Reviewer's report

**Title:** Characterizing pre-dialysis care in the era of eGFR reporting: a cohort study

**Version:** 3  **Date:** 12 October 2010

**Reviewer:** Paul Stevens

**Reviewer's report:**

Thankyou for the opportunity to review this paper. The authors describe a retrospective study of PCP and nephrologist CKD practices before and after routine eGFR reporting. Whilst it is always interesting to compare and contrast different practices I did not see anything particularly novel in this analysis. I also struggled a little with the design which may reflect my lack of understanding of their system. It appeared that both pre- and post-reporting cohorts were retrospectively selected from secondary care, not primary care. This is a flaw. The authors acknowledge a number of limitations, which should also include the lack of creatinine calibration, but their biggest limitation for the number of analyses the data was subjected to is the relatively low numbers of patients included in the cohorts for a study such as this.

The authors state that no educational activities were undertaken prior to eGFR reporting, what about after? I don’t believe it is reasonable to expect PCP performance in CKD management to improve purely through introduction of automated eGFR reporting, this needs to be accompanied by academic detailing. To expect PCPs (or general physicians for that matter) to access and read KDOQI guidance simply because they receive an eGFR in addition to a serum creatinine result is unreasonable.

Whilst ACE/ARB usage is of interest the key questions for ACE/ARB prescribing are was prescribing appropriate (ie were ACE/ARBs where indicated) and was prescribing appropriately monitored.

Minor. Reference 2 is used to support a statement that the incidence of obesity, diabetes and hypertension is increasing. The reference is from nearly 2 decades ago and is therefore of questionable relevance.