respiratory depression. Both codeine and dihydrocodeine, which are constituents of two of the three opiate preparations identified in this study (table), have been reported to cause prolonged narcosis in patients with renal impairment. NSAIDs can exacerbate existing renal impairment and can, in their own right, cause renal damage, eg, tubulo-interstitial nephritis.

The risks of drug toxicity amongst elderly patients with renal impairment, could be reduced by increasing awareness that renal impairment can accompany normal serum creatinine concentrations, and that prescribing opiates and NSAIDs in the presence of renal impairment is potentially dangerous. To further minimise drug toxicity, the creatinine clearances of elderly patients could be routinely calculated on deciding their discharge and their drug prescriptions reviewed before discharge. We plan to disseminate these guidelines (box 2) within our unit and to review their effects on the recognition of renal impairment and on discharge drug prescribing in a future study.

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Images in medicine

A fortunate adverse drug reaction

A 21-year-old woman presented with this isolated lesion suggestive of superficial skin necrosis of her left lower leg. She was hospitalised and a skin biopsy demonstrated limited papillary dermal oedema. A thorough search failed to reveal the presence of any infection or thrombophilic state, leading to a clinical suspicion of an unusual manifestation of drug hypersensitivity. The patient’s history included Arnold-Chiari malformation, mild mental retardation and ‘recurrent seizures’ for which she had been prescribed phenytoin (600 mg/day, serum levels 16 μg/dl) a couple of months earlier. Close observation and electroencephalogram studies during the attacks revealed them to be ‘pseudoseizures’. Phenytoin was discontinued with no ill effects and the skin lesion gradually cleared spontaneously.

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