



Evidence of cardiac injury and dysfunction in dogs with acute kidney injury

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1 **SUMMARY**

2

3 **Objectives:** Cardiac involvement in the course of acute kidney injury (AKI) is described in humans as
4 cardiorenal syndrome type 3 but has received only limited attention in dogs. This study was designed to
5 evaluate cardiac injury and dysfunction in canine AKI and their association with outcome.

6

7 **Methods:** This prospective cohort study enrolled 25 client-owned dogs with AKI. Cardiac manifestations
8 were evaluated with thoracic radiographs, echocardiography, 24h Holter monitoring and cardiac troponin I
9 concentrations (cTnI) at admission and 7-10 days later.

10

11 **Results:** Most dogs were diagnosed with leptospirosis (n=19, 76%) and presented with moderate to severe
12 AKI, IRIS grades III–V. Dogs with ≥ 100 ventricular premature complexes (VPCs) per 24h in the first
13 examination (n=9) had significantly higher initial cTnI concentrations ($P=0.005$) and a worse outcome
14 ($P=0.040$) compared to dogs with fewer VPCs. In ROC curve analysis, the number of VPCs was more
15 predictive of outcome (AUC 0.85, $P<0.001$) than cTnI concentrations (AUC 0.78, $P=0.022$).

16

17 **Clinical significance:** AKI seems to be associated with cardiac injury and dysfunction in dogs. The data did
18 not indicate a cardiac cause of poor outcome in dogs with increased VPCs, but an association possibly
19 reflecting the severity of the disease.

20

21 **Keywords:** Acute kidney injury, arrhythmias, Holter monitoring, cardiac troponin I, echocardiography

22

23 INTRODUCTION

24 The interplay between the cardiovascular and renal systems involves multiple shared mechanisms related to
25 volume regulation and adaptive responses to loss of function. Most kidney diseases may thus be expected to
26 have direct or indirect cardiovascular effects that may include systemic hypertension, left ventricular
27 hypertrophy, fluid volume dysregulation, as well as manifestations of the underlying disease or iatrogenic
28 complications (Bagshaw *et al.* 2013, Ronco *et al.* 2008). When the primary condition is acute kidney injury
29 (AKI), these interactions are termed acute renocardiac syndrome or cardiorenal syndrome type 3 in people.
30 Several studies suggest that this syndrome also affects dogs (Mastrorilli *et al.* 2007, Porciello *et al.* 2008,
31 Sharkey *et al.* 2009).

32 Cardiac diseases may be of functional or structural nature. Cardiac arrhythmias reflect functional
33 myocardial disorders and long-term Holter electrocardiographic monitoring is typically indicated for their
34 reliable quantification (Lipski *et al.* 1976, Marino *et al.* 1994, Meurs *et al.* 2001, Miller *et al.* 1999, Wess *et al.*
35 *et al.* 2010). Serum cardiac troponin concentration is regarded as the most accurate blood test for the evaluation
36 of myocardial damage, with cardiac troponin I (cTnI) being the most sensitive (Adams *et al.* 1993, Schober *et al.*
37 *et al.* 2002, Shaw *et al.* 2004). Veterinary studies indicate that a large number of noncardiac diseases, including
38 renal failure (Porciello *et al.* 2008, Sharkey *et al.* 2009), leptospirosis (Mastrorilli *et al.* 2007), babesiosis
39 (Lobetti *et al.* 2002), ehrlichiosis (Diniz *et al.* 2008), immune-mediated haemolytic anaemia (Gow *et al.*
40 2011), snake envenomation (Segev *et al.* 2008), pyometra (Pelander *et al.* 2008), systemic inflammation
41 (Langhorn *et al.* 2013) and gastric dilatation volvulus (Burgener *et al.* 2006), may induce myocardial injury
42 and increased cTnI concentrations. In addition, several human studies have suggested that cTnI concentrations
43 may be affected by decreased renal clearance (Diris *et al.* 2004, Fahie-Wilson *et al.* 2006) and haemodialysis
44 (Assa *et al.* 2013, Deleaval *et al.* 2006, Farkouh *et al.* 2003, Tun *et al.* 1998, Wayand *et al.* 2000), but these
45 findings remain controversial.

