ience of adapting the dosage of medications in patients with chronic vs. acute RF. In diabetic patients on treatment with OAD who suffer an episode of acute RF, and especially in those cases that require renal replacement therapy with dialysis, we suggest proceeding with great caution. The patient should be administered rapid-acting insulin and basal insulin analogues, with frequent monitoring and control of glycaemia in the context of the evolution of renal function parameters. This management should be carried out with special emphasis in patients with oligoanuria, since the dosage of insulin will have to be modified based on the recovery of diuresis in these patients.

We hope this has contributed to clarifying some of the aforementioned controversial aspects of this issue.

Conflicts of interest

The authors declare that they have no conflicts of interest related to the contents of this article.

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Discrepancies between the summary of characteristics and the recommended use of metformin in the treatment of type 2 diabetes mellitus patients

Nefrologia 2012;32(6):837-8

doi:10.3265/Nefrologia.pre2012.Sep.11656

To the Editor:

We read with great interest the editorial published in the last issue of *Nefrología* titled: "About the discrepancies between clinical consensus documents, clinical practice guidelines, and legal regulations in the treatment of type 2 diabetes mellitus",[1] and we would like to make a brief commentary on this article.

Firstly, we wish to state that this editorial inspired a great deal of interest since it updates and includes several innovative aspects, such as indications for use, based on the summary of characteristics information, for oral anti-diabetic medications (OAD), insulin, and glucagon-like peptide analogues, which are used in the treatment of patients with type 2 diabetes mellitus (DM2); however, we would also like to know the opinion of the authors regarding the legal aspects of the use of these drugs, especially in the case of metformin in renal failure patients.

In the section of the editorial dedicated to metformin, the authors specify that this molecule is eliminated through the kidneys, which supports the contraindi-

cation stated on the summary of characteristics for use in patients with creatinine clearance rates <60ml/min, due to the risk of lactic acidosis. However, it can be used in patients with glomerular filtration rates (GFR) of as low as 30ml/min/1.73m^2 [sic].

Based on the recommendations provided by the NICE guidelines and studies such as Shaw et al. and Lipska et al., the authors later suggest a contraindication for metformin in patients with GFR<30ml/min/1.73m^2 and utilisation with precaution in patients with GFR<45ml/min/1.73 with risk factors for developing lactic acidosis, allowing for its use in patients with moderate chronic kidney disease (estimated GFR: 30-50ml/min/1.73m^2).[1]

We published an earlier article in the journal of *Nefrología* on this topic, in which we bring attention to the need for health care professionals that prescribe OAD, especially metformin (this being the OAD indicated in the initial treatment of patients with DM2 and the most heavily used), to be able to do so within the legal framework that regulates its use based solely on the drug summary of characteristics, not guidelines, consensus documents, or isolated studies.[2]

As such, and after reading the editorial in question, we continue with the same doubts that prompted our article. Is it illegal to administer metformin in patients with creatinine clearance rates <60ml/min, as described by the drug summary of characteristics and as recommended by the Spanish Society for Diabetes, which also contraindicates its use in patients with a GFR<60ml/min/1.73m^2?[3]

In addition, nephrologists treat a large number of diabetic patients with various levels of renal failure who are sent from other specialists and later transferred back to them. Should we prescribe medications outside of the guidelines established in their respective summary of characteristics to these patients, without generating potential legal conflicts in a medical society that is becoming more and more judicialised?

With this in mind, we would like to know the opinion of the authors of the aforementioned editorial, and would also like to highlight the need for Spanish research groups studying diabetes to contemplate these aspects when elaborating guidelines or research documents that serve as reference materials for proper medical practice.

Conflicts of interest

The authors declare that they have no conflicts of interest related to the contents of this article.

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Authors reply:
Discrepancies between the summary of characteristics and the recommended use of metformin in the treatment of type 2 diabetes mellitus patients

Nefrologia 2012;32(6):838-9

doi:10.3265/Nefrologia.pre2012.Oct.11783

To the Editor:

We would like to thank Del Pozo et al.[1] for their interest in our review[2] and their thoughtful question. The use of metformin in patients with a glomerular filtration rate (GFR) <60ml/min/1.73m^2, that is to say, outside of the appropriate range established by the drug summary of characteristics, continues to be a source of substantial controversy, prompting discussion in several recent scientific conferences and consensus documents.[3-5]

The prescription of medications in conditions that fall outside of the recommendations established in summary of characteristics is a common practice in our profession, whenever approved and validated by the scientific community through a process of discussion of pros and cons or with the provision of informed consent. The summary of characteristics is a document that is not set in stone, must contain updated and current information regarding the medication, and tends to be modified whenever aspects of drug safety are updated or new indications come to light. However, this does not always occur, since the cost for modifying technical data sheets can be very high, and this can often produce a situation in which modifications are not cost-effective because the medication in question is quite inexpensive, such as in the case of metformin.

In patients with moderate chronic kidney disease (CKD), the lack of therapeutic alternatives following the suspension of metformin may require the use of much more costly medications (such as dipeptidyl peptidase-4 inhibitors) or insulin treatment, which prompts some reluctance in the af-