By raising the subject of the role of primary care in managing chronic kidney disease, Brady and O'Donoghue may have sparked a timely debate.[1] It would also be good to hear from primary care physicians on this issue.

While they call for primary care to take ownership of the problem, it seems clear that colleagues I have spoken to are mystified and confused. Here is a new disease that apparently one in 10 people have, no longer the rare condition we were brought up with as students, and that clever kidney doctors managed with strange diets, pills, potions, and transfusions (not quite leeches). Little wonder we, as GPs, have been frightened off from believing we had a role, especially as the patients don't complain of anything. So now we have a role, what should it be? I believe it turns out to be rather easier than we imagine.

First, find the patients. We're doing the bloods anyway. They nearly all fall into just four categories.

These are people with diabetes, hypertension, older people, and then people with intrinsic kidney disease. The latter is for the clever kidney doctors and can be found because they have rapidly deteriorating kidney function and/or heavy proteinuria or blood, or a family history of polycystic kidneys.

The rest are for us to manage. We find them by looking for them in our populations with diabetes and hypertension. The older population with ageing kidneys will declare themselves along the way with high blood pressure. If these older people don't have high blood pressure there's nothing for us to do apart from give usual healthy living advice.

Once identified we need to treat their vascular risk factors, especially lifestyle and hypertension. Get their blood pressure to target levels of <140/90 mmHg, and if they have significant proteinuria, use ACE inhibitors or ARBs and aim for <130/80 mmHg. I have a low threshold for adding statins although the jury is still out about how effective they are in more severe renal impairment.[2] One meta-analysis showed benefit in all cause mortality, CVD mortality, non-fatal CVD events, and a reduction in 24-hour urinary protein excretion.[3] We don't need to worry about bicarbonates and bone disease at the stage we are dealing with, unless something crops up in our routine blood tests.

To keep the critics of primary care at bay, make sure patients records are Read Coded correctly, and the QOF will do the rest in terms of auditing the population.

Primary care is getting there but the mystique of CKD has to be removed. This will come with time and education.

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MRSA screening: is it really necessary in primary care?

In a period of economic restrictions within the NHS, the cost of Meticillin Resistant *Staphylococcus aureus* (MRSA) screening for healthy individuals receiving minor surgical interventions is becoming increasingly difficult to justify; with lack of evidence to support the effectiveness of this intervention.

Reduction in healthcare associated infections, especially MRSA, is a government target and hence a priority for primary care trusts (PCTs). All patients undergoing elective surgery should now be screened and de-colonised of MRSA prior to surgery.[5]

MRSA colonisation increases the risk of developing infections (ranging from superficial to invasive) following surgery,[2,3] that can be difficult and costly to treat, resulting in prolonged hospital stays for affected in-patients.[4]

In NHS Walsall approximately 3000 patients are currently referred annually for all minor surgery in primary care. We audited the results of MRSA screens from 25 June 2009 to 7 December 2009 for patients undergoing vasectomy/carpel tunnel decompression to assess whether the policy was being adhered to and to make recommendations based on the findings.

The audit found that of the 230 patients screened for MRSA (72 carpel tunnel and 158 vasectomy) only one positive case (nasal swab) was identified from a vasectomy patient.

We calculated the cost of these tests to be approximately £3 each, totalling £690, not taking into account administration, transport, and other related costs.

In an attempt to add to the body of knowledge around screening in primary care we recognise that the financial implications to NHS Walsall are minimal, however, for larger organisations there may be savings if screening activities are reviewed.

The Department of Health reports that 30% and 3% of the general population carry *Staph. aureus* and MRSA, respectively.[1] Although our sample size was small, we found that one patient (0.4%) tested positive for MRSA; this is lower than the predicted value of 3% (approximately seven patients from our population sample).

However, our study population is not representative of the general population as they were offered surgery in primary care, indicating that they are healthier than patients undergoing this intervention in hospital.

Based on our findings we recommend a 'risk-based approach' to MRSA screening in primary care as it does not seem effective to screen relatively well patients with no risk factors or evidence of benefit.

In the current economic climate with financial constraints, it will become increasingly difficult to support

interventions that are not cost-effective.

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Glycaemic control and mortality

The last sentence of the article by Landman *et al*[1] states, 'for patients with moderate glycaemic control and longstanding diabetes, it may be better to focus on other risk factors, such as smoking, high blood pressure, and lipid profile disturbances, than to aim for increasingly lower therapeutic values for HbA_{1c}'.

However, this observational cohort study showed no significant difference in baseline characteristics between the survivors and the deceased in blood pressure, lipids, and smoking characteristics.

Surely an implication of this study is that the benefits of interventions noted in other studies do not necessarily translate to improvements in the wider context of general practice.

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Authors' response

In our article, published in the March edition of this journal, we state that 'it may be better to focus on other risk factors, such as smoking, high blood pressure, and lipid profile disturbances, than to aim for increasingly lower therapeutic values for HbA_{1c}.'[1] The validity of our conclusions was confirmed by a recently published large retrospective study.[2] Although the design was different, it emphasised the absence of benefit of strict glycaemic control in patients with longer diabetes duration. In fact, this study even showed an increased mortality in patients with HbA_{1c} under 7.5% who underwent treatment intensification with insulin.

In his comment to our article, Searle points out that there are no baseline differences in these risk factors between the survivors and the deceased in our study.[3] Although this observation is correct, we respectfully disagree that it contradicts our statement. Absence of differences in baseline characteristics, for example smoking, does not mean that smoking is not an independent risk factor for mortality. To answer the question whether smoking, blood pressure, and cholesterol levels are related to mortality, Cox regression analyses, including correction for confounders, are an option in order to better interpret a (possible) effect of, in this case, HbA_{1c} on mortality. For example, in the same study cohort, we studied the relationship between mortality and lipid profile in different age groups.[4] In this study, higher cholesterol levels did relate to mortality.

We agree with Searle that the benefits of interventions, as studied in randomised controlled trials, do not necessarily translate to improvements in daily practice. Many trials include a selected population and are, therefore, not representative of the general population. However, our results more or less confirm the results of these trials, like the UKPDS, that we discussed in our article.

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Dementia: the deception is broken; naked truth looks OK

We are warmed and encouraged by the supportive responses,[1–3] to our challenge to the National Dementia Strategy in its current form.[4]