inflammatory enteropathy: FRE with hypocobalaminemia. (pannus OD)	While awaiting test results of the first exam (patient was chronically ill but appeared very stable), patient suddenly collapsed due to haemo-abdomen. Fluid resuscitation. Splenectomy (1,7kg) and ovariohysterectomy were performed, and intestinal biopsies were obtained. Hospitalisation post-surgery for one day, recovered quickly! Medicinal treatment: amoxicillin-clavulanic acid 15 mg/kg bid po, milbemycime-oxime 12,5mg + praziquantel 125mg (Milbemax®) once weekly for 4 weeks, cobalamin 1000µg (Cobalin®) supplementation daily for 3 months. Dexamethasone eye drops tid for pannus. Later, hypo-allergenic insect-based diet was started and advised to stay on this diet.	Leucocytosis peaked right before hemoabdomen. Leucocytosis dropped one day after surgery (180.000) with now moderate non-regenerative anemia (likely due to hemo-abdomen). One week postop, patient was doing relatively well: appetite normal, no more panting, but still mild diarrhea. Hct almost normalized, leucocytosis went down (57.000), thrombocyte count normalized, CRP normalized. Recheck after +/- one month. Leucocytosis got worse again (90.000, with neutrophilia 75.000), vitB12 normal, TLI normal, CRP normal. Switched to hypoallergenic diet with significant improvement toward enteritis. Recheck hematology after 6 months (owners did a recheck later than planned): patient is thriving, shiny coat, no more diarrhea. CBC leucocytosis 40.000 with neutrophilia of 27.000, BC normal, vitB12 normal. Although significant improvement over time, CBC never returned to normal. Owner opted not to search for a possible extra explanation. Owner was advised to continue hypo-allergenic diet, and perform bi-annual bloodwork. Unfortunately, owner never repeated bloodwork.	Immunology and clinical pathology