46 To the authors' knowledge, only few studies have reported cardiac involvement in canine kidney
47 disease, and these were limited to demonstrating elevated cTnI concentrations (Mastrorilli *et al.* 2007,
48 Porciello *et al.* 2008, Sharkey *et al.* 2009). However, without further cardiologic evaluation, the clinical
49 relevance of these findings remains unclear. The goal of the present study was to evaluate the presence of
50 functional and structural cardiac injury in dogs with AKI using Holter recordings, cTnI measurements,

51 thoracic radiographs and echocardiography, and to assess possible associations between these findings and
52 outcome. We hypothesized that AKI is associated with cardiac arrhythmias and elevated cTnI concentrations,
53 and that cardiac injury may indicate severe disease and increased mortality.

54

55 **MATERIALS AND METHODS**

56 **Animals**

57 Dogs diagnosed with AKI between April and December 2013 were enrolled in this prospective cohort study.
58 Small dogs weighing less than 7kg and dogs with dyspnoea were excluded due to the size of the Holter
59 recorder and the potential breathing impairment caused by the recorder attachment system. Other exclusion
60 criteria were chronic kidney disease and pre-existing heart disease, as well as splenic disease or pancreatitis,
61 which have been associated with myocardial injury (Marino *et al.* 1994, Serra *et al.* 2010). The diagnosis of
62 AKI required at least 2 of the following criteria: renal azotaemia persisting for ≥ 24 h after correction of
63 prerenal factors, an increase in serum creatinine concentration ≥ 100 $\mu\text{mol/L}$ or $\geq 100\%$ from baseline,
64 persistent oligoanuria after volume repletion; and evidence of tubular injury based on urinalysis (Fraune *et al.*
65 2013). All procedures were conducted in accordance with the Animal Welfare Act (xx), and subject to
66 informed owner consent.

67

68 **Diagnostic examinations and grouping**

69 Initial diagnostics included a complete blood count, biochemical and coagulation profiles, venous blood gas
70 analysis, urinalysis, and abdominal ultrasound. Additional diagnostics, performed as indicated to identify the
71 aetiology, included microscopic agglutination test (MAT) using a panel of ubiquitous and locally prevalent
72 serovars (*L. interrogans* serovars Australis, Autumnalis, Bataviae, Bratislava, Canicola, Hardjo,
73 Icterohaemorrhagiae, Pomona, Pyrogenes, Sejroe, and Tarassovi and *L. kirschneri* serovar Grippotyphosa)
74 and a *Leptospira* IgM assay (Test-it lateral flow, LifeAssay Diagnostics, Cape Town, South Africa (Abdoel *et*
75 *al.* 2011)). A diagnosis of leptospirosis was confirmed by either a 4-fold titre increase on paired serologies, a
76 single MAT titre $\geq 1:800$ for non-vaccine serovars, or a positive IgM assay (Schuller *et al.* 2015).

77 Cardiac evaluation, performed within 48h of presentation, included physical examination, thoracic
78 radiographs evaluated by a board-certified radiologist, transthoracic echocardiography performed by a board-

79 certified cardiologist, 24h Holter monitoring and serum cTnI concentrations. Echocardiography was
80 performed with an Aloka ProSound Alpha 5SV machine and a 5-MHz sector transducer in unsedated dogs.
81 Serum samples were stored at -80°C and batched for measurements of cTnI concentrations (Centaur XP TnI-
82 Ultra assay, Siemens Healthcare Diagnostics, Eschborn, Germany) (Beck *et al.* 1997). The measurement
83 range was 0.006—50 ng/mL and the laboratory upper reference limit was 0.06 ng/mL (Serra *et al.* 2010).
84 Holter monitoring was performed using a 2-channel CardioMem CM 3000 recorder and the CardioDay
85 software (GETEMED, Teltow, Germany). All recordings were subsequently checked manually by the same
86 examiner (XX). Holter recording and cTnI measurement was repeated 7-10 days after the initial examination.

87 The dogs were grouped based on the number of ventricular premature complexes (VPCs) during the
88 first examination into Group 1 (<100 VPCs/24h) or Group 2 (\geq 100 VPCs/24h). This cut-off was chosen as it
89 has been suggested as pertinent to detect relevant arrhythmias in previous studies (Hall *et al.* 1991, Meurs *et*
90 *al.* 2001, Olsen *et al.* 1999, Ulloa *et al.* 1995, Wess *et al.* 2010).

