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(CASE REPORT)

CLINICAL AND HEMATOBIOCHEMICAL RESPONSE TO MOLNUPIRAVIR AND SUPPORTIVE THERAPY IN A CAT WITH SUSPECTED EFFUSIVE FELINE INFECTIOUS PERITONITIS AND ANISOCORIA: A CASE REPORT

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ABSTRACT

Feline infectious peritonitis (FIP) is a fatal immune-mediated disease caused by virulent feline coronavirus (FCoV), and ocular or neurological involvement complicates its management. This report describes the clinical course and serial hematological and biochemical changes in an 18-month-old intact male domestic shorthair cat with suspected effusive FIP, anisocoria and paraparesis treated with oral molnupiravir and supportive therapy. The cat presented with a 14-day history of lethargy, progressive inappetence, recurrent fever, weight loss and abdominal distension. Examination revealed a fluid-filled abdomen, pale mucous membranes, approximately 5% dehydration, paraparesis, aqueous flare and anisocoria with a larger left pupil. Abdominocentesis yielded yellow, Rivalta-positive effusion. Laboratory findings included non-regenerative anemia, neutrophilia with a left shift, lymphopenia, hyperglobulinemia, hypoalbuminemia (albumin-to-globulin [A/G] ratio 0.29) and hyperbilirubinemia, and a rapid FCoV antibody test was positive. Molnupiravir (15 mg/kg orally every 12 hours for 84 days) was combined with intravenous lactated Ringer's solution, maropitant, an S-adenosylmethionine–silybin supplement, nutritional support and topical gentamicin. Appetite and temperature improved by day 7, effusion was no longer detected and the pupils were symmetrical by day 28, and gait was stable from day 56. The A/G ratio increased to 0.90 and hematological variables were within reference intervals by day 84, after a transient increase in alanine aminotransferase on day 14. The cat was in clinical remission at the end of treatment. Because the diagnosis was not confirmed by molecular or tissue testing, this report describes an association between treatment and recovery rather than proof of efficacy.

Keywords: Feline coronavirus; Feline infectious peritonitis; Molnupiravir; Albumin-to-globulin ratio; Anisocoria; Uveitis

1 INTRODUCTION

Feline infectious peritonitis (FIP) is a systemic disease that develops when feline coronavirus (FCoV) acquires the ability to replicate efficiently in monocytes and macrophages, producing a perivascular pyogranulomatous inflammation and, in the effusive form, protein-rich cavitary effusions [1, 2]. Young cats, intact males and cats from multi-cat environments are over-represented, and stressful events such as rehoming or the introduction of new cats often precede disease onset [2, 3]. Ocular lesions, most commonly anterior uveitis and chorioretinitis, and neurological signs occur in a substantial minority of cases and indicate involvement of sites that are relatively protected from systemic drugs [3–5].

Nucleoside analogues, notably GS-441524 and its prodrug remdesivir, have transformed the prognosis of FIP, although higher doses are generally required when the eyes or central nervous system are involved [2, 6–8]. Molnupiravir (EIDD-2801) is an oral prodrug of β-D-N^4-hydroxycytidine (NHC), a ribonucleoside analogue that causes lethal mutagenesis of the viral genome [9]. Retrospective reports, case series, a cohort comparison with GS-441524 and an open-label trial have described remission rates with molnupiravir comparable to those of GS-441524, typically at 10–20 mg/kg every 12 hours for 84 days [10–14]. Oral doses of about 15 mg/kg produce serum NHC concentrations several-fold above in vitro effective concentrations against FCoV, but penetration into the aqueous humor and cerebrospinal fluid has not been measured [15]. Published reports from Indonesia remain scarce [16].

Most published molnupiravir data are aggregated across many cats, and detailed descriptions of the sequential laboratory trajectory in individual cats with concurrent ocular and neurological signs are limited. The aim of this report is to describe the clinical presentation, hematological and biochemical abnormalities, treatment and follow-up of a cat with suspected effusive FIP, anisocoria and paraparesis treated with molnupiravir and supportive therapy. The report is structured according to the CARE guidelines for case reports, adapted to the veterinary setting [17], and it is not intended to establish a causal effect of the drug.

