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.

Although several authors have previously shown that circulating anti-insulin 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.

We 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.