91

92 **Treatment and outcome**

93 Therapy was adapted individually to the clinical needs of the dogs and consisted mainly of intravenous fluids,
94 gastric protectants, antemetics, analgesics, antibiotics, and antihypertensives. In addition, dogs received renal
95 replacement therapy as intermittent haemodiafiltration when this was indicated based on clinical condition,
96 degree of azotaemia, potassium concentration and urine production. The outcome was defined as either fatal
97 (death or euthanasia), full recovery (discharge without residual azotaemia) or partial recovery (discharge with
98 persisting azotaemia).

99

100 **Statistical analyses**

101 Statistical analyses were performed using commercial software (MedCalc 13.0.6.0, Ostend, Belgium; NCSS
102 9.0.15, Kaysville, Utah, USA). A sample size calculation was performed to estimate the number of dogs
103 needed to show an increased number of VPCs (from 10 ± 5 to a mean \geq 100 VPCs/24h) and an elevated
104 concentration of cTnI (from 0.092 ± 0.066 to a mean \geq 0.2 ng/ml), using previously published populations of
105 normal dogs as references (Maier *et al.* 2010, Meurs *et al.* 2001). Samples of 6 (VPCs) and 11 dogs (cTnI)

106 were identified as necessary to show these differences with a 90% power, and the study was therefore
107 designed to include the first 25 eligible dogs.

108 Comparison of categorical data was performed using Fisher's exact test. Continuous data were
109 assessed for normality with normal probability plots and D'Agostino-Pearson test. Comparison between
110 groups for continuous data was performed using independent samples t-tests when normally distributed and
111 Mann-Whitney tests otherwise. Comparison between the first and second cTnI concentrations was performed
112 using a Wilcoxon signed-rank test. Correlation between cTnI concentrations and creatinine was evaluated
113 using Spearman's rank correlation. Prediction of outcome based on cTnI concentrations or VPCs was
114 evaluated using ROC curve analysis and the optimal cut-off based on the Youden index. Significance was set
115 at $P < 0.05$ throughout.

116

117 **RESULTS**

118 **Dogs and general diagnostic evaluation**

119 During the 9 months of the study, 70 dogs were diagnosed with AKI at the authors' institution. Twenty-five
120 dogs met the inclusion criteria and were enrolled (Table 1). These were 7 mixed breed dogs and 18 dogs from
121 12 different breeds. Nineteen of the 25 dogs (76%) were diagnosed with leptospirosis based on paired MAT
122 seroconversion ($n=11$, 58%), positive MAT titre at presentation ($n=13$, 68%), or a positive IgM assay at
123 presentation ($n=13$, 68%). Positive serovars in the first MAT serology ($n=19$) included Australis (68%),
124 Bratislava (58%), Pomona (16%), and Autumnalis (11%). Other causes of AKI included anaesthesia-related
125 ischaemia ($n=1$), renal thrombosis ($n=1$), grape toxicity ($n=1$), unidentified toxic nephrosis ($n=1$), and
126 unknown aetiology ($n=2$).

127 The level of azotaemia at presentation ranged from mild to severe with serum creatinine and urea
128 concentrations ranging between 294—1359 $\mu\text{mol/L}$ and 20—106 mmol/L , respectively (Table 2). Six dogs
129 (24%) were classified as IRIS AKI grade III, 8 dogs (32%) grade IV, and 11 dogs (44%) grade V.

130 Abnormalities found on routine bloodwork included anaemia ($n=13$; 52%), leukocytosis ($n=17$; 71%),
131 left shift ($n=10$; 42%), hyperbilirubinaemia ($n=10$; 40%), hyperkalaemia ($n=7$; 28%), hypokalaemia ($n=9$;
132 36%), total hypercalcaemia ($n=8$; 32%), ionized hypocalcaemia ($n=9$; 38%), hyperphosphataemia ($n=25$;
133 100%), acidaemia ($n=9$; 38%), metabolic acidosis ($n=10$; 42%), and increased anion gap ($n=18$; 75%) (Table

134 2). No differences between the groups were found for any of the parameters analysed (Table 2). Urinalysis
135 was available for 22 dogs and revealed proteinuria (n=17; 77%) and renal glucosuria (n=17; 77%).

136 Abdominal ultrasonography supported the diagnosis of AKI with normal renal architecture,
137 renomegaly, and perirenal effusion. No evidence of chronic kidney disease, pancreatitis or splenic disease was
138 observed.

139

140 **Cardiac evaluation**

141 At initial physical examination all dogs were considered normovolaemic and a grade II-III left-sided systolic
142 heart murmur was identified in 3 dogs. Thoracic radiographs did not show any abnormal cardiac-related
143 findings. However, 9/19 (47%) dogs with leptospirosis demonstrated evidence of pulmonary haemorrhage
144 with peribronchial cuffing and moderate interstitial to alveolar lung patterns.