2 CASE PRESENTATION

2.1 Signalment and history

A domestic shorthair cat named Hexos, an 18-month-old intact male weighing 3.4 kg, was presented to Klinik Hewan Nusantara Vet with a complaint of reduced appetite, weakness, recurrent fever, weight loss and abdominal enlargement that had become more evident over the preceding days. According to the owner, signs began approximately 14 days before presentation with reduced activity, increased sleeping and gradually declining appetite. About 7 days before presentation the owner noticed weight loss and that the cat felt warmer than usual; the cat appeared weak and less responsive to play. Over the last 4 days the abdomen enlarged progressively despite falling food intake. There was no history of significant vomiting or diarrhea, and urination frequency was reported as normal.

The cat was kept indoors with three other cats and fed commercial dry food with occasional wet food. At presentation it was eating an estimated 25–50% of its usual ration, and water intake was slightly reduced. Vaccination was incomplete, deworming was irregular, and there was no known history of chronic disease or of previous treatment for the current illness. A new cat had been introduced into the household approximately one month before onset of signs.

2.2 Clinical examination

The cat was conscious but lethargic, weak and poorly responsive. Rectal temperature was 39.2 °C, heart rate 190 beats/min and respiratory rate 36 breaths/min. Body condition score was 5/9, mucous membranes were pale pink, capillary refill time was 2 seconds, and dehydration was estimated at approximately 5%. Abdominal palpation revealed distension with a fluid wave. Neurological observation showed paraparesis (Figure 1a). Ocular examination revealed aqueous flare consistent with anterior uveitis and anisocoria, with the left pupil larger than the right (Figure 1b). Fundoscopy and tonometry were not performed.

2.3 Diagnostic investigations

Abdominocentesis was performed and 160 mL of yellow effusion described as protein-rich was removed (Figure 1d). The fluid foamed readily and contained yellow gelatinous clots consistent with fibrin (Figure 1e). The Rivalta test on the effusion was positive. A point-of-care rapid immunochromatographic FCoV antibody test performed on a blood sample was positive (Figure 1c). Cytology, culture and FCoV RT-PCR of the effusion were not performed.

Hematology revealed normocytic normochromic anemia with an absolute reticulocyte count that was inadequate for the degree of anemia, consistent with a non-regenerative anemia. Leukocytosis was characterized by mature neutrophilia, a left shift and monocytosis, accompanied by lymphopenia and a low automated platelet count (Table 2). Platelet clumping was not excluded by blood smear review. Serum biochemistry showed hyperproteinemia due to

marked hyperglobulinemia, hypoalbuminemia and a markedly decreased albumin-to-globulin (A/G) ratio of 0.29, together with hyperbilirubinemia and mildly increased alanine aminotransferase (ALT), aspartate aminotransferase (AST) and alkaline phosphatase (ALP) activities. Urea nitrogen, creatinine, glucose, sodium and potassium were within reference intervals (Table 3)



Figure 1: Clinical findings at presentation. (a) Weakness and posture associated with paraparesis; (b) ocular appearance of the patient; (c) rapid immunochromatographic FCoV antibody test showing control (C) and test (T) lines; (d) abdominocentesis yielding yellow effusion; (e) effusion collected in a kidney dish (160 mL), showing foam formation and yellow gelatinous clots consistent with fibrin.

2.4 Diagnostic assessment

Effusive FIP was considered the most likely diagnosis on the basis of the signalment (young intact male from a multi-cat household with a recent stressor), the history of recurrent fever and progressive weight loss, the presence of a yellow, Rivalta-positive effusion, a low A/G ratio, lymphopenia, neutrophilia, non-regenerative anemia and hyperbilirubinemia, and concurrent ocular and neurological signs [2, 3, 18]. Differential diagnoses included septic peritonitis, lymphoma, lymphocytic cholangitis and, given the uveitis and neurological signs, toxoplasmosis and retroviral infection. Because cytology, RT-PCR and immunostaining were not performed, the diagnosis was classified as suspected FIP.

