



Feline Hypotension

micro drip study guide

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Back to Akiro



PE

- Tacky mucous membranes
- BV sounds NSF
- Turgid UB – painful upon palpation
- No overt orthopedic abnormalities
- Erythematous penis

MDB

- PCV/TS: 57% / 8.9 g/dL
- Lactate: 4.7 mmol/L
- VBG: pH 7.214, BE -9 mmol/L, HCO₃ 17 mmol/L
- CBC: WBC 25.2 K/uL (94% neutrophils, no bands), HCT 58%, PLT 236 K/uL
- CHEM: ALB 4.3 g/dL, CREA 9.5 mg/dL, BUN 174 mg/dL, PHOS 15.1 mg/dL, tCa 9.6 mg/dL, BG 163 mg/dL, K⁺ 8.2 mmol/L

Let's go back to our patient, let's get some more information about Akiro. We did our physical examination, tacky mucous membranes, he had good bronchial vesicular sounds they were unremarkable. His urinary bladder was very turgid and elicited a pain response from him.

There were no overt orthopedic abnormalities on the primary survey but he did have an erythematous penis. We obtained a minimum database, paxil total volume total solids excuse me, lactate venous blood gas the CBC chem and what you can see here is mildly elevated packed cell volume and hyper anemia.

Probably most consistent with relative erythrocytes dehydration et cetera. Our lactate is high we never want to see it above two. We have a metabolic acidosis that is being contributed to by the lactate. We have a neutrophil glucose cytosis without ban so no left shift. Our manual PCB correlated pretty closely with our calculated hematocrit and our platelets were fine. And we have severe azotemia and hyperphosphatemia with a normal calcium, mild hypoglycemia most likely a stress response and hyperkalemia at 8.2.

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New Problems

- Dehydration
- Turgid painful UB
- Erythematous penis
- Hyperlactatemia
- Metabolic acidosis
- Mature neutrophilia
- Azotemia
- Hyperglycemia
- Hyperphosphatemia
- Hyperkalemia

L

mmol/L, HCO₃ 17

94% neutrophils, no

236 K/uL

CREA 9.5 mg/dL, BUN

1 mg/dL, tCa 9.6

, K⁺ 8.2 mmol/L

So we modify our problem list and hopefully you're all very comfortable taking this these new problems with the existing problem list and coming up...

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Diagnoses

1. UO
2. AKI (grade IV) – post-renal, pre-renal, ± intrinsic renal
3. Late decompensatory hypovolemic shock

mol/L, HCO₃ 17

6 neutrophils, no

5 K/uL

A 9.5 mg/dL, BUN

g/dL, tCa 9.6

8.2 mmol/L

with your diagnoses. Akiro has urethral obstruction, he has a grade four acute kidney injury that is certainly post renal in nature, pre-renal in nature. And we always have to prepare the owners that there may be an intrinsic renal component, we won't know until we treat him and see what happens to his azotemia.

And he is presented in late decompensatory hypovolemic shock. Why late decompensatory? Because he had the triad of death hypotension, hypothermia and bradycardia. So when we have patients like Akiro we need to heat them up.

Correct Hypothermia



Prevent if possible	• Heat-seeking & heat-conserving behaviors
Passive surface rewarming	• External covers (i.e.: blankets)
Active surface rewarming	• Warm water bottles, forced air blankets
Active core rewarming	• Warm H ₂ O enemas, warmed IVF, warmed pleural/peritoneal/UB/gastric lavage

OK and I know I am preaching to the proverbial choir here when I talk about and mention prevent the hypothermia in the first place, if you can. But I still think it's always worth remembering why we need to avoid it as much as possible. That's why we've been discussing it.

So utilize your technician and nursing team and your assistance teams and train them to look for these heat seeking behaviors and heat conserving behaviors in our patients. Maybe the patient that is burying itself under towels isn't just trying to reduce anxiety and hide from you because they are nervous being in a foreign environment, they may be trying to get warm.

OK, so don't take that type of attention for granted. We have different rewarming practices, we call them passive surface rewarming, active surface rewarming and active core rewarming. So the way I simplistically explain it is passive rewarming is taking the towel off the shelf and putting it directly on your patient.

Active service rewarming would be taking the towel off the shelf throwing in the dryer to warm it up for five or 10 minutes. And then taking that warm blanket and throwing it over your patient.

OK, we also use our forced air blankets, our bare huggers, our hot dogs. A lot of people will use warmed water bottles or warmed rice bags.

OK, what we're not going to use is heat lamps or electrical heating pads because we need to avoid thermal injury or the risk of thermal injury.

And very rarely but still worth mentioning is the potential need for active core rewarming strategies like warm water enemas or infusing warm intravenous fluids. Every once in a while doing lavishes of various cavities or organs like the urinary bladder or the stomach.