Renal disease is often progressive once glomerular filtration rate falls by 25% of normal. Early detection is important to prevent further injury and progressive loss of renal function.

Between 0.5 and 10% of the population have isolated proteinuria defined as proteinuria in the presence of otherwise normal urinary sediment, a radiologically normal urinary tract and the absence of known renal disease.[3]

In adult protein-osmolality versus protein-creatinine ratio in the estimation of quantitative proteinuria from random samples of urine are equally accurate, but in proteinuria in children and adolescent protein/creatinine ratio was superior to protein/osmolality ratio for predicting abnormal amount of proteinuria.[4]

Twenty-four hour collection of urine is arduous and often inaccurate. Use of the protein/creatinine ratio in single sample makes allowance for the reliable degree of urinary dilution.[5]

In our context most of the people are illiterate lacking proper health awareness and not having easy access to health facilities, early recognition and take care about renal diseases seem to be difficult.

This study shows that spot urine protein/creatinine ratio is reliable method to extrapolate 24 hours proteinuria in the patients with normal renal function and mild to moderate CRF which can be used to detect renal diseases in early stage with convenient way so that effective intervention can be instituted to slow the progression of the disease, as we know that once patient goes in end stage renal disease, renal replacement therapy is not only unaffordable but is not easily accessible for general population in our society.

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MALARIA, HIV AND SYPHILIS

Dear editor,

In their article of study of malaria in relation to HIV and syphilis among patients visiting Bheri Zonal Hospital,[1] Kandel et al have truly made a brave attempt by conducting such a study in a zonal hospital, but there seems to be a few important particulars that have been overlooked or had not been taken into consideration, which I would like to bring to your kind notice and if possible get them clarified by the authors.

To start with, the authors have not qualified their study group. They have only mentioned about "suspected risk group" with signs of anemia, splenomegaly with fever with chills and sweats, without mentioning about the baseline demographic profile, clinical findings and preliminary laboratory values such as hemoglobin level of their study population. Neither have they mentioned the geographic origin of their sample population. It has been stated that the population has been taken from the patients that had attended the hospital or were admitted there, but it has not been qualified whether this is representative of the entire zone or just the nearby vicinity of the hospital. Moreover, in their methodology they have not fully specified the criteria for their "malaria, HIV and syphilis suspected patients". Anemia, splenomegaly and classical fever pattern would definitely indicate a possibility of malaria, but no definite criteria (clinical or otherwise) for suspicion of HIV or syphilis seems to have been indicated. Furthermore, whether their study population had been properly randomized before conducting the final analysis has not been indicated.

The authors have tried to study malaria in relation to HIV and syphilis; but only a total of 12 cases out of the 223 (that is 5.38%) were found to have serological evidence of malaria. Furthermore, only 6 cases were positive for HIV (2.7%) and 12 for RPR (5.4%). So, if we are to be guided by their "title" then the actual study population that should have been taken for final analysis should have been only 30 (and not 223). Obviously this number is too small to be of any statistical significance.

Recently authors from India have commented that HIV infection is associated with increased risk of severe malaria even with normal $CD4^+$ counts; however the severity of disease and mortality are not increased.[2] But, prior HIV infection impairs protective immune response to Plasmodium falciparum in residents of hypoendemic areas[2]. Although the authors have acknowledged the same, drawing corollary from the works of Whitworth in Uganda,[3] this is not very well documented in their present work. In malaria endemic zones like Southeast Asia a larger population needed to be studied before any comment can be made because it is a well known fact that there might be decreased clearance of parasites from the blood in patients of HIV.[4]

The authors have made some contradicting comments in their discussion. At one instance they have stated that the co-infection of malaria and HIV was "not statistically significant ($p<0.5$)" in their research, but then later on in their discussion they have suggested that "a small correlation does exist between the two". As such it does become a bit ambiguous for the readers in trying to decide which of the two statements to believe.

The correlation of sexually transmitted diseases including syphilis with HIV is very well known, and this forms the backbone of many ongoing community-based programmes. However, in their article only 2 patients are found to have both HIV and syphilis (<1% of study population) and this the authors have acknowledged by saying that they did not find any definite statistically significant correlation in their study population. Moreover, they have not discussed any definite reasons as to why this disparity has occurred in their study group. In this respect, it might have been better if the authors had qualified the age-group, sexual practices, literacy and occupation and other characteristics of their study population (which I have already mentioned), because sexually transmitted infections most clearly reflect trends in risky sexual behaviors.[5] Moreover, syphilis is particularly associated with sexual HIV transmission and is also known to facilitates it.[5,6]

Besides, the authors have taken RPR as their marker for syphilis, which is neither very sensitive nor specific. What is even more controversial is that it is a known fact that malaria itself might be a cause of false positive RPR. As such, it really interests me to know why they choose such a vague marker in their line of research rather than one of the many definite markers like TPHA or FTA-abs. As they had taken ELISA for malaria and HIV as their standard, would it not have been appropriate if they had also chosen a specific immunoassay testing for syphilis as their standard too?

Moreover, the authors have discussed the relationship of malaria and HIV very well in their article but they have somehow lost their way about the portion relating to syphilis. Hence, I believe that it would have been better if they had kept their research limited to HIV and malaria rather than diversifying it with the addition of syphilis.

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CHALLENGE OF QUALITY CONTROL OF SPUTUM SMEAR MICROSCOPY

Dear editor,

I have gone through the editorial "Quality control of sputum for AFB examination in Big Hospitals and private laboratories".[1] In the editorial. it has rightly been raised the burning issue of diagnosis of Tuberculosis by sputum microscopy and quality assurance of AFB microscopy in Big Hospitals and private laboratories of urban areas. Smear microscopy is that most practical way to positively identify