2.5 Therapeutic intervention

Treatment was started on the day of presentation (day 0) and is summarized in Table 1. Molnupiravir was administered orally at 15 mg/kg every 12 hours, with a planned course of 84 days. The owner gave informed consent for off-label use of the drug

Lactated Ringer's solution was administered intravenously. On the basis of a body weight of 3.4 kg and 5% dehydration, the theoretical fluid deficit was 170 mL, and maintenance requirements were estimated at approximately 136 mL/day (40 mL/kg/day); the rate was adjusted to hydration status, perfusion and ongoing losses. Maropitant was given at 1 mg/kg subcutaneously every 24 hours to control nausea and support appetite. A commercial S-adenosylmethionine–silybin hepatoprotective supplement (Samylin®) was given orally at one tablet every 24 hours because of hyperbilirubinemia and increased liver enzyme activities. A high-energy convalescent diet was offered orally and increased gradually towards the resting energy requirement (approximately 175 kcal/day, calculated as 70 × body weight$^{0.75}$). Gentamicin eye drops were applied to both eyes, one drop every 12 hours.

Table 1: Treatment administered to the cat

Drug / therapy	Dose and frequency	Route	Indication
Molnupiravir	15 mg/kg q12h for 84 days	PO	Antiviral therapy for suspected FIP
Lactated Ringer's solution	Deficit 170 mL + maintenance ≈136 mL/day, adjusted to response	IV	Correction of dehydration and support of perfusion
Maropitant	1 mg/kg q24h	SC	Antiemetic, support of appetite
S-adenosylmethionine–silybin (Samylin®)	1 tablet q24h	PO	Hepatoprotective support
Convalescent diet	Increased gradually to RER (≈175 kcal/day)	PO	Nutritional support
Gentamicin eye drops	1 drop per eye q12h	Topical (OU)	Ocular therapy

IV, intravenous; OU, both eyes; PO, oral; q12h, every 12 hours; q24h, every 24 hours; RER, resting energy requirement; SC, subcutaneous.

2.6 Follow-up and outcomes

The clinical course is summarized in Table 4. Temperature and appetite improved by day 7, dehydration had resolved and the effusion had almost resolved by day 14, and by day 28 abdominal ultrasonography showed no detectable effusion and the pupils were symmetrical. Paraparesis improved progressively, and gait was stable from day 56. On day 84 the cat was clinically stable with no observable signs of active FIP; molnupiravir was discontinued and the cat was considered to be in clinical remission. No other adverse events were observed.

Hematocrit increased gradually and was within the reference interval by day 84; neutrophil counts normalized by day 28, lymphocyte and platelet counts by day 14, and neutropenia was not observed (Table 2). Albumin increased and globulin decreased progressively, and the A/G ratio rose from 0.29 to 0.36, 0.56 and 0.90 on days 14, 28 and 84 (Table 3). Total bilirubin fell sharply by day 14. ALT increased from 125 U/L to 142 U/L on day 14 and then declined to 76 U/L by day 84 without changes in treatment. Renal variables remained within reference intervals.

Table 2: Hematological findings at presentation and during treatment

Parameter	Reference interval	Day 0	Day 14	Day 28	Day 84
RBC (×10^6/μL)	6.9–10.1	4.80 ↓	5.20 ↓	5.80 ↓	7.70
Hemoglobin (g/dL)	10.9–15.7	7.8 ↓	8.5 ↓	9.8 ↓	12.3
Hematocrit (%)	31–48	24 ↓	26 ↓	30 ↓	38
MCV (fL)	40–52	50	–	–	–
MCH (pg)	13–17	16.3	–	–	–
MCHC (g/dL)	32–35	32.5	–	–	–
Absolute reticulocytes (×10^3/μL)	9–61	20	–	–	–
WBC (×10^3/μL)	5.1–16.2	22.5 ↑	15.2	11.6	8.5
Segmented neutrophils (×10^3/μL)	2.3–11.6	19.3 ↑	12.0 ↑	8.3	5.4
Band neutrophils (×10^3/μL)	0–0.1	0.7 ↑	–	–	–
Lymphocytes (×10^3/μL)	0.9–6.0	0.7 ↓	1.1	1.5	2.2
Monocytes (×10^3/μL)	0–0.7	1.7 ↑	–	–	–
Eosinophils (×10^3/μL)	0.1–1.8	0.1	–	–	–
Platelets (×10^3/μL)	195–624	170 ↓	210	255	298

↑, above and ↓, below the reference interval; –, not measured.

