

LETTERS

POLYPHARMACY AND ACUTE KIDNEY INJURY

A few clarifications pleaseNicholas D Moore *clinical pharmacologist*

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Lapi and colleagues' paper makes good pharmacological sense but I have a few comments.¹

Firstly, the authors state that they adjusted for indication but it seems that they did this for antihypertensive drugs only. Was the indication for the use of non-steroidal anti-inflammatory drugs (NSAIDs) included? NSAIDs are usually used for acute pain, and some of these indications (such as infections) might be involved in acute renal failure. Of course this would not explain the differential risk between double and triple therapy, but it might need to be looked at.

Secondly, the use of paracetamol seems to be greater in cases than in controls. Paracetamol may be a cyclo-oxygenase-2 (COX 2) inhibitor, which may have renal effects. Did the authors look at the risk of renal failure associated with the use of paracetamol?

Thirdly, the 30 day period of increased risk after onset of treatment presumably refers to the date of prescription of the

NSAID because the antihypertensives were used chronically, or does it refer to the change from one to two antihypertensives?

Lastly, NSAIDs are used for much less than 30 days at a time for most indications, and indications differ between different NSAIDs. Ones with long half lives, like piroxicam, are used more long term for chronic inflammation and those with short half lives, like ibuprofen, are used short term for common pain. Would this, in addition to the duration of COX inhibition, be a confounder?

Competing interests: None declared.

1 Lapi F, Azoulay L, Yin H, Nessim SJ, Suissa S. Concurrent use of diuretics, angiotensin converting enzyme inhibitors, and angiotensin receptor blockers with non-steroidal anti-inflammatory drugs and risk of acute kidney injury: nested case-control study. *BMJ* 2013;346:e8525. (8 January.)

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