AKI. Instead of incorporating other South Asian populations, just investigate the Chinese populations of Northern China vs Central vs Southern China and compare the results with Chinese people living in Taiwan or other countries.

All these people are relatively homogenous and their socioeconomic factors may be very similar or different. This study would tell us how this single ethnic population reacts to cardiac surgery and postoperative organ dysfunction. The Chinese life style is known to be much higher and better than other South Asian countries. Patient care would be improved substantially.

A similar investigation occurred years ago, around 1966–7 which dealt with two ethnic Caucasian populations in two different countries investigating a neuromuscular blocking agent to see the difference in response. This study pointed out that even in similar ethnic groups, there are different reactions. Comparing Chinese groups for AKI would be very interesting and noteworthy to all physicians, anaesthesiologists, and surgeons alike.

**Declaration of interest**

None declared.

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**Ethnicity and acute kidney injury: the correct definition of acute kidney injury?**

**Reply from the authors**

Editor—We are grateful for this opportunity to reply to Dr Atwal and his colleagues’ comments on our article.1

We used the relatively low fractional change in serum creatinine as it has been previously described in one of our papers.2 Loef and colleagues3 in using the same criteria have shown that the immediate and small decline in renal function is associated not only with early mortality but also mortality in the longer term. A fractional change in serum creatinine of at least 25% represents a decrease in GFR of at least 20% which may be significant in the long term.4 This will identify patients who require specific preventive measures during the follow-up period. We have also analysed the data based on the AKIN criteria and there is a racial difference in that the Malays have a higher risk compared with the Chinese [odds ratio (OR) 1.457, confidence interval (CI) 1.04–2.0, P=0.02], but the Indians did not reach statistical significance (OR 1.399, CI 0.95–2.0, P=0.08). We shall be repeating the analyses with a bigger sample of patients.

Our study population is unique as the city state is relatively homogenous with a high standard of healthcare and access to healthcare from patients is unimpeded. The two heart centres are public institutions doing more than 80% of all heart surgeries in the country and the distribution of patients between the centres is fairly even, often with porosity between the two. The referral base to these hospitals comes from the various public primary care clinics with little surgeon bias.

**Declaration of interest**

None declared.

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Pharmacological perioperative brain neuroprotection: nimodipine?

**Editor**—I read with great interest the article ‘Pharmacological perioperative brain neuroprotection: nimodipine?’ by Bilotta and colleagues.1 The authors reviewed 25 randomized clinical trials addressing perioperative pharmacological neuroprotection. They concluded that only atorvastatin and magnesium sulphate were associated with a lower incidence of new postoperative neurologic deficits. I would like to draw your attention to a missing prospectively performed, randomized clinical trial with 30 patients published in Neurosurgery revealing the neuroprotective efficacy of perioperative nimodipine medication for the preservation of facial and cochlear nerve functions in vestibular schwannoma surgery.2 The results were significant for a better outcome for both hearing (P=0.041) and facial nerve (P=0.045) preservation in the group of patients who received a