Lesão Renal Aguda Anúrica: Um Diagnóstico a Não Esquecer

Anuric Acute Kidney Injury: A Diagnosis Not to Forget

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A 66-year-old man, heavy smoker, with medical history of hypertension and peripheral arterial disease, presented to the emergency department with anuria. The physical examination revealed signs of fluid overload and laboratory showed serum urea 183 mg/dL (15-45), serum creatinine 9.6 mg/dL (0.4-1.0), hemoglobin 14.1 g/dL (12.0-15.0), potassium 5.2 mmol/L (3.6-5.1), LDH 509 U/L (0-247). A renal ultrasound with Doppler suggested asymmetric kidneys and doubtful renal arterial perfusion. A computed tomography (CT) angiography was then performed and confirmed abdominal aortic thrombosis with complete lumen occlusion in the emergency of renal arteries (see white arrow in image 1 and 2), with revascularization of the lower limbs by large collaterals and permeability of the celiac trunk and the superior mesenteric artery. He started haemodialysis. Vascular surgery evaluated the patient and there was no surgical feasibility given the high probability of unviable renal parenchyma. He was then anticoagulated, remained on haemodialysis and three year later he still keeps his daily life activities without intermittent claudication despite the abdominal aortic thrombosis.

This image intends to illustrate a rare cause of acute kidney injury (AKI). Although classically the clinical presentation may vary from acute limb ischemia, neurologic symptoms of the lower extremities and abdominal symptoms, in this case the patient just presented with anuric AKI and nowadays he still has no lower limbs or abdominal involvement, despite being on haemodialysis.

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