145 Initial echocardiographic examination was performed on all but one dog, considered too unstable to be
146 evaluated. One dog was considered hypovolaemic, based on reduced filling of the left heart, and all others
147 were considered normovolaemic. Valvular insufficiency was observed in 15 dogs (63%), including both
148 atrioventricular valves in 6 dogs (25%), mitral valve alone in 5 dogs (21%), tricuspid and pulmonic valves in
149 3 dogs (13%), and pulmonic valve alone in 1 dog (4%). All other echocardiographic parameters were within
150 normal limits in all dogs.

151 Holter monitoring was performed in all 25 dogs at initial evaluation and in 21 dogs surviving for the
152 second evaluation. One recording at the second evaluation contained only 6h of readable data and was
153 excluded. During the first evaluation, VPCs were detected in 20 dogs (80%); 16 dogs (64%) had <100
154 VPCs/24h (Group 1) and 9 dogs (36%) \geq 100 VPCs/24h (Group 2) (Table 3). No other arrhythmias were
155 identified and antiarrhythmic therapy was not considered indicated in any dog. No difference was found
156 between the groups for any of the signalment, disease, clinical or laboratory parameters evaluated (Tables 1
157 and 2). However, initial cTnI concentration was increased in 23 dogs (92%) and was significantly higher in
158 Group 2 than in Group 1 (Table 3, Figure 1). No correlation was observed between the initial cTnI and
159 creatinine concentrations ($r_s=0.229$; $P=0.270$).

160 During the second evaluation, VPCs were detected in 11/20 dogs (55%); 17 dogs (85%) had <100
161 VPCs/24h and 3 dogs (15%) \geq 100 VPCs/24h. The cTnI concentrations were significantly lower compared to
162 the first evaluation ($P=0.008$). No difference was found between groups for both parameters (Table 3).

163

164 **Treatment and Outcome**

165 Seventeen dogs (68%) required renal replacement therapy, a treatment not associated with a difference in the
166 number of VPCs ($P=0.192$), initial cTnI concentrations ($P=0.336$) or outcome ($P=0.621$).

167 Twenty dogs (80%) recovered from their disease and were discharged from hospital, 8 dogs with
168 complete and 12 dogs with partial recovery. Of dogs not surviving, 3 were euthanized and 2 died. Main causes
169 of fatal outcome included severe pulmonary haemorrhages ($n=2$), persistent seizures ($n=2$), and lack of renal
170 recovery ($n=2$). Necropsy was performed in 2 dogs and revealed interstitial nephritis and thrombi in multiple
171 organs in one dog and acute tubular necrosis and interstitial nephritis in the other. Both hearts were
172 macroscopically and histologically unremarkable.

173 Mortality was significantly higher in Group 2 than in Group 1 ($P=0.04$, Figure 2). Although initial
174 cTnI concentrations were higher in dogs that died (median 1.75 ng/ml; range 0.28—47.15) than in survivors
175 (median 0.39 ng/ml; range 0.04—3.07), this difference was not statistically significant ($P=0.057$). Based on
176 ROC curve analysis (Figure 3), the number of VPCs/24h at presentation was predictive of outcome with an
177 AUC of 0.85 (95% CI, 0.65—0.96, $P<0.001$) and a calculated optimal cut-off of 18 VPCs/24h (sensitivity
178 100%, specificity 70%). Initial cTnI concentrations were also predictive of outcome with an AUC of 0.78
179 (95% CI, 0.57-0.92, $P=0.023$) and a calculated optimal cut-off of 0.65 ng/ml (sensitivity 80%, specificity
180 70%).

181

182 **DISCUSSION**

183 Data from the present study indicate that functional and structural myocardial injuries commonly occur in
184 canine AKI. Although none of the fatalities seemed to be directly cardiac related, increased numbers of VPCs
185 were associated with higher mortality, suggesting an indirect association or a common cause. Disease severity
186 was not obviously different between the groups but the study was not designed and powered to examine this
187 aspect.

