Detection of proteinuria is always a significant clinical event; even small amounts of protein in the urine are usually associated with some form of renal disease. Furthermore, a persistently high level of proteinuria is a direct marker for the presence of severe underlying kidney pathology. It has also been shown that once detected, efforts to reduce the level of proteinuria may help to slow the rate of disease. Proteinuria may be caused by a variety of pathologies and once detected must be appropriately evaluated. Testing the urine for the presence of protein is easily undertaken in clinical practice and hence is amenable as a screening test in the general population and for those who are at particular risk of renal failure. Many different methods exist for the quantifying of protein in the urine and the question therefore to be answered is which screening test is the most appropriate for general use? This was the subject of a retrospective study undertaken by Methven and colleagues in Scotland. The case notes of over 5000 patients with chronic renal disease who attended a nephrology clinic were studied between 1999 and 2008. Two methods for quantifying proteinuria were compared—albumin:creatinine ratio (ACR) and total protein: creatinine ratio (TPCR). It should be noted that the National Institute for Health and Clinical Excellence (NICE) recommend using the ACR method in all patients who have chronic kidney disease. TPCR on the other hand is favoured by the Scottish Intercollegiate Guidelines Network (SIGN). Patients were followed up for a median period of 3.5 years. Proteinuria was found to be associated with a significantly increased risk for renal replacement therapy and also with premature death. However, TPCR was found to identify a significant number of patients at risk (16%) who were not identified by using ACR alone. This particular subgroup of patients had a higher risk for renal disease with subsequent increased mortality risk.

The authors reasonably question whether current NICE guidelines for screening for proteinuria in patients with chronic renal disease should at least be reconsidered and appropriately revised.

**Hospital readmission in the over 75s: what needs to be done?**

We are readily aware of the increasing demand on health and social care services due to population ageing. Hospital admissions for any reason in all healthcare systems represent a significant pressure on limited resources. Readmission is widely accepted as a marker of quality for hospital care. The systematic review undertaken by Garcia-Perez and colleagues from Spain attempted to explore the factors associated with the risk for readmission of patients aged over 75 years. A relative paucity of relevant and robust studies that addressed the question was identified. Available evidence identified a number of factors associated with a higher risk for readmission in this age group. Interestingly, neither age nor sex seemed to play a significant role in this context. The limited observed effect of age on readmission might have been due to the narrow age range of the subjects studied and the interaction between advancing age and co-morbidity. The review did highlight the following risk factors: previous hospital admission prior to the index admission, length of hospital stay with a longer stay representing a higher risk of subsequent readmission, reduced levels of functional ability and associated morbidities. While these conclusions are useful to both clinicians and those who commission and provide healthcare services for the older patient, the question is what can be done about this? The authors quite reasonably argue for vigilance with respect to older patients who possess these risk factors. They recommend that future research and
intervention strategies should focus on collaborative efforts between primary, secondary and social care to reduce the burden caused by repeated admissions in the older patient. What is needed is a systematic review that will identify interventions that effectively reduce the risk of hospital readmissions in this age group. I have undertaken a preliminary search for studies that have attempted to address this issue and predictably, the evidence is limited. There is a belief however that home based strategies may be more effective than hospital interventions but more attention needs to be devoted to this important topic.

Is mediastinoscopy still the test of choice for the diagnosis of lung cancer?

Currie and colleagues describe the use of a relatively novel diagnostic methodology in respiratory medicine: endobronchial ultrasound-transbronchial needle aspiration (EBUS-TBNA). For many years mediastinoscopy has represented the standard method used for accurate staging of the mediastinum in suspected lung cancer and for assessment of mediastinal lymphadenopathy. However this standard procedure is invasive and requires a general anaesthetic with resulting in-patient stay. Mediastinoscopy is considered to be a relatively safe procedure which nevertheless has a complication rate; it is also limited by the fact that not all hilar and mediastinal lymph nodes are readily accessible by this method. EBUS-TBNA on the other hand, enables the sampling of both hilar and mediastinal nodes using ultrasound incorporated into a flexible fibre-optic bronchoscope. The technique is usually undertaken with patients sedated but awake and cooperative. The paper using illustrative case histories describes both the technical issues associated with EBUS-TBNA and the diagnostic benefit. EBUS-TBNA is therefore attractive but has some limitations. A considerable degree of skill and expertise is required on behalf of clinical staff. Like many new technologies, it is relatively expensive to set up. However, overall savings could well be achieved as a result of reduction in the number of mediastinoscopies previously required. It would have been useful to see a full economic business case that would support the more widespread introduction of EBUS-TBNA. Perhaps a thorough health technology assessment of EBUS-TBNA is required?

Michael Bannon  
Editor, QJM