




institution of interventional measures that have been shown to be effective in reducing proteinuria, retarding the progression of kidney disease, and improving cardiovascular mortality and morbidity, with the consequent improvement of outcomes for all individuals at increased risk.

Sir Robert Hutchison (1871–1960) must have had a premonition of things to come, when at the turn of the past century he noted that; the ghosts of dead patients that haunt us do not ask why we did not employ the latest fad of clinical investigation. They ask us, why did you not test my urine? 

REFERENCES

1. Keane WF, Eknoyan G. Proteinuria, albuminuria, risk, assessment, detection and elimination (PARADE). A position paper of the National Kidney Foundation. *Am J Kidney Dis* 1999; 33:1004–1010.
2. Grimm RH Jr, Sandson KH, Kasiske B, Keane WM, Wahi M. Proteinuria is a risk factor for mortality over 10 years of follow up. MRFIT Research Group. Multiple Risk Factor Intervention Trial. *Kidney Int* 1997; 63(suppl 63):S10–S14.
3. Peterson JC, Adler S, Burkart JM, et al. Blood pressure control, proteinuria and the progression of renal disease. The Modification of Diet in Renal Disease Study. *Ann Intern Med* 1995; 123:754–762.
4. Mutner P, He J, Hamm L, Loria C, Whelton P. Renal insufficiency and subsequent death resulting from cardiovascular disease in the United States. *J Am Soc Nephrol* 2002; 13:745–753.
5. Gerstein HC, Mann JF, Yi Q, et al. Albuminuria and risk of cardiovascular events, death and heart failure in diabetic and nondiabetic individuals. *JAMA* 2001; 286:421–426.
6. SoRelle R. Increases in urinary albumin excretion predict risk of death from all causes as well as those from cardiovascular disease. *Circulation* 2002; 106:e9037–e9038.
7. Leoncini G, Sacchi G, Viazzi F, et al. Microalbuminuria identifies overall cardiovascular risk in essential hypertension. *J Hypertens* 2002; 20:1315–1321.

8. Hillege HL, Fidler V, Diercks GF, et al. Urinary albumin excretion predicts cardiovascular and noncardiovascular mortality in the general population. *Circulation* 2002; 106:1777–1782.
9. Mann JFE, Gerstein HC, Pogue J, Bosch J, Yusuf S, for the HOPE Investigators. Renal insufficiency as a predictor of cardiovascular outcomes and the impact of ramipril: The HOPE randomized trial. *Ann Intern Med* 2001; 134:629–636.
10. Keane WF. Proteinuria: Its clinical importance and role in progressive renal disease. *Am J Kidney Dis* 2000; 35(suppl 1):S97–S105.
11. Kashif W, Siddiqi N, Dincer AP, Dincer HE, Hirsch S. Proteinuria: How to evaluate an important finding. *Cleve Clin J Med* 2003; 70:535–547.
12. Schwab SL, Christensen RL, Dougherty K, Klahr S. Quantification of proteinuria by the use of protein-to-creatinine ratios in single urine samples. *Arch Intern Med* 1987; 147:943–944.
13. Chitalia VC, Kothari J, Wells EJ, et al. Cost-benefit analysis and prediction of 24-hour proteinuria from the spot urine protein-creatinine ratio. *Clin Nephrol* 2001; 55:436–447.
14. National Kidney Foundation. K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease: evaluation, classification and stratification. *Am J Kidney Dis* 2002; 39(suppl 1):S25–S27.

ADDRESS: Garabed Eknoyan, MD, Department of Medicine, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030; e-mail geknoyan@bcm.tmc.edu.

CORRECTIONS

Osteoporosis in men

(MARCH 2003)

“Osteoporosis in men: Suspect secondary disease first,” by Angelo Licata, MD, PhD (*Cleve Clin J Med* 2003; 70:247–254) contained a typographic error. On page 251 the T-score range for osteopenia was listed as between –1.5 and –2.5. The World Health Organization criteria specify –1.0 to –2.5. We would like to thank Dr. Stefan Monev, of Oshkosh, Wis, for pointing this out.

Preventing kidney failure

(APRIL 2003)

TABLE 2 in “Preventing kidney failure: Primary care physicians must intervene earlier” by Christopher J. Hebert, MD (*Cleve Clin J Med* 2003; 70:337–344) contained a typographic error. The exponent of the serum albumin concentration should be positive, not negative. The corrected table is shown at right. We would like to thank

Dr. Robert Misson, of San Luis Obispo, Cal, for pointing this out.

TABLE 2

Three formulas for calculating the glomerular filtration rate (GFR)

MDRD formula (most accurate – calculator at www.kdoqi.org)

$$\begin{aligned} \text{GFR} = & 170 \times \text{serum creatinine concentration}^{-0.999} \\ & \times \text{age}^{-0.176} \\ & \times 0.762 \text{ (if female)} \\ & \times 1.18 \text{ (if race is black)} \\ & \times \text{blood urea nitrogen concentration}^{-0.17} \\ & \times \text{serum albumin concentration}^{0.318} \end{aligned}$$

24-hour creatinine clearance
(intermediate accuracy, least convenient)

$$\text{GFR} = \frac{\text{urine creatinine concentration} \times \text{volume in mL}}{\text{serum creatinine concentration} \times \text{time in minutes}}$$

Cockcroft-Gault formula (least accurate, most convenient)

$$\text{GFR} = \frac{(140 - \text{age}) \times \text{weight in kg} \times (0.85 \text{ if female})}{72 \times \text{serum creatinine concentration}}$$