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doi: 10.1093/ndt/gfp438

Advance Access publication 8 September 2009

Reply

Sir,

We appreciate the interest and contribution of Liberek *et al*. to the controversy regarding timely initiation of dialysis. We agree that the findings of our study should not be used to advocate a late or low eGFR start on dialysis. In fact, as an observational cohort study, our study simply describes outcomes of those in whom dialysis was started at different levels of eGFR, and the data suggest that eGFR values should not be used in isolation, either to make a judgement on starting dialysis or as an auditing tool for the quality of ESRF care [1]. In fact, we describe an excellent example of 'confounding by indication': those with higher eGFR appear to be sicker, thus leading physicians to commence dialysis. Interestingly, however, the European Best Practice Guidelines [2] recommend ensuring that all patients have started dialysis before eGFR < 6 ml/min/1.73 m^2, regardless of the presence or absence of signs and symptoms.

Methods of assessing residual renal function that consider weight, and thus indirectly muscle mass and nutrition, such as creatinine clearance, are preferable in this setting and particularly relevant in Liberek's own study [3] of peritoneal dialysis patients in whom appropriate nutrition had a significant role. Traynor *et al*. [4] published results on survival and dialysis initiation utilizing the Cockcroft–Gault formula, which at least incorporates weight. The results are consistent with our findings and also contradict the concept of 'early' or 'healthy' start.

While our study uses age and diabetes as indicators of comorbidity, both van Manen *et al*. [5] and Stel *et al*. [6] have found that after adjusting for age and diabetes, further adjustments for comorbidity made little further difference in European populations. Furthermore, it is interesting that Stel *et al*. found that the distribution of causes of death was similar in high, medium and low eGFR groups [6].

Finally, we welcome the sentiment that the individual decision of dialysis timing involves a clinical judgement of nephrologists on the basis of a variety of clinical features, particularly fluid overload in patients with left ventricular dysfunction. This is valuable to consider not only when met with studies that counter-intuitively appear to suggest a benefit in delaying the start of dialysis, but also when met with contradictory recommendations of a healthy early start. While we hope that the randomized controlled IDEAL trial [7] may be able provide some answers next year, meanwhile our study and that of Stel *et al*. demonstrate that nephrology is a specialty that values the physician who adopts a patient-centred approach.

Conflict of interest statement. KS is the Chair of the Scottish Renal Registry. AL is provincial executive director of the BC Provincial Renal Agency, BCPRA.

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doi: 10.1093/ndt/gfp443

Advance Access publication 11 September 2009

Non-diphtheria corynebacteria and CAPD infections

Sir,

The comprehensive analysis of the large scale ANZDATA presented by Dr D. Johnson and co-workers [1] highlights the increasing importance of non-diphtheria Corynebacteria as emerging pathogens in the population of patients on continuous ambulatory peritoneal dialysis. This is in accordance with smaller reports of Corynebacteria peritonitis [2,3] or exit-site/tunnel infections [4,5] by Corynebacteria. Regrettably, the incomplete data of the Register question both the correct diagnosis of peritonitis as well as the therapeutic recommendations for this infectious complication.

Firstly, rapid identification of potentially multi-resistant non-diphtheria Corynebacteria to the species level may be difficult with commercially available systems. However, as not all Corynebacteria play a role in peritonitis, it is essential to identify correctly pathogenic Corynebacteria. Currently, the genus Corynebacteria consist of 59 validly described species, of which 35 species are considered to be clinically relevant. Only a few C. species (predominantly C. striatum, C. aquatum, C. jeikeium) have been implicated in CAPD infection [6]. These organisms are even today frequently