188 Previous studies evaluating dogs with non-renal diseases found similar associations between short-
189 time electrocardiography, cTnI, and outcome (Diniz *et al.* 2008, Lobetti *et al.* 2002, Schober *et al.* 2002). To
190 avoid over-interpretation of small numbers of VPCs, a cut-off of 100/24h was used in the present study.
191 Although this is clearly higher than numbers expected in healthy dogs (10 ± 5 VPCs/24h), similar cut-offs
192 (100-150 VPCs/24h) have been used to detect clinically relevant disease in breeds prone to arrhythmias (Hall
193 *et al.* 1991, Olsen *et al.* 1999, Ulloa *et al.* 1995, Wess *et al.* 2010).

194 Valvular insufficiencies were observed in 63% of the dogs from the present study. However, these
195 were minimal and not associated with structural alterations of the heart chambers and were, therefore, not
196 expected to cause relevant myocardial injury (O'Brien *et al.* 2006, Spratt *et al.* 2005). Cardiac changes
197 associated with AKI, including left ventricular hypertrophy in rats (Burchill *et al.* 2008) or impaired systolic
198 function in humans (Bagshaw *et al.* 2013), were not observed in the present study.

199 Acute kidney injury may increase the risk for cardiac injury by inducing pro- and anti-inflammatory
200 cytokines and activating the sympathetic and renin-angiotensin-aldosterone systems (Bagshaw *et al.* 2013).
201 Furthermore, metabolic disturbances characteristic of AKI, including acidaemia, hyperkalaemia,
202 hypocalcaemia, hyperphosphataemia, azotaemia, and anaemia, may have profound effects on myocardial
203 electrical activity and function (Bagshaw *et al.* 2013, Serra *et al.* 2010, Zeidman *et al.* 2004). Although no
204 significant difference was found between groups for any of these parameters in the present study, this could, at
205 least in part, be due to small sample sizes and different pre-referral therapeutic interventions. As population
206 size was designed to address power with regards to the principal aims of the study, further investigations
207 should evaluate the role of these factors in AKI-related myocardial injury. Overzealous fluid therapy has been
208 described to predispose to VPCs and impaired myocardial performance (Bagshaw *et al.* 2013, Ip *et al.* 2011).
209 However, this was unlikely a factor in the present study, based on physical examination, thoracic radiographs
210 and echocardiography.

211 A great number of dogs required renal replacement therapy, and this intervention may increase the
212 risk of hypotension, hypovolaemia and rapid electrolyte and fluid shifts and therefore cause myocardial injury
213 (Selby *et al.* 2007). Haemodiafiltration may further affect cTnI concentrations by partial clearance of this 24-
214 kDa molecule (Tattersall 2007, Wayand *et al.* 2000). However, the short half-life of cTnI (approximately 2h)
215 (Katus *et al.* 1989), the timing of expected increase (4-12h after cardiac injury) (Goldmann *et al.* 2001), and

216 the timing of blood sampling (prior to the first treatment and ≥ 4 d after the last treatment) make it unlikely that
217 dialysis affected cTnI concentrations in the present study (Assa *et al.* 2013, Deleaval *et al.* 2006, Farkouh *et*
218 *al.* 2003, Tun *et al.* 1998).

219 Decreased renal clearance has also been suggested to increase cTnI concentrations. However, the
220 absence of correlation between azotaemia and cTnI in the present study suggests that this did not play a major
221 role in cTnI elevations, paralleling results from other studies (Ellis *et al.* 2001, Mastroilli *et al.* 2007,
222 Porciello *et al.* 2008, Van Lente *et al.* 1999). Based on these considerations, data in the present study support
223 the hypothesis of a real and severe myocardial injury associated with canine AKI (Gallegos *et al.* 2004,
224 Ricchiuti *et al.* 1998).

225 Leptospirosis has been shown to affect the cardiovascular system and has been associated with
226 arrhythmias, increased cTnI concentrations, and myo-, endo-, or pericarditis (Mastroilli *et al.* 2007, Skerk *et*
227 *al.* 2011). Given that 76% of the dogs in the present study were diagnosed with leptospirosis, the extent to
228 which myocardial injury was due to AKI itself or due to leptospirosis remains unclear.

229 In conclusion, the results of the present study confirm our hypotheses that AKI is associated with
230 cardiac arrhythmias and substantial but reversible myocardial injury. The worse outcome for affected animals
231 is likely multifactorial and may result from higher disease severity, but this could not be substantiated in the
232 present study. Further studies focusing on the inflammatory and the neuro-endocrine status of canine AKI are
233 necessary to evaluate more precisely the possible pathophysiologic processes responsible for these cardiorenal
234 effects.

