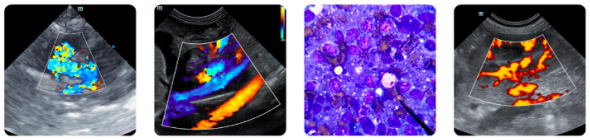

PATIENT

Rubble Eure

SPECIES

Canine

BREED

Pit Mix

SEX

Neutered male

AGE

4 ½ years

WEIGHT

45 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Tracy Eure

HOSPITAL NAME

Moyock AH

REFERRING VET

Dr. Eure

INVOICE

73366

DATE

3/9/26

History

Rubble is a 4½ -year-old neutered Pit bull cross that underwent general anesthesia for a routine dental with extractions. Pre-anesthesia CBC and serum biochemistry was within reference range. No issues evident with induction, during the procedure, or with recovery. At discharge he showed normal activity, behavior, and appetite but approximately 48 hours he later became depressed which then progressed to anorexia, lethargy, and PuPd. No issues had been evident with prior anesthesia for neutering.

CBC

CBC done 48 hours after the procedure showed polycythemia, leukocytosis, neutrophilia, and monocytosis. On serum biochemistry severe azotemia and elevated SDMA and total proteins was evident, with basal cortisol within reference range. These findings are indicative of acute kidney injury (AKI) and as Rubble was showing PuPd and with no hyperkalemia this would be indicative of the polyuric phase of AKI. The polycythemia could be ascribed to dehydration and the leukocytosis, neutrophilia and monocytosis to the dental procedure.

Post-Anesthetic AKI

Post-anesthetic AKI is an uncommon but recognized complication where a dog develops sudden kidney dysfunction within hours to days after anesthesia or surgery. It is usually due to reduced kidney perfusion, hypotension, or nephrotoxic drug exposure during the peri-operative period. Clinically obvious post-anesthetic AKI occurs in roughly 1–2% of dogs, but subclinical kidney injury may occur in up to 5–10%, especially when hypotension occurs during surgery.

FURTHER RECOMMENDATIONS

Treatment focuses on restoring renal perfusion and preventing further damage, which seems to be the case with Rubble as there has been a dramatic improvement in the degree of azotemia. The drop in urine specific gravity is most likely secondary to the fluid therapy rather than ongoing tubular damage; however, ongoing low-grade tubular damage should be assessed by urine cystatin B.

As there has been a good improvement, ongoing management would be to taper the fluid therapy off over the next 48-72 hours with monitoring of urine production, serum urea and creatinine, and ideally urine cystatin B. The end goal is to ensure that there is no increase in the serum urea and creatinine levels as the fluids are tapered down and discontinued. In some cases, serum urea and creatinine may take a few weeks to completely normalize, with some cases always remaining elevated as there has been a degree of permanent renal damage. In these cases, monitoring of the UPC is indicated.

Feeding a renal diet is only indicated if the serum urea and creatinine does not completely normalize, which would be indicative of early chronic kidney disease. If the UPC is > 0.5 then adding either an angiotensin inhibitor (enalapril) or angiotensin receptor blocker (telmisartan).

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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