Table 3: Serum biochemical findings at presentation and during treatment

Parameter	Reference interval	Day 0	Day 14	Day 28	Day 84
Total protein (g/dL)	6.6–8.4	9.0 ↑	9.1 ↑	8.1	7.6
Albumin (g/dL)	3.2–4.3	2.0 ↓	2.4 ↓	2.9 ↓	3.6
Globulin (g/dL)	2.9–4.7	7.0 ↑	6.7 ↑	5.2 ↑	4.0
A/G ratio	0.8–1.5	0.29 ↓	0.36 ↓	0.56 ↓	0.90
Total bilirubin (mg/dL)	0–0.1	1.20 ↑	0.40 ↑	0.15 ↑	0.08
ALT (U/L)	28–109	125 ↑	142 ↑	114 ↑	76
AST (U/L)	17–48	68 ↑	61 ↑	48	36
ALP (U/L)	11–49	62 ↑	–	–	–
Urea nitrogen (mg/dL)	17–35	26	24	23	22
Creatinine (mg/dL)	0.8–2.1	1.2	1.1	1.0	1.1
Glucose (mg/dL)	71–182	122	–	–	–
Sodium (mEq/L)	149–158	152	–	–	–
Potassium (mEq/L)	3.8–5.5	4.1	–	–	–

A/G, albumin-to-globulin; ALP, alkaline phosphatase; ALT, alanine aminotransferase; AST, aspartate aminotransferase. ↑, above and ↓, below the reference interval; –, not measured.

Table 4: Timeline of the case

Time	Events
Day −14	Onset of reduced activity, increased sleeping and gradually declining appetite
Day −7	Weight loss, increased body warmth noticed by owner, weakness
Day −4	Progressive abdominal distension despite reduced food intake
Day 0	Presentation; fever, ascites, dehydration, paraparesis, aqueous flare and anisocoria (left pupil larger); abdominocentesis (160 mL), Rivalta test positive, FCoV antibody test positive, hematology and biochemistry; molnupiravir and supportive therapy started
Day 7	Temperature 38.9 °C, appetite improved, abdominal distension reduced
Day 14	More active, appetite nearly normal, dehydration resolved, effusion nearly resolved; ALT peak (142 U/L), A/G ratio 0.36
Day 28	Normal appetite and activity, no effusion on ultrasonography, pupils symmetrical; A/G ratio 0.56
Day 56	Gait stable, body weight increased, no fever or gastrointestinal signs
Day 84	Clinically stable, no observable signs of active FIP; A/G ratio 0.90, hematology within reference intervals; molnupiravir discontinued; clinical remission

3 DISCUSSION

This cat recovered clinically during 84 days of oral molnupiravir with supportive care, following the time course described in larger cohorts, with defervescence and improved appetite within the first week and resolution of effusion within the first month [11–13].

The diagnosis deserves critical appraisal. No single non-invasive test confirms FIP, and guidelines recommend combining signalment, history, clinical signs, effusion analysis and laboratory findings, with confirmation by detection of FCoV antigen or RNA where possible [2, 18]. The signalment, history and laboratory abnormalities in this cat matched those most frequently reported in confirmed cases [3]. An A/G ratio below 0.4 increases the likelihood of FIP, whereas a ratio above 0.6–0.8 makes it unlikely [5]. The Rivalta test has high sensitivity but limited specificity, with false-positive results in septic peritonitis and lymphoma, although its accuracy is higher in young cats [19]. A positive FCoV antibody

test indicates exposure, which is common in multi-cat households, and has little diagnostic value on its own [5, 20]. Without cytology, RT-PCR or immunostaining the diagnosis remains presumptive, and response to treatment cannot replace confirmatory testing [2].

The serial laboratory data provide the main descriptive contribution of this report. Hematocrit normalized by day 84, and the A/G ratio rose progressively, reaching the reference interval only at day 84. In 59 molnupiravir-treated cats, hematocrit and A/G ratio returned to reference values about 6 to 7 weeks after starting treatment [12], and normalization of FIP-associated abnormalities was also reported in a prospective trial [13]. The slower recovery of globulin compared with clinical signs is consistent with hyperglobulinemia reflecting chronic immune stimulation that resolves gradually once viral replication is controlled [1, 2]. The rapid fall in bilirubin is compatible with resolving inflammation-associated cholestasis or hemolysis [3]. The low automated platelet count at presentation should be interpreted cautiously because feline platelets clump readily [21].

