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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Analgesic nephropathy

SIR,—I wonder if you will publish a comment on your leading article on analgesic nephropathy (31 January, p 339). There is compelling evidence that Australians do have more analgesic nephropathy. My interest was stimulated in 1959, when soon after arriving in Australia I recognised what to me was a new kidney lesion—namely, renal papillary necrosis with pigmented papillae. This lesion appeared frequently on necropsy tables in Melbourne hospitals, whereas in six years spent carefully scrutinising kidneys in London at the Royal Postgraduate Medical School, I had recognised only one, which I kept among my "rare case" collection.

This anecdotal experience was strengthened by a study carried out from 1959 to 1962, which revealed 92 clinical cases of analgesic nephropathy in this hospital.[1] Necropsy studies in Australia have revealed renal papillary necrosis in 8·7-21·4% of all necropsies, compared with 0·16% in the United Kingdom.[2] The Australian Kidney Foundation Registry has a record of every patient dialysed or transplanted since programmes commenced in 1963. Over this period analgesic nephropathy has accounted for 20-25% of all cases of end-stage renal failure. Phenacetin was removed from many over-the-counter analgesics in Australia as early as 1962 and from the last two popular compounds in 1967 and 1975 respectively; and yet analgesic nephropathy remains distressingly frequent, still accounting for 35% of patients accepted for dialysis in Queensland (table).

Analgesic nephropathy with clinical features and renal lesions identical to those seen with phenacetin-containing medications has continued to develop in patients who have taken only aspirin-salicylamide-caffeine or aspirin-paracetamol-caffeine mixtures.[3] Hopefully, recent restrictions which place these mixtures on prescription will reduce the numbers presenting for costly treatment of end-stage renal failure.

Number and proportion of new patients with analgesic nephropathy in 1980: data from the Australian Kidney Foundation dialysis and transplant registry

State	No with analgesic nephropathy	Total No in registry	%
Queensland	29	84	35
New South Wales	66	235	28
Victoria	10	117	9
South Australia	5	57	9
Western Australia	6	45	13
Australia	116	538	22

Even if abuse of over-the-counter analgesics ceases, a steady trickle of iatrogenic papillary necrosis associated with prescription of non-steroidal anti-inflammatory agents is likely to continue. Patients with rheumatoid arthritis commonly show papillary necrosis at necropsy,[4-6] but if they develop renal failure this occurs at an age at which dialysis is not usually considered. Recently we have seen renal papillary necrosis related to prolonged treatment with non-steroidal anti-inflammatory agents, given during childhood for Still's disease and congenital hip disease; and similar cases have been reported from elsewhere.[7]

We have also investigated the possibility that there may be a genetic predisposition to analgesic nephropathy and have found an association between HLA-B12 and analgesic nephropathy.[8]

PRISCILLA KINCAID-SMITH

University of Melbourne
Department of Medicine,
Royal Melbourne Hospital,
Melbourne, Victoria,
Australia 3050

[1] Dawborn JK, Fairley KF, Kincaid-Smith P, King WE. *Q J Med* 1966;35:69.