

Deliberating a Re(n)al-world Research Setting

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Singh et al. are sincerely congratulated for their exemplary research endeavor assessing the spectrum of acute kidney injury (AKI) amongst non-COVID-19 patients across 200 adult patients admitted to four intensive care units (ICUs) in their tertiary care center.¹ Ahead of the interesting observations on the AKI pattern emanating from the index study, there remain additional points necessitating deliberation for improved comprehension of the subject.

Firstly, the authors outline an increased incidence of community-acquired compared to hospital-acquired AKI in their setting. Quite understandably, they attribute the same to restricted surgeries during times of pandemic.¹ Appropriate to the context, Boyer et al. elaborate an even more important role of the nature of surgical interventions in determining the overall predisposition to postoperative AKI.² Withstanding, one misses the account of the type of surgeries performed in the Singh et al. prospective study. Notably, so the study involved two surgical ICUs with post-surgery being the third leading etiology with a 22.5% contribution to the AKI burden.¹ Moreover, with one of the ICUs being dedicated to cardiothoracic surgical care, the operative use of cardiopulmonary bypass would have also been far from benign with regards to AKI as an outcome.^{1,2}

Secondly, the lack of data on the diagnostic-therapeutic procedural use of contrast agents in the critically ill culminating into AKI, limits the understanding of the disease spectrum in the present study.¹ Contrast administration, alongside accentuating the propensity to AKI has relevant prognostic implications highlighted by Cheng et al. in a large cohort of 2,77,898 hospitalized patients.³ Furthermore, the former group discovered elevated all-cause mortality in the post-contrast AKI subset with persistent renal dysfunction (RR; 95% CI: 3.77; 1.61–8.81, *p*-value = 0.002).³ Talking of mortality, Singh et al. pinpoint a heightened use of inotropes amongst the non-survivors.¹ Falling short of elucidation of the nature of hemodynamic support, we believe it is a case of the use of an inclusive terminology given almost 2 out of 3 non-survivors manifested sepsis, which in all likelihood would have mandated vasopressor administration.⁴

Lastly, with the 30-day mortality following AKI under evaluation in the Singh et al. study, factors such as hypoalbuminemia are equally difficult to overlook considering meta-analysis by Wiedermann et al. propounds 147% increased odds of death for every 10 gm/L decrement of serum albumin in AKI patients.^{1,5}

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