than 30 mL/min (0.50 mL/s), microalbuminuria or unexplained reduction of GFR at any level. On the basis of these definitions, nephrology consultation could identify reversible causes of disease, but long-term follow-up might not be required. Thus, the referral recommendation is in keeping with current general medical practice principles. Bernstein and Rigatto suggest a reduced ability to retard disease progression at stage C in their system; however, accumulating data demonstrate that even at GFR levels between 15 and 30 mL/min (0.25 to 0.50 mL/s) some cardioprotective and renoprotective benefits can be achieved.[3-6]

In the K/DQOI staging system, stage 5 chronic kidney disease represents kidney failure, defined by GFR less than 15 mL/min (less than 0.25 mL/s) or by the need for dialysis. Neither the K/DQOI publication[2] nor our article[1] suggests that a GFR of less than 15 mL/min is an indication for dialysis per se. Thus, concern about an increase in resource utilization may well represent a misunderstanding of the staging system and clinical plan. As stated in our paper, we recommend adoption of Canadian Society of Nephrology guidelines regarding the timing of initiation of dialysis.[7]

There are many similarities between the scheme proposed by Bernstein and Rigatto and the K/DOQI staging system.[2] The latter classification was formulated by a multidisciplinary team following an extensive literature review, has been published and thus widely disseminated, and has extensive associated materials for patients and allied health professionals. Although the classification may not be perfect, uniform terminology and concepts are important in communication with the general public, patients and clinicians for purposes of clinical care and research. In a recently published article,[8] one of us has described the very controversies alluded to in Bernstein and Rigatto's letter, along with the advantages of adopting the approach espoused in our *CMAJ* article.[1]

Given that kidney disease is a major predictor of outcome in all populations studied (i.e., patients with various coexisting illnesses), the need for accurate assessment with an evidence-based classification system (accompanied by associated action plans) outweighs the issue of potential misclassification, which in most cases will be transient. Failure to agree upon and use a common, if flawed, terminology, could retard our ability to pursue important clinical questions and improve patient care.

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Correction

In a letter concerning absolute and relative risk reductions,[1] the first paragraph of the letter should have concluded with the following sentence: "Relative risk reduction does not take into account the incidence of primary and secondary end points, which is expressed by the absolute risk reduction." Because of an error introduced during copyediting, the term "incidence of" was missing from the published version. In addition, the surname of the letter author was spelled incorrectly; it should be Kerigan.

Reference

1. Kerrigan AT. No absolutes [letter]. *CMAJ* 2003;169(7):651.