

the management of TB in young immigrants and refugees.

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[One of the authors responds:]

The purpose of the immigration medical examination (IME) is to “identify those who may pose a risk to public health or safety, or may place excessive demands on Canadian health and social services.”¹ With respect to TB this primarily involves the detection of people with active infectious (i.e., respiratory) TB and not those with extrapulmonary TB or latent TB infection. Applicants identified as having active TB abroad are denied entry to Canada until they have completed a satisfactory course of treatment and have been reassessed. Those with abnormal chest radiography findings that are consistent with latent TB infection or a history of TB are referred for medical surveillance once they arrive in Canada.²

Despite efforts to identify all cases of active respiratory TB in migrants to Canada through the IME process, some cases of the disease do unfortunately occur in recent migrants. Possible reasons include progression to active disease after a person has undergone the IME but before immigration to Canada or presence of active TB when a person applies for refugee status from within Canada. Although the focus of our article² was the medical surveillance of recent immigrants, not the IME, Wallace

Watson raises a legitimate and frequently asked question regarding the role of tuberculin skin testing as part of the IME. The Immigration Subcommittee of the Canadian Tuberculosis Committee has issued an evidence-based advisory committee statement addressing questions about tuberculin skin testing of new migrants to Canada (see page 1035).³

Children are also screened for symptoms of active TB disease during the IME, but, as for adults, they are not screened for latent TB infection. As highlighted by Noni MacDonald, a child up to 5 years of age who is infected with *Mycobacterium tuberculosis* has a 2.2 to 5 times greater risk of progression to active TB disease⁴ than an adult without risk factors for disease progression. Our article² was a summary of the full guidelines for the investigation and follow-up of individuals placed under immigration medical surveillance. The more comprehensive guideline does discuss young children, recommending that “[y]oung persons (particularly those ≤ 5 years of age) infected with TB who have been identified through investigations of their parent(s) or guardian(s) may be at increased risk of progression to active disease and are likely to tolerate therapy without complications.”⁵ MacDonald’s point about the need for physicians to have information specific to the management of TB in young immigrants and refugees is well taken, and the issue of incorporating specific pediatric recommendations into future Canadian Tuberculosis Committee advisory statements will be raised at the next meeting of the committee.

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Nephrology care in Canada

Caroline Stigant and associates¹ raise several controversial issues in their article on caring for adults with chronic kidney disease. How these issues are resolved could have major implications for the delivery and cost of nephrology care in Canada.

First, the authors do not clearly address the question of who should be tested for kidney disease. People with hypertension, diabetes, cardiovascular disease and autoimmune disease (the risk factors listed in Box 4 of the article) are at high risk and should be screened by urinalysis and by testing for serum creatinine. Conversely, the utility of unselected population screening for renal disease (e.g., by dipstick) is very low,^{2,3} and should not be recommended.

The authors suggest that estimating equations be used to identify patients with low glomerular filtration rate (GFR) (e.g., their Table 2). Arguments both for⁴ and against⁵ this strategy have been published. Stigant and associates¹ argue the pro position, but the con argument is also compelling. Applying estimating equations universally will lead to the “labelling” and referral of many patients who would not otherwise have been identified as having renal failure. These patients will have different demographic characteristics (older age, more women, higher proportion with nonproteinuric renal disease) and probably a lower risk of progression than those identified on the basis of serum creatinine level.^{4,5} The benefits of nephrological intervention in such patients is unclear. Moreover, current nephrology resources could not possibly