In This Issue of JAMA

February 24, 2015
Volume 313, Number 8
Pages 765-868

Research

NSAIDs, Antithrombotic Therapy After Myocardial Infarction 805

Use of nonsteroidal anti-inflammatory drugs (NSAIDs) is discouraged after myocardial infarction; however, use of NSAIDs is widespread. In an analysis of Danish health and mortality administrative registries, Olsen and colleagues examined the association of NSAID use with risk of bleeding and cardiovascular events in 61 971 patients with incident myocardial infarction. The authors found that among patients receiving antithrombotic therapy after myocardial infarction, concomitant use of NSAIDs was associated with increased risk of bleeding and excess thrombotic events during a median follow-up of 3.5 years. In an Editorial, Campbell and Moliterno discuss hazards of adding NSAIDs to antithrombotic therapy after myocardial infarction.

Editorial 801

Gene Variant Associated With Vincristine-Related Neuropathy 815

Vincristine—a part of every treatment protocol for childhood acute lymphoblastic leukemia (ALL)—is often associated with a dose-limiting peripheral neuropathy. Diouf and colleagues performed a genome-wide single-nucleotide polymorphism analysis in a cohort of 321 patients receiving treatment for childhood ALL and found that a polymorphism in the promoter region of the *CEP72* gene was associated with increased risk and severity of vincristine-related peripheral neuropathy. In an Editorial, McLeod discusses benefits and risks associated with personalized medicine.

Editorial 803
Author Video Interview jama.com

Management of Oral Anticoagulant-Associated ICH 824

Data to inform the acute and long-term treatment of patients with oral anticoagulant-associated intracerebral hemorrhage (OAC-ICH) are limited. In a retrospective cohort study involving 1176 patients with OAC-ICH, Kuramatsu and colleagues assessed the associations of anticoagulation-reversal and blood pressure levels with hematoma enlargement, and the association of OAC-resumption with patient outcomes. The authors report that reduced rates of hematoma enlargement were associated with systolic blood pressure less than 160 mm Hg at 4 hours and reversal of international normalized ratio levels to less than 1.3 within 4 hours of admission. Resumption of anticoagulant therapy was associated with a lower risk of ischemic events without increased bleeding complications.

Humanities

Opinion

LETTERS

Editor in Chief
Howard Bauchner, MD

131 YEARS
OF CONTINUOUS
PUBLICATION

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Clinical Review & Education

GFR, Albuminuria for Detection and Staging of Kidney Disease 837

Laboratory measurements are required to detect asymptomatic and early-stage kidney disease. Levey and colleagues summarize evidence from recent guidelines and reviews supporting the use of glomerular filtration rate (GFR) and albuminuria for detection and staging of acute and chronic kidney disease in adults. The authors review clinical characteristics of acute and chronic kidney disease, provide guidance for initial and confirmatory assessment of GFR and albuminuria for diagnosis and staging, and discuss indications for testing in special populations and assessing kidney function for drug dosing.

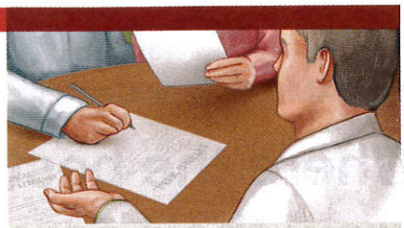
Continuing Medical Education jamanetworkcme.com

Hydroxychloroquine and the Retina 847

Patients with rheumatoid arthritis, systemic lupus erythematosus, and other autoimmune diseases are often treated with hydroxychloroquine—placing them at risk of irreversible toxic maculopathy. An article in *JAMA Ophthalmology* reported that many patients are not undergoing recommended routine monitoring for this serious adverse effect. In this From the JAMA Network article, Marmor and Melles discuss factors to consider in hydroxychloroquine dosing and the importance of annual screening to detect early signs of retinal toxicity.

Elevated Lactate Levels in a Non–Critically Ill Patient 849

This JAMA Diagnostic Test Interpretation article by Chen and colleagues presents a man with diffuse B-cell lymphoma involving the abdomen who was seen in the emergency department after 5 days of nausea and vomiting. He was afebrile and normotensive and he had mild tachycardia. Physical examination revealed a large, firm mass near the umbilicus, without abdominal rigidity or rebound tenderness. He had an elevated serum lactate level and low bicarbonate, low $Paco_2$, and marginally acidotic pH venous blood gas results. How would you interpret these findings?



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Editor's Audio Summary
Howard Bauchner, MD, summarizes and comments on this week's issue.

Author Reading

AUDIO Jennifer Doudna, MD, reads her Viewpoint "Genomic Engineering and the Future of Medicine."

Author Interview
VIDEO Interview with William E. Evans, PharmD, author of "Association of an Inherited Genetic Variant With Vincristine-Related Peripheral Neuropathy in Children With Acute Lymphoblastic Leukemia"

Instructions for Authors
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