**Table 1. Serum and urine chemistries**

<table>
<thead>
<tr>
<th>Chemistry</th>
<th>+/-</th>
<th>-/-</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine sodium mmol/l</td>
<td>69 ± 18.72</td>
<td>79 ± 24.46</td>
<td>0.35</td>
</tr>
<tr>
<td>Urine creatinine mg/dl</td>
<td>37.3 ± 14.37</td>
<td>32.3 ± 12.01</td>
<td>0.45</td>
</tr>
<tr>
<td>Urine uric acid mg/dl</td>
<td>24.8 ± 7.6</td>
<td>16.9 ± 6.36</td>
<td>0.04*</td>
</tr>
<tr>
<td>Serum sodium mmol/l</td>
<td>156 ± 3.91</td>
<td>154 ± 2.62</td>
<td>0.25</td>
</tr>
<tr>
<td>Serum creatinine mg/dl</td>
<td>0.30 ± 0.12</td>
<td>0.43 ± 0.24</td>
<td>0.14</td>
</tr>
<tr>
<td>Serum uric acid mg/dl</td>
<td>0.8 ± 0.95</td>
<td>0.8 ± 0.55</td>
<td>0.91</td>
</tr>
<tr>
<td>Urine sodium/urine creatinine</td>
<td>1.98 ± 0.19</td>
<td>0.53 ± 0.03</td>
<td>0.002*</td>
</tr>
</tbody>
</table>

*P < 0.05.

![Fig. 1. Ratio of urine sodium to urine uric acid.](image)

Conflict of interest statement. The authors have no conflict of interest to declare.


doi:10.1093/ndt/gfk081

Advance Access publication 31 January 2006

**Tests for latent tuberculosis**

Sir,

In their article, Shankar and colleagues underline the significant burden of tuberculosis within their population and the importance of identifying latent infection in those with end stage renal disease (ESRD) [1]. They found significant rates of anergy to cutaneous tuberculosis skin testing in those with ESRD (44% vs 16% in control group). The study adds to the evidence in other populations and supports the notion that cutaneous anergy limits the value of this test [2]. We have previously reported the use of molecular biological techniques to help improve the diagnostic certainty of clinical infection with tuberculosis in this patient group [3]. Similarly, novel molecular techniques have recently been developed to detect the presence of latent tuberculous infection. Immunoassays based on the detection of interferon-γ to specific *Mycobacterium tuberculosis* antigens ESAT6 and CFP10, appear to be specific and sensitive for the diagnosis of latent tuberculosis [4]. These techniques can detect latent infection in immunosuppressed patients and can differentiate between those previously vaccinated with the Bacillus Calmette Guérin (BCG) strain, a known confounding factor with tuberculin skin testing [5]. Importantly, the detection of latent disease using these assays seems to correlate with patients who will develop clinical infection [6]. We, therefore, recommend the consideration of these techniques to improve the management of this complex group of patients.

Conflict of interest statement. None declared.

Respiratory Medicine Timothy B. L. Ho
Frimley Park Hospital NHS Foundation Trust, Camberley
Surrey, UK
Email: timho@doctors.org.uk


doi:10.1093/ndt/gfl001