

Diabetes in aboriginal populations

Contrary to John Anderson's claims,¹ diabetes in aboriginal populations has nothing to do with socioeconomic factors, nor can alleged genetic characteristics explain the high prevalence of diabetes in these populations, as the case of American and Mexican Pima Indians patently demonstrates. Pima Indians living in the United States are ravaged by diabetes, whereas those who live in Mexico, despite their lower socioeconomic status, are free of diabetes.² Therefore, the prevalence of this disease in American Pima Indians can only be ascribed to the fact that they consume Western foods not in their traditional diet, which are unavailable to their Mexican counterparts. These "genetically unknown"³ foods are rich in fat and contain sucrose in solid form or in concentrations exceeding the physiologic limit imposed by evolution.⁴

A group of Australian Aborigines virtually recovered from diabetes in 5 weeks by returning to their traditional diet.⁵ Similarly, a group of obese Hawaiians lost an average of 7.8 kg each in 3 weeks by consuming their traditional foods to satiety, without changing their sedentary lifestyle.⁶

Rather than continuing to look for putative genetic mutations responsible for diabetes epidemics in aboriginal populations after their contact with Westerners, it might be more rewarding to look for genetic mutations that confer relative resistance to diabetes in Westerners, despite their consumption of some diabetogenic foods that humankind is genetically unequipped to handle.⁷

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Technology list found wanting

I must address some of the inequities and inaccuracies in Caralee Caplan's editorial in *CMAJ's* technology issue.¹ In her description of how a list of current technologies in medicine was generated, she commented that she polled people in 34 clinical specialties. As a result, she presented a list in which a substantial number of the new technologies ascribed to certain disciplines actually are imaging or interventional technologies that are performed largely by radiologists. Further, interventional radiology and interventional neuroradiology, subspecialties in their own right, were not even mentioned. It is insulting in this day and age that diagnostic imaging was not considered to be a clinical specialty and that many of the procedures performed by radiologists were categorized by other physicians as being under the purview of their specialty. I realize that to some this may seem like hairsplitting and turf protection, but in an endeavour such as this to catalogue many of the emerging technologies that will have an impact on medical practice I believe appropriate attribution of the technology and technical skills is important. To include angioplasty and stenting of carotid arteries under the heading cardiology or to include functional MRI,

SPECT scans, intra-arterial thrombolysis and endovascular coiling of aneurysms under the heading neurology, neurosurgery and vascular surgery is insulting and demeaning to the radiologists across the country who perform the bulk of these procedures. I would encourage Caplan to update her email list to include clinical specialists in diagnostic imaging.

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Reference

1. Caplan C. A technological journey: specialty spotlights and beyond [editorial]. *CMAJ* 1999; 161(9):1124-7.

I read with interest Caralee Caplan's attempt to chronicle recent technological advances in medicine.¹ I was disappointed, however, to note the lack of a section dealing with geriatric medicine. Given the changing demographics of the population, seniors are certainly going to continue to be beneficiaries of advances in diagnostic and therapeutic technology. I proffer my own incomplete list in this regard, hoping that more erudite readers will add to the list (Caplan mentioned some of these items under other specialties and subspecialties): advanced neuroimaging in dementia, newer and more accessible methods of bone-density measurement, cognition-enhancing pharmacotherapy, intelligent drug-monitoring computer systems to decrease or prevent adverse drug events, electronic mobility aids, electronic antiwandering devices and safe environments for habitual wanderers, and computerized gait-analysis devices to prevent falls.

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