235

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352 **Figure legends**

353

354 **Figure 1.** Bar chart showing the median (95% confidence intervals) for cTnI concentrations in the 2 groups of
355 dogs: group 1, 16 dogs with AKI and <100 VPCs/24h; group 2, 9 dogs with AKI and ≥ 100 VPCs/24h.

356

357 **Figure 2.** Frequency chart showing outcome in the 2 groups of dogs: group 1, 16 dogs with AKI and <100
358 VPCs/24h; group 2, 9 dogs with AKI and ≥ 100 VPCs/24h.

359

360 **Figure 3.** ROC curves representing the predictive value of the parameters VPCs (AUC 0.85) and cTnI (AUC
361 0.78) on outcome for dogs with AKI.

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Table 1. Clinical data in dogs with acute kidney injury and <100 VPCs/24h (Group 1) or \geq 100 VPCs/24h (Group 2).

Variable		All dogs (n=25)	Group 1 (n=16)	Group 2 (n=9)	P-value
Gender	Male [n (%)]	16 (64%)	10 (63%)	6 (67%)	1.000
	Female [n (%)]	9 (36%)	6 (37%)	3 (33%)	
Body weight, kg [median (range)]		25.1 (7.2—57.0)	21.5 (7.2—57.0)	26.3 (11.8—47.6)	0.396
Age, years [median (range)]		6.7 (0.3—13.5)	5.6 (0.3—13.5)	8.5 (0.4—12.1)	0.536
Leptospirosis [n (%)]		19 (76%)	13 (81%)	6 (67%)	0.630
Pulmonary haemorrhage [n (%)]		9 (36%)	5 (31%)	4 (44%)	0.671
Renal replacement therapy [n (%)]		16 (64%)	9 (56%)	7 (78%)	0.401
Survival at 90 days [n (%)]		20 (80%)	15 (94%)	5 (56%)	0.040

VPCs ventricular premature complexes.

Table 2. Median (25th-75th percentile) of laboratory data in dogs with acute kidney injury and <100 VPCs/24h (Group 1) or ≥100 VPCs/24h (Group 2).

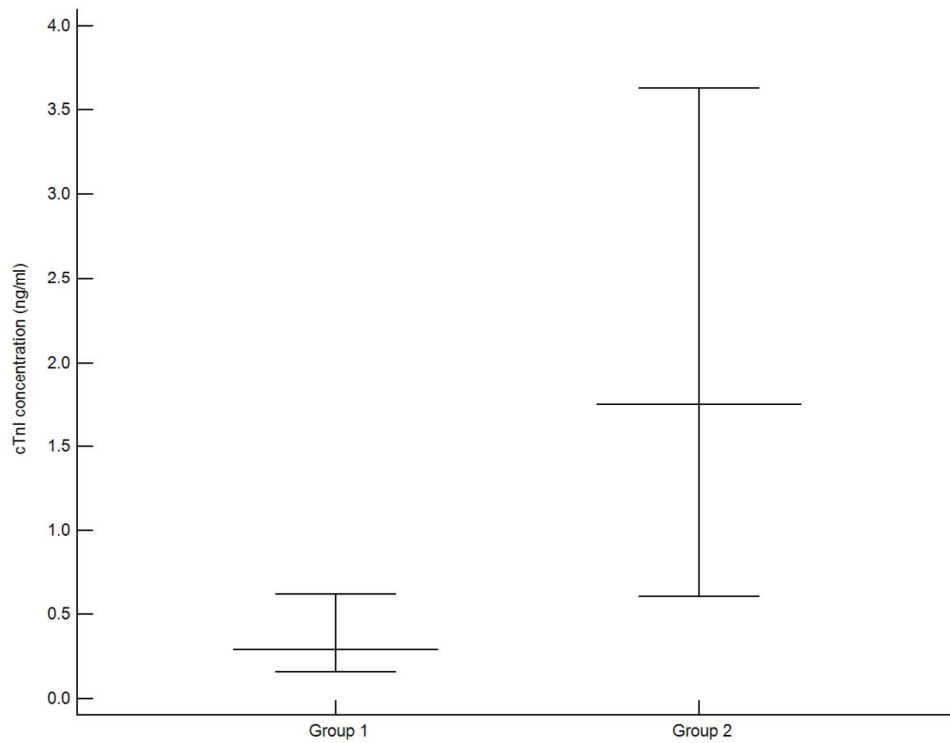
Parameter	All dogs (n=25)	Group 1 (n=16)	Group 2 (n=9)	P-value
Hematocrit (L/L)	0.39 (0.33—0.44)	0.39 (0.34—0.43)	0.36 (0.32—0.47)	0.909
WBC (x10 ⁹ /L)	14.22 (11.57—21.59)	13.66 (11.55—20.67)	15.68 (12.85—21.18)	0.387
Creatinine (μmol/L)	748 (492—1082)	704 (463—1095)	892 (548—1069)	0.711
Urea (mmol/L)	57.69 (42.63—62.71)	47.00 (40.26—61.33)	59.54 (53.82—66.62)	0.428
Na (mmol/L)	145 (143—148)	144 (142—148)	147 (143—149)	0.410
K (mmol/L)	4.61 (3.96—5.6)	4.58 (4.03—5.49)	5.18 (3.93—5.60)	0.737
P (mmol/L)	4.27 (2.69—6.03)	4.32 (2.42—5.60)	4.09 (3.36—6.45)	0.692
Total Ca (mmol/L)	2.62 (2.31—2.89)	2.52 (2.20—2.87)	2.71 (2.56—3.03)	0.174
Ionized Ca (mmol/L)	1.14 (1.03—1.24)	1.16 (1.02—1.26)	1.09 (1.04—1.21)	0.788
pH	7.34 (7.29—7.37)	7.36 (7.31—7.37)	7.31 (7.29—7.34)	0.144
HCO ₃ ⁻ (mmol/L)	19.0 (17.1—21.6)	19.6 (18.0—21.7)	17.5 (16.6—19.7)	0.449
PCO ₂ (mmHg)	36.2 (34.9—40.0)	36.3 (35.2—39.1)	35.5 (33.5—40.8)	0.644

