

Letters to the editor

OVERVIEW

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Austrian syndrome

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Editor – thank you for publishing the article about Austrian syndrome.¹

There is just one thing I would like to mention; the article ends with 'We also propose that this syndrome should be renamed as Osler's syndrome with Osler's tetrad, in acknowledgement that Sir William Osler was the first to describe the triad of pneumonia, meningitis and endocarditis with presence of 'micrococci' in affected tissues and blood.'

I am aware that there is a language barrier as some really old articles are in German, but it is not the full truth that Osler was the first; Mandal *et al*'s article does not mention Richard Heschl at all. Heschl described a case series of patients with endocarditis, pneumonia and meningitis in 1862.² If we take the historical background into account, and the fact that there was no 'bacteriology' in the 1860s (eg Ferdinand Julius Cohn published 'Untersuchungen über Bakterien' in 1872, Robert Koch described *Bacillus anthracis* in 1876), Heschl was as close to the pathophysiology as he could have been in the early 1860s.

I would like to propose another approach, if we have to rename the syndrome (do we have to?), then to name it Heschl syndrome, or do as with all the other syndromes and get rid of the eponymous names and call the pathophysiology something like 'Pneumococcal multiorgan infestation syndrome affecting heart, lung and central nervous system' as a (very long – apologies) description for the syndrome. ■

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References

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Perioperative diabetes management in patients with kidney disease

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Editor – We read with interest the article 'Perioperative diabetes care' by Ketan Dhatariya and Nicholas Levy.¹

We wanted to highlight the challenges involved in management of diabetic patients with chronic kidney disease (CKD), acute kidney injury (AKI) and AKI on CKD. We believe that it is important to note the role CKD and AKI play in the management of patients with diabetes. There is a well-known association between diabetes and development of CKD. Mathew *et al* found that CKD was an independent risk factor for postoperative morbidity and mortality, with a strength of association similar to that of diabetes, stroke or coronary disease.²

The risk of side effects of some antidiabetic medications, such as metformin and thiazolidinediones, increases in patients with CKD. Zanchi *et al* have concluded that only sitagliptin, saxagliptin and linagliptin may be used in advanced kidney disease, while GLP-1 agonists are contraindicated.³

Furthermore, there are multiple mechanisms by which surgery can lead to the development of AKI, especially in patients with a known history of CKD. The use of non-steroidal anti-inflammatory drugs for pain management, contrast-media for imaging studies and volume depletion during surgery are all contributing factors. Hobson *et al* recommend using different predictive strategies, including scoring systems and clinical judgement to determine the risk of AKI in patients undergoing surgery.⁴ Some hospitalised patients are on anticoagulants for various reasons. Anticoagulation-related nephropathy is a significant but underdiagnosed complication of anticoagulant treatment. It is most commonly associated with warfarin but some studies suggest its association with novel anticoagulants as well.⁵

There is a known strong association between type 2 diabetes and atrial fibrillation, increasing the likelihood that the patients have been prescribed anticoagulants. We therefore believe that more detailed guidelines are needed to determine the best approach to perioperative management of patients with diabetes and comorbid kidney disease, including finding the best AKI prevention strategies, reducing the risk of medication side effects, finding the optimal anticoagulation regimen and ensuring long-term renal protection. ■

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