Response to Tribute to Dr. Rifkin

While reading your tribute to Dr. Harold Rifkin (1), it occurred to me that many diabetes health care professionals may not have seen the oral history of Dr. Rifkin published 2 years ago (2). *Diabetes Care* readers may also be unfamiliar with the oral history process. This kind of manuscript requires a great deal of preparation for and effort in its execution. Considerable care was taken to ensure that we followed methodologies developed within this field of scholarly inquiry. We had the guidance of a historian, Norman Silber, PhD, JD, for the preparation of background information, outlines, and many drafts of interview questions. This was followed by 2 days of taping and then transcribing the 5 hours of interviews and finally, careful editing to reduce 100 pages of transcription to a published manuscript of only eight pages.

If you found this work helpful in writing your tribute, I am grateful for that. The subject of our oral history, Dr. Harold Rifkin, was a wise, humorous, and often self-deprecating man. As a principal consultant to the Einstein Diabetes Research and Training Center (DRTC) for many years, Dr. Rifkin provided strength and continuity for its focus on the diabetes team and the patient. It was certainly my privilege to participate in preserving and passing on his insights and stories.

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References

1. Clark CM Jr: A tribute to Harold Rifkin: 1916–1997. *Diabetes Care* 20:1631, 1997
2. Walker EA, Wylie-Rosett J: Harold Rifkin, MD: selections from an oral history. *Diabetes Spectrum* 8:256–263, 1995

We wish to thank Dr. Walker and her colleague and recommend the above cited article to those who wish more information and insight into Dr. Rifkin's career. It was certainly a very helpful resource for us as we prepared our tribute to him.

Charles M. Clark, Jr., MD

Dr. Julio Santiago

I want to respond to the major loss received by the diabetes community with the sudden passing of Dr. Julio Santiago. Dr. Santiago was a diabetes researcher of international pre-eminence, a devoted clinician to thousands of people with diabetes, and a visionary supporter of behavioral scientists working in diabetes. I am proud to call Julio, who introduced me to diabetes research in 1978, my mentor. "I can teach you about diabetes," Dr. Santiago said. "We need to know more from you about normal child development and family dynamics." This is the first dimension of Julio's legacy for behavioral scientists—his instinctive sense that families matter.

Dr. Julio Santiago simply knew that an understanding of normal human development and family functioning was essential to the delivery of optimal care. In 1978, there was no body of research about the importance of psychological issues for the health outcomes of patients with IDDM; there was no Behavioral Medicine Council of the American Diabetes Association; there had not yet been any contributions from behavioral science to clinical trials or national research programs. Julio simply understood that families were the scaffolding upon which a healthy life for a child with diabetes was built.

A second dimension of Julio's legacy to behavioral research in diabetes was his recognition of the expertise of others. Before the concept of a "multidisciplinary team" became common, Julio valued and engaged behavioral scientists for their expertise in both research and clinical care. Julio supported behavioral science collaborators both in St. Louis and in his national work with the American Diabetes Association, the Diabetes Control and Complications Trial, and the Diabetes Prevention Program.

With respect to the role of the behavioral sciences in diabetes, Julio was truly a clinical visionary. I believe Julio's enormous support for behavioral scientists will be identified as a key legacy among the many significant contributions that he made to the diabetes community.

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Julio's death is a great personal and professional loss to us all. Thanks for expressing this so well.

Charles M. Clark, Jr., MD

Cifenline Succinate and Dementia in an Elderly NIDDM Patient

Cifenline succinate, a class Ia antiarrhythmic agent, is widely used to treat patients with ventricular and supraventricular tachycardia (1). There are several reports indicating that overdose of cifenline succinate induced hypoglycemia in nondiabetic subjects (2–4). We describe a case of repeated hypoglycemia and dementia associated in an elderly NIDDM patient with renal impairment although the dose of cifenline succinate was low.

An 85-year-old woman was referred to our department on 22 March 1996 because of unexplained dementia. She had a 10-year history of diabetes that was managed by diet therapy only (mean HbA_{1c} 6.8%). She was receiving 50 mg enalapril daily for hypertension. Since 2 February 1997, she had been given 100 mg cifenline succinate twice a day for bifocal ventricular extrasystoles. From the beginning of March 1997, she had repeated episodes of emotional lability, reduced intellectual capacity, and abnormal behavior. Although dementia was first suspected, we noticed that these symptoms were linked with a hypoglycemic episode on 22 March. Blood glucose level was 1.3 mmol/l, serum insulin level was 122 pmol/l, and HbA_{1c} was 4.5%. Hypoglycemia was rapidly corrected with intravenous glucose infusions; an intravenous glucose drip infusion was required to prevent relapse. Laboratory tests revealed renal failure (blood urea nitrogen 20.7 mmol/l, serum creatinine 141 μmol/l, calculated creatinine clearance 0.15 ml/s). Since it is thought that hypoglycemia was induced by cifenline succinate, this agent was stopped. The blood glucose concentration then returned to normal, and the intravenous glucose drip could be stopped.