VPCs ventricular premature complexes, WBC white blood cell count.

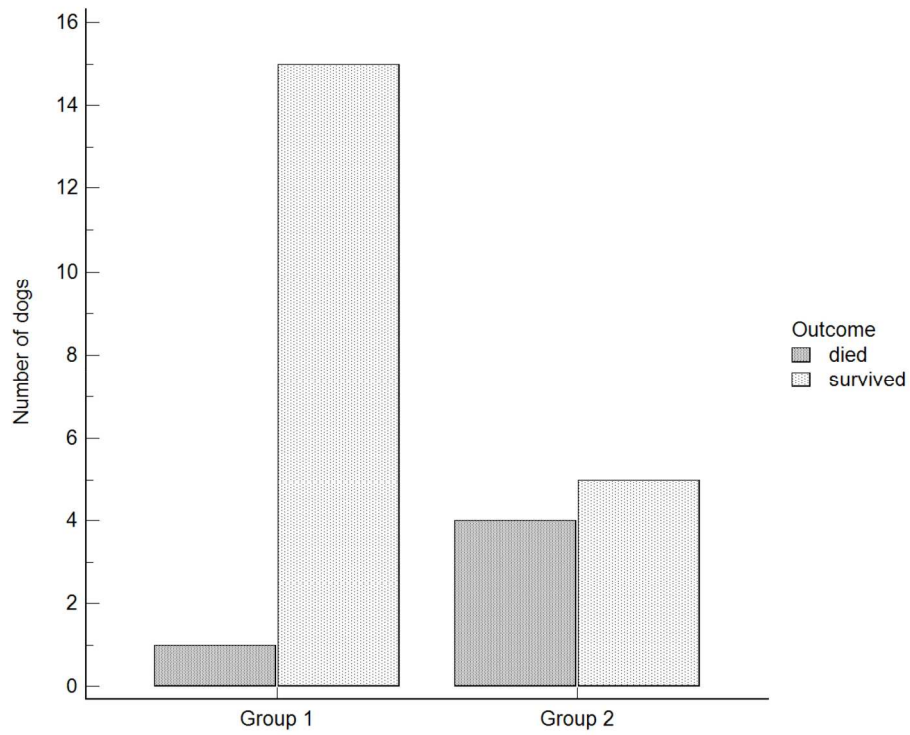
Table 3. Concentrations of cTnI and 24h-Holter monitoring in dogs with acute kidney injury and <100 VPCs/24h (Group 1) or \geq 100 VPCs/24h (Group 2) at initial examination