The transient rise in ALT on day 14, which declined without dose modification, resembles the self-limiting ALT increases reported in about 30% of molnupiravir-treated cats [11, 12]; however, ALT was already increased at presentation, so drug effect cannot be distinguished from disease activity. Neutropenia, reported mainly at higher doses [10], did not occur. NHC is mutagenic in mammalian cells in vitro [22], and a molnupiravir-associated mutational signature has been identified in SARS-CoV-2 genomes [23]; owners should wear gloves when handling the drug and pregnant people should avoid contact [2]. Long-term safety in young cats has not been established.

The anisocoria raises an important interpretive question. In anterior uveitis, the affected eye is usually miotic because of ciliary spasm and prostaglandin release [24]; thus, the smaller right pupil may have been the inflamed eye. Alternatively, mydriasis of the left eye may have resulted from posterior segment lesions such as chorioretinitis or retinal detachment, optic neuritis, or a central nervous system lesion, all of which have been reported in FIP [4, 5]. The concurrent paraparesis supports possible neurological involvement, although weakness from systemic disease, anemia and hypoalbuminemia may also have contributed. Because fundoscopy, tonometry and neurological localization were not performed, these possibilities could not be distinguished. Ocular and neurological FIP are often treated with higher antiviral doses because of the blood–ocular and blood–brain barriers [2, 7]. The dose used here (15 mg/kg q12h) lies in the upper part of the range used for effusive FIP and corresponds to doses suggested for neurological disease in early reports [10, 11]; the return of pupillary symmetry by day 28 and stable gait by day 56 suggest that this dose was sufficient in this cat, but tissue penetration of NHC into the eye and central nervous system has not been measured [15].

Topical gentamicin is an antibacterial without anti-inflammatory activity, whereas symptomatic management of anterior uveitis relies on topical corticosteroids or non-steroidal anti-inflammatory drugs [24]. Resolution of the anisocoria is therefore more plausibly explained by control of the systemic disease, and topical anti-inflammatory therapy with intraocular pressure monitoring would be recommended in similar cases.

Supportive therapy likely contributed to early stabilization. Fluid plans based on estimated deficit, maintenance needs and ongoing losses are recommended [25], and maropitant is an effective antiemetic in cats at 1 mg/kg once daily [26]. S-adenosylmethionine and silybin support hepatic glutathione in cats, but clinical efficacy data in feline liver disease are limited [27], so their contribution to the improvement in liver variables cannot be determined.

This report has limitations. The diagnosis was presumptive; effusion cytology, quantitative effusion protein, FCoV RT-PCR, immunostaining and testing for other infectious causes of uveitis were not performed. Ophthalmic and neurological examinations were incomplete, platelet counts were not verified by smear, and follow-up after treatment ended was not reported, so relapse cannot be excluded. As a single uncontrolled case with concurrent therapies, this report cannot establish causality, although spontaneous remission of FIP is very rare [2].

4 CONCLUSION

In this cat with suspected effusive FIP, anisocoria and paraparesis, oral molnupiravir at 15 mg/kg every 12 hours for 84 days with supportive care was associated with clinical remission, resolution of effusion and anisocoria, and progressive normalization of hematological and biochemical abnormalities. The A/G ratio recovered more slowly than clinical signs, and ALT increased transiently in the second week. Confirmatory diagnostic testing, complete ophthalmic and neurological examination and long-term follow-up are recommended in future cases.

STATEMENTS ON COMPLIANCE WITH ETHICAL STANDARDS

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Disclosure of conflict of interest

The authors declare no conflict of interest regarding the publication of this article.

Statement of ethical approval

This report describes routine clinical care of a client-owned animal; no experimental procedures were performed, and formal ethical approval was not required. Molnupiravir is not licensed for veterinary use and was administered off-label.

Statement of informed consent

Written informed consent was obtained from the owner for treatment and for publication of clinical data and images.

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