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

[The author responds:]

Robert Ashforth and Shabbir Alibhai have underlined some of the difficulties inherent in creating a list of technologies using a computerized reviewer database and email. First, my initial survey was limited to those reviewers with accurate email addresses in the database. Second, *CMAJ*'s reviewer database includes only a small fraction of Canada's specialists, and certain specialties are clearly underrepresented. For example, of reviewers with email addresses in the database, there are 64 specialists in hematology–oncology, 14 in gastroenterology and only 13 representing radiology and nuclear medicine combined.

Furthermore, with space limitations in the journal, the challenge was to keep the list as complete as possible without being repetitive. Thus, specialties dealing with similar disease processes were combined under 1 heading. Although inhaled nitric oxide for hypoxemic repiratory failure was listed as a critical-care technology, it could just as easily have been described as a technology "belonging" to respirology. Similarly, telemedicine, a technology with important applications in many medical fields, was listed under the heading cardiology and cardiac surgery simply because several cardiologists cited telemedicine as a key development.

In this vein, my choice not to include diagnostic imaging as a heading was certainly not an attempt to attribute radiologic technologies and skills to other specialists, but was rather an effort to show the wide-ranging applications of imaging technologies in virtually all areas of the body and of medicine. As I emphasized in my editorial, new imaging techniques have changed the way we see disease, and technological advances in radiology have had an impact well beyond the bounds of a single specialty.

The list is by no means comprehensive. It was meant to give readers a sense of the directions technology has taken, to be a springboard for more detailed descriptions and to serve as an invitation to specialists, like Ashforth and Alibhai, to tell us more about what they do.

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A new register for clinical trial information

I applaud David Hailey for recognizing that "Schering Health Care and Glaxo Wellcome have taken important steps in making information available about ongoing trials in which they are involved."[1]

Having recognized the need for global access to information, Glaxo Wellcome recently introduced a clinical trials register to ensure that as much information as possible is available to researchers and clinicians. The goal is to facilitate systematic review of late-stage clinical data and, ultimately, to improve patient care.

Researchers already have access to much clinical trial information because the submission of clinical trial reports to peer-reviewed journals has long been established as a means of subjecting data to the rigorous scrutiny of the medical community. However, not all data generated through the drug-development process are published, meaning that an unpublished pool of potentially valuable data exists.

Medical researchers and other health care professionals can access the clinical trials register through a password-protected area of the Glaxo Wellcome external R&D Web site (www.glaxowellcome.ca). The site allows users to access our study protocols and unpublished late-stage clinical trial data when reviewing information on specific medications. The register will also make researchers aware of research in progress, thereby avoiding duplication of effort.

In addition to establishing and maintaining the register, we remain committed to publishing clinical trials in peer-reviewed journals. Each trial in the register will be assigned a unique identifier, which researchers can use to link each publication back to the original trial. Because a single trial may generate several publications, the unique identifier will help people reviewing the literature to identify specific trials and avoid duplication of trial data.

Because access to information about specific medications can improve patient care, Glaxo Wellcome has taken the lead in developing this clinical trials register for the use of medical researchers and clinicians. We encourage the rest of the research-based pharmaceutical industry to join us.

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Reference
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Migrants from China

I was upset to read the article "BC's Chinese migrants a healthy lot, MDs find."[1] The article stated that 34% of the passengers on the fourth boat had chronic hepatitis B, which means that these passengers are infective. If over one-third of them have a disease that, if transmitted, is life threatening, how can we call them a healthy lot? I find this outrageous. Even the outcome of the disease to the migrant and the cost to our medical system leave me wondering why our government allows this to continue.

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Reference
1. Kent H. BC's Chinese migrants a healthy lot, MDs find. *CMAJ* 2000;162(2):256.

[The news and features editor