Patients taking high-potency statins may have a higher rate of hospitalization for acute kidney injury (AKI), according to a study in the *British Medical Journal*.

Drawing on nine population-based cohort studies and a meta-analysis from North America and the United Kingdom, the researchers analyzed data from more than two million adults (40 years or older) who began taking statin therapy between 1997 and 2008. Treatment with high-potency statins—rosuvastatin 10 mg or higher, atorvastatin 20 mg or higher, or simvastatin 40 mg or higher—was evaluated for association with hospitalization for AKI. Patients with heart failure, CKD, and patients starting high-potency statin therapy were also excluded. The new study shows a possible increase in hospitalization for AKI among patients starting high-potency statin therapy, especially during the first few months. Although the absolute risk appears small, the association may have clinical implications for prescribing high-potency statins, “particularly when treatment with a low potency statin is an option” [Dormuth CR, et al. 2013; 346:f880].

Previous studies have suggested possible adverse renal effects of lipid-lowering statin therapy. However, the specific nature of this relationship—including whether there is any dose–response effect—remains unclear.

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In patients with heart failure and decreased ejection fraction, aliskiren does not improve postdischarge outcomes—but does increase the risk of renal function decline and other key adverse events, reports a trial in the *Journal of the American Medical Association*.

The international Aliskiren Trial on Acute Heart Failure Outcomes study included 1615 hemodynamically stable patients with heart failure. All had decreased left ventricular function, with left ventricular ejection fraction 40 percent or lower (mean 28 percent), signs and symptoms of fluid overload, and elevated natriuretic peptides. In the hospital, patients were randomly assigned to treatment with aliskiren, 150 mg/day (increasing to 300 mg/day as tolerated), or placebo in addition to standard therapy.

Forty-one percent of patients had diabetes, and the mean estimated GFR was 67 mL/min/1.73 m². Baseline medications included diuretics in about 96 percent of patients, β-blockers in 82 percent, and angiotensin-converting enzyme inhibitors or angiotensin receptor blockers in 84 percent. Aliskiren did not reduce the follow-up risk of cardiovascular death or heart failure readmission, compared with placebo. The primary outcome rates were 24.9 percent versus 26.5 percent at 6 months and 35.0 percent versus 37.3 percent at 12 months, respectively.

Aliskiren was associated with an increased likelihood of decline in estimated GFR to less than 30 mL/min/1.73 m²: 10.9 percent versus 9.1 percent. The patients receiving aliskiren also had increased rates of hyperkalemia, severe hyperkalemia, and hypotension.

Adding direct renin inhibition to standard treatment for chronic heart failure and reduced ejection fraction might further improve outcomes by reducing “aldosterone escape.” The new multicenter trial finds no such improvement in outcomes with aliskiren, but it does show increased rates of hypotension, hyperkalemia, and worsening renal function. More study is needed to evaluate the possible benefits of aliskiren for nondiabetic patients with heart failure [Gheorghiade M, et al. 2013; 309:1125–1135].