



basal insulin was adjusted to optimize pre-meal glucose levels, administration of insulin lispro led to a significant decline in the level of glycated hemoglobin, from 8.8% to 8.0%, without an increase in the risk of hypoglycemia. Others have also reported significant improvements in levels of HbA_{1c} (by 0.3% to 0.4%) with insulin lispro and basal insulin adjustments.^{2,3} Thus, the concerns raised by the authors about a tendency for “higher fasting and preprandial blood glucose levels with this analogue” and a lack of “differences in the HbA_{1c} level” have now been addressed.

The question of how the meal plan should be adjusted when insulin lispro is used has also been addressed recently, by Ronnema and Viikari,⁴ who showed a significant improvement in levels of HbA_{1c} (by 0.2%) when snacking between meals was reduced.

Quality-of-life issues have now been explored to a greater degree than described in the article, particularly in an extensive paper by Kotsanos and colleagues.⁵

Finally, to mention the use of insulin lispro after meals in a paragraph entitled “Contraindications” is somewhat misleading, given that there is growing evidence that this practice may be a suitable alternative in selected situations.⁶⁻⁸ In fact, the postprandial use of insulin lispro has recently been approved in Europe.

Loren D. Grossman, MD

Associate Vice-President, Clinical Research
Eli Lilly Canada Inc.
Scarborough, Ont.
Received by email

References

1. Ebeling P, Jansson P, Smith U, Lalli C, Bolli GB, Koivisto VA. Strategies toward improved control during insulin lispro therapy in IDDM. *Diabetes Care* 1997;20:1287-9.
2. Jansson P, Ebeling P, Smith U, Conget I, Coves M, Comis R, et al. Glycemic control in IDDM is improved by optimized combination of insulin lispro and basal in-

sulin [abstract]. *Diabetes* 1997;46(Suppl 1):162A.

3. Sindaco P, Ciofetta M, Lalli C, Torlone E, Perriello G, Brunetti P, et al. Importance of basal insulin in treatment of IDDM with lispro insulin [abstract]. *Diabetes* 1997;46(Suppl 1):331A.
4. Ronnema T, Viikari J. Reduction of snacks when switching IDDM patients from regular insulin to lispro insulin [abstract]. *Diabetologia* 1997;40(Suppl 1):A350.
5. Kotsanos JG, Vignati L, Huster W, Andrejasic C, Boggs MB, Jacobson AM, et al. Health-related quality-of-life results from multinational clinical trials of insulin lispro. *Diabetes Care* 1997;20:948-58.
6. Scherthner G, Wein W, Sandholzer K, Equiluz-Bruck S, Birkett M. Postprandial insulin lispro — a new option in type 1 diabetic patients [abstract]. *Diabetes* 1997;46(Suppl 1):98A.
7. Stiller R, Gudat U, Pftzner A, Trautmann ME, Haslbeck M. Postprandial treatment with lispro insulin [letter]. *Diabetes Metab* 1997;23:232-3.
8. Strachan MWJ, Frier BM. Optimal time of administration of insulin lispro. *Diabetes Care* 1998;21:26-31.

[One of the authors responds:]

Yes, a fair number of articles on insulin lispro appeared between the submission and publication of our article. As Dr. Grossman indicates, some of these have dealt with the importance of basal insulin, HbA_{1c} levels, quality-of-life issues and the optimum time for administration of insulin lispro. Although most studies have not demonstrated efficacy in reducing levels of HbA_{1c}, we too hope that the few studies that do show this effect represent the trend for the future and that other investigations will confirm the result by bringing confounding factors under control. However, the reductions in HbA_{1c} levels achieved to date have been small, and some of the latest studies involving adjustment of basal insulin^{1,2} have not shown an improvement in HbA_{1c} levels.

Ellen L. Toth, MD

Associate Professor
Division of Endocrinology
Department of Medicine
University of Alberta
Edmonton, Alta.

References

1. Holleman F, Schmitt H, Rottiers R, Rees A, Symanowski S, Anderson JH, et al. Reduced frequency of severe hypoglycemia and coma in well-controlled IDDM patients treated with insulin lispro. *Diabetes Care* 1997;20:1827-32.
2. Burge MR, Waters DL, Holcombe JH, Schade DS. Prolonged efficacy of short-acting insulin lispro in combination with human ultralente in insulin-dependent diabetes mellitus. *J Clin Endocrinol Metab* 1997;82:920-4.

In defence of the military

The media in Canada seem to take every opportunity to criticize established authority. Some of their favourite targets include government, big business, doctors and the military.

Now a freelance article in the official publication of the Canadian medical profession has joined the chorus of criticism of Canada's Armed Forces. Michael O'Reilly, in his article “MD at centre of Somalia controversy finds peace in Northern Ontario” (*CMAJ* 1998;158[2]:244-5), states, “As [Dr. Barry] Armstrong sees it, the disease of incompetence that led to the Somalia débâcle is winning out: ‘It is a running sore in the body of the Canadian Forces that won't heal.’”

Some would question whether peacekeeping should be the primary role for the Canadian Forces. In retrospect, it was a serious mistake to select a frontline assault force, the Canadian Airborne Regiment, for service in an area where the mission was poorly defined. The shooting and torture of Somalis is inexcusable, and it is to Armstrong's credit that he brought this issue to public attention.

However, I think it is inappropriate to attach the label “incompetent” to the entire Armed Forces. When it comes to the business of warfare, our Armed Forces are as good as anyone else's.

Robert Shepherd, MD

Gatineau, Que.