Letters

individuals when, in effect, they were tested in 13 (10 before their publication [5] and 3 more by us for verification), a level that exceeds any research recommendations, including their own (7).

Next, they state, "Discarding means with inconsistent values is questionable[...]." It is difficult to imagine that contrasting responses to foods with reliable glycemic index/glycemic load values is a methodological flaw. The fact that predictive power improves with inclusion of foods eliciting unreliable responses suggests that either a property other than glycemic index is responsible or that only a subset of individuals are responsive to the property. Both options undermine the utility of the glycemic index concept.

Finally, Wolever and Brand-Miller recognize that "large between-subject variation of glycemic responses exists." This recognition is completely consistent with our findings and undermines the predictive value of the glycemic index classification of foods. The glycemic index rating is a property of a food, not a response of an individual. There would be no point in testing foods and publishing their glycemic index values, as these authors have done, nor creating diets based on this property if individual responses to their ingestion are highly variable.

In the larger picture, our findings do not argue against the potential health benefits of a low-glycemic index diet. The balanced inclusion of fruits, vegetables, nuts, legumes, and whole grains that comprise such a diet are wholesome and may aid weight management through mechanisms independent of their glycemic index rating.

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Standards of Medical Care in Diabetes

Response to position statement of the American Diabetes Association

I write in reference to the recently updated and circulated "Standards of Medical Care in Diabetes," in particular part II, "Screening for Diabetes," which were recently updated and published in the American Diabetes Association (ADA) 2006 Clinical Practice Recommendations (1). I would like to take issue with the use of the phrase "standards of medical care in diabetes," which is used to title all the individual components of these recently updated ADA guidelines. I think this phrase is unhelpful for both the health care community and the public at large, in that it strongly suggests that these guidelines are the definitive source to inform a "standard of care" for diabetes. Any deviation from the guideline may then be interpreted as "substandard care."

A number of these guideline recommendations cite a level of evidence "E" (i.e., based on "[e]xpert consensus or clinical experience"). In most taxonomies, this is considered the weakest level of evidence available. The U.S. Preventive Services Task Force (USPSTF), in their most recently circulated guidelines, assigns an "I" ("inconclusive") rating to whether asymptomatic individuals should be routinely screened for type 2 diabetes and a

"B" rating ("fair evidence that the services improve important health outcomes and concludes that benefits outweigh harms") to screening adults with hypertension or hyperlipidemia.

Given the importance of defining a standard of care for any disease management, I teach medical students that wellconstructed guidelines developed by a nonpartisan group and based on a good level of evidence (such as the "B" rating by USPSTF) are the best informants of standard of care. Given the "I" rating by USPSTF, there clearly is room for clinical judgment when it comes to screening the general population. I respectfully suggest that it would be more helpful if the ADA guidelines, instead of being titled "Standard of Medical Care in Diabetes," were titled something like "ADA Consensus Panel Guidelines."

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Standards of Medical Care in Diabetes

Response to Power

e would like to thank Dr. Power for his letter (1) and allowing us to comment on the appropriateness of the title for our clinical practice guidelines, the evidence levels used in our guidelines, and specifically our recommendation regarding screening for type 2

diabetes (2). The title "Standards of Medical Care in Diabetes" was chosen because in the view of the American Diabetes Association (ADA), the recommendations represent what we consider the "standards" for the care of patients with diabetes. We see a need to define these so that providers have a guide for assessing their care. They have become the basis for the diabetes guidelines of many organizations and for the diabetes measures now used by the Health Plan Employer Data and Information Set (HEDIS), as well as for many of the quality improvement initiatives by the government, payers, and medical groups.

Each of the recommendations is given an evidence level so the reader can clearly see what supports the recommendation. Dr. Power is correct that "expert consensus" is the lowest level of evidence, although it is important to realize that a great deal of what is done in medical care is based on this level of evidence. On the other hand, many of the recommendations made in the "Standards of Medical Care in Diabetes" have higher levels of evidence.

Regarding our recommendation on screening for diabetes, we actually recommend that "screening be considered," leaving a clear component of clinical judgment in the decision process as to whether a particular patient should or should not be screened. The U.S. Preventive Services Task Force (USPSTF) was evaluating the evidence for "routine screening," not the consideration of what we regard as "targeted screening," which may explain the different evidence levels. Of note, the ADA was asked to comment on the USPSTF statement before its publication and felt that their approach to only recommend screening for those with documented hypertension or dyslipidemia was problematic, as the very definition of what constitutes high blood pressure and dyslipidemia is different for those with diagnosed diabetes than for those without diabetes. We were (and continue to be) concerned that following their advice might allow a person with undiagnosed diabetes to remain undiagnosed until their blood pressure or lipid levels increase over time to a higher level than recommended for those with diabetes. As we know that cardiovascular disease (CVD) risk begins at levels of blood glucose below the diagnostic threshold for diabetes, such an approach could lead to advanced levels of CVD (and other complications of diabetes) when the diagnosis is finally made.

We continue to feel that the title "Standards of Medical Care in Diabetes" is appropriate and that screening of individuals (as opposed to populations) for diabetes should be considered based on the risk factor analysis described.

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The Effect of Insulin Antibodies on the Metabolic Action of Inhaled and Subcutaneous Insulin

Response to Heise et al.

lthough several authors have previously shown that circulating antiinsulin antibodies do affect the pharmacokinetics and pharmacodynamics of injected insulin (1-4), Heise et al. (5) were unable to show this effect in relation to the increase in anti-insulin antibodies induced by inhaled insulin. Heise et al., however, have applied a study design based on the questionable method of the euglycemic clamp (5), which had been criticized before because of its potential imprecision in demonstrating the biological effects of exogenous insulin (6). This method had not been used in the earlier studies (1-4), which, however, had reported serum free insulin levels (Heise et al. failed to do so). I wonder if the determination of serum free insulin levels would help to explain the apparent discrepancy between the data reported by Heise et al. (5) and those of the previous studies (1-4)?

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The Effect of Insulin Antibodies on the Metabolic Action of Inhaled and Subcutaneous Insulin

Response to Chantelau et al.

e thank Prof. Chantelau (1) for his inquiry about serum free insulin levels in our study (2). Free insulin levels were measured in the fasting state (i.e., before trial drug administration) at baseline and at weeks 12 and 24.