was of concern in the Diabetes Control and Complications Trial[3] and has also been discussed in a recent meta-analysis.[4] In the latter study, it was found that the odds ratio for hypoglycemia was 2.99 for intensive treatment (with regular insulin) relative to conventional treatment, and there was a significant relation (p = 0.005) with the degree of reduction in level of hemoglobin A_{1c}.

It is this context in which the information on hypoglycemia associated with insulin lispro must be interpreted. I hope that our paper was not misinterpreted as implying that hypoglycemia is not a risk with this therapy. However, the concept of a ratio between hemoglobin A_{1c} and hypoglycemia is an important one, particularly if the reduction in hypoglycemia for the same level of hemoglobin A_{1c} can be achieved with respect to severe hypoglycemia, coma or overnight hypoglycemia, as reported by Holleman and associates.[5]

In this era of evidence-based medicine, it can be difficult to express qualitative views, let alone to quote experience, so I dare say that McCormack and Bassett might also be sceptical of the extensive published and unpublished "evidence" that patients like insulin lispro and that they usually choose to continue taking this drug at the end of clinical trials because it gives them more flexibility and is more reliable in its effect on hypoglycemia. Hypertensive patients may not be able to assess whether a particular drug is more or less protective with regard to cardiovascular outcomes, but when it comes to the subjective experience of hypoglycemia, might diabetic patients know best?

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References

1. Bloomgarden ZT. American Diabetes Association annual meeting, 1997: obesity, diabetes prevention, and type 1 diabetes. *Diabetes Care* 1997;20:1913-7.
2. Zinman B. The physiologic replacement of insulin. An elusive goal. *N Engl J Med* 1989;321:363-70.
3. DCCT Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993;329: 977-86.
4. Egger M, Davey Smith G, Stettler C, Diem P. Risk of adverse effects of intensified treatment in insulin-dependent diabetes mellitus: a meta-analysis. *Diabet Med* 1997;14(11):919-28.
5. 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.

Assessing osteoporosis risk

In reply to a letter from a participant in the BC Study of Osteoporosis Risk[1] David Kendler[2] states that the review of bone mineral density testing

prepared by the BC Office of Health Technology Assessment (BCOHTA) was never made public. In fact, the report (entitled *Bone Mineral Density Testing: Does the Evidence Support its Selective Use in Well Women?*) has been distributed widely to the public, to universities and to health sciences libraries and is available free of charge to any member of the public by contacting the BCOHTA (604 822-7049).

The BCOHTA report discusses the problems of risk assessment — limitations that neither Kendler's letter nor the BC Study of Osteoporosis Risk address. The review found that the available methods of measuring bone mineral density, including calcaneal ultrasonography, with and without risk assessment lead to misdiagnosis of well women more often than not. Kendler was one of several BC clinicians invited by the BCOHTA in January 1996 to inform our review. None of the local clinical proponents of bone mineral density technologies have been able to provide a substantive challenge to the scientific analysis of the limitations of these technologies laid out in the report.

Kendler implies that because of the BCOHTA report, hospital administrators withdrew support for the Study of Osteoporosis Risk. Although we would be pleased to take full credit for this decision, Kendler's clinical colleagues also deserve mention for their on-the-record criticism of the study.[3]

The truly tragic dimension of Kendler's study is demonstrated by the testimonial from Agnes Sovereign.[1] This woman has been quadriplegic for the past 6 years and has suffered from multiple sclerosis for 16 years. She has been led to believe not only that the heel ultrasound test was necessary to determine that she had "seriously deficient" bone density, but also that this test result could somehow help clinicians to help her. Rather than lobbying to improve seriously underfunded services such as home care nursing and physiotherapy programs, Kendler has encouraged societies of people with cerebral palsy, multiple sclerosis, paraplegia and other disabilities to rally support for an unproven technology.

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References

1. Sovereign A. Debating the management of osteoporosis risk [letter]. *CMAJ* 1998;158 (5):586.
2. Kendler D. Debating the management of osteoporosis risk [letter]. *CMAJ* 1998; 158(5):586-7.
3. Munro M. Unproven bone-scan tests cancelled. *The Vancouver Sun* 1997 Jan 9; Sect B:2c.

[The author responds:]

The work of the Study of Osteoporotic Fractures Research Group on osteoporosis risk assessment clearly supports the use of measurement of bone mass and identification of risk factors to determine risk of fracture.[1] Yet this evidence has been cited by Ms. Green and Drs. Bassett and Kazanjian to support their position that bone density measurement has no role in the assessment of fracture risk in postmenopausal women: in a recent non-peer-reviewed, government-sponsored publication, they viewed risk assessment as a "diagnostic" technology for predicting fracture.[2] The fact that some women with low bone density will not experience fracture is, for these nonclinicians, justification to refute risk management.

But there are more insidious features to the actions of the BCOHTA. Despite public outcry, the BC government has maintained a moratorium on the acquisition of new bone density instruments since 1993. Thus BC has only 7 funded instruments. Reports such as those produced by the BCOHTA are often used to justify parsimony in provincial government captial spending.

In the end, patient care and clinical needs must prevail. Our patients demand the highest quality of health care and must insist that technology assessment groups refrain from dictating lower standards of clinical care to their physicians.

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Disclosure: Dr. Kendler has performed research with pharmaceutical companies and equipment manufacturers in areas related to the subject of this letter.

References

1. Cummings SR, Nevitt MC, Browner WS, Stone K, Fox KM, Ensrud KE, et al. Risk factors for hip fracture in white women. Study of Osteoporotic Fractures Research Group. *N Engl J Med* 1995; 332:767-73.
2. Green CJ, Bassett K, Foerster V, Kazanjian A. *Bone mineral density testing: Does the evidence support its selective use in well women?* Vancouver: University of British Columbia; 1997. British Columbia Office of Health Technology Assessment report no 97:2T.

Snowbirds: an unwelcome sign that winter's coming

We are just coming into the time of year I dislike most: the pre-Florida checkup season. Typically, these visits involve elderly patients, who come in mid-autumn not to obtain 6-month prescriptions for their medications and their flu shots (they will schedule visits to my office for those purposes just before departure, so that their supplies of medication will be sufficient for their stay in