Time	Parameter	All dogs	Group 1	Group 2	P-value
T0	Number of dogs (n)	25	16	9	
	VPCs/24h [median, (IQR)]	17 (2—321)	5 (0—14)	711 (304—3183)	
	cTnI, ng/mL [(median (IQR)]	0.59 (0.19—1.81)	0.29 (0.16—0.63)	1.75 (0.68—3.23)	0.005
	cTnI >reference [n (%)]	23 (92%)	14 (88%)	9 (100%)	0.520
T1	Number of dogs (n)	21*	14	7*	
	VPCs/24h [median, (IQR)]	1 (0—50)	1 (0—17)	42 (0—854)	0.495
	<100 VPCs/24h [n (%)]	17 (85%)	13 (93%)	4 (67%)	0.202
	\geq 100 VPCs/24h [n (%)]	3 (15%)	1 (7%)	2 (33%)	
	cTnI, ng/mL [(median (IQR)]	0.22 (0.05—0.52)	0.12 (0.04—0.31)	0.23 (0.10—1.54)	0.168
cTnI >reference [n (%)]	14 (67%)	8 (57%)	6 (86%)	0.337	

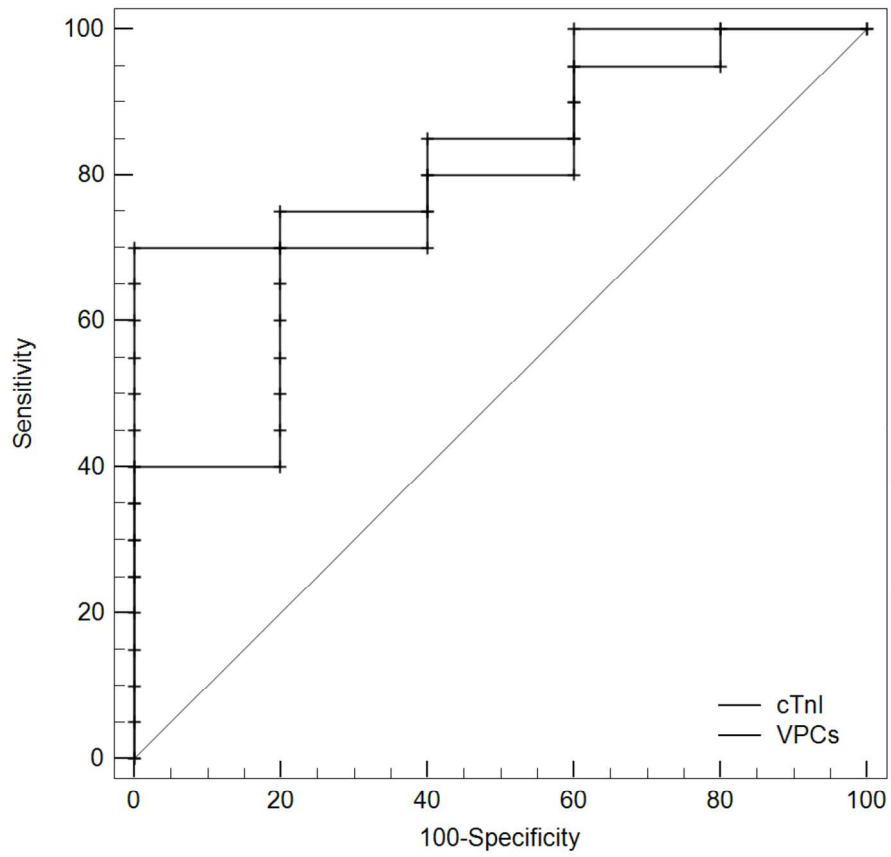
* Holter data missing due to incomplete recordings in 1 dog, cTnI cardiac troponin I, IQR interquartile range, T0 initial examination, T1 follow-up examination, VPCs ventricular premature complexes.



Bar chart showing the median (95% confidence intervals) for cTnI concentrations in the 2 groups of dogs:
group 1, 16 dogs with AKI and <100 VPCs/24h; group 2, 9 dogs with AKI and ≥100 VPCs/24h.
221x177mm (300 x 300 DPI)



Frequency chart showing outcome in the 2 groups of dogs: group 1, 16 dogs with AKI and <100 VPCs/24h; group 2, 9 dogs with AKI and ≥100 VPCs/24h.
214x173mm (300 x 300 DPI)



ROC curves representing the predictive value of the parameters VPCs (AUC 0.85) and cTnI (AUC 0.78) on outcome for dogs with AKI.
196x180mm (300 x 300 DPI)