the WHI (20 × 0.77% = 15.4%). We could use both the approaches described above. For the crude approach, the risk difference is now approximately 15.4% × 0.32 or 4.93% and the NNT 100/4.93 or just slightly above 20. Using the hazard ratio approach for this patient also yields an NNT of just over 20.

As we have shown here, differences between naïve approaches to calculating NNT based on event rates and more sophisticated approaches based on survival analysis may not be large enough to change clinical decisions. We suggest that clinicians who are interested in using the NNT to help guide their practice should not be overly concerned about inaccuracies that may arise from estimating the NNT from event rates, especially when using data from large, randomized trials with high rates of follow-up. What they must avoid is applying NNTs from trial data without considering how their patient's baseline risk may differ from that of the patients in the trial. That mistake could lead to serious miscalculations of the NNT that *would* have implications for clinical decision-making.

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## How to diagnose diabetes

In their commentary on the impact of new guidelines for glucose tolerance testing, Andrew Lyon and associates[1] argue against increased use of the oral glucose tolerance test (OGTT) on the grounds of poor reproducibility, cumbersomeness and questionable cost-effectiveness. They rightly conclude that devoting resources to programs that can help patients to modify their risk for diabetes is preferable to performing more OGTTs. However, it would have been appreciated if they had considered the simplified or abbreviated version of the glucose tolerance test[2,3] in terms of its suitability for detecting new cases of diabetes; this form of the test would be both reliable and less expensive.

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Andrew Lyon and associates[1] point out that the Canadian Diabetes Association's new clinical guidelines may increase the burden on laboratories because of increased use of the OGTT. I would like to add that the diagnosis of diabetes is mainly initiated by family doctors, but they may be too busy to implement any screening or to follow up appropriately once diabetes has been identified.[2] The burden on family practitioners to initiate mass testing and