



morning debating issues.

Memorial's dean of medicine, Dr. Ian Bowmer, met them to discuss emerging initiatives, and specifically the development of academic rural centres of health and the nurse-practitioner program. (The province is considering legislation that will regulate the role of nurse practitioners, who are currently being trained to supplement physician services in rural areas.)

"We have not recognized our rural preceptors appropriately, and that's

the thinking that brought us to the academic centre concept," said Bowmer. "At such a centre everyone participates in a teaching environment and on-call duty is reduced."

He said the province jumped at the idea of interdisciplinary teaching units and the program has developed quickly, particularly at Port aux Basques. "The good news is that there is going to be new money for these centres, there is a source for some federal funds. The idea of the

pilot centres at Twillingate and Port aux Basques is to demonstrate that these are a good idea and should be established all around the province."

Dr. Conleth O'Maonaigh, who practises on Fogo Island, has some major concerns about the pilot project. "What about preceptors elsewhere who don't get paid? How are they going to feel? And what if the pilot fails? What happens to the faculty who have been hired?" — *Sharon Gray*, information officer, Memorial University.

Research Update • *Le point sur la recherche*

Changing thinking about gestational diabetes

Targeting pregnant women with risk factors for gestational diabetes makes screening for the condition more efficient and lessens the test burden for many women, Toronto researchers have found (*N Engl J Med* 1997;337[22]:1591-6).

According to some existing guidelines, all pregnant women should undergo a blood glucose screening test at 24 to 28 weeks' gestation, followed by an oral glucose-tolerance test among women with positive results. The study suggests that a different strategy could save about a third of pregnant women the bother of the screening test and yet detect just as many of the women with gestational diabetes.

"The goal is to minimize the burden on women," explains Dr. C. David Naylor, study coauthor and chief executive officer at the Institute for Clinical Evaluative Sciences. There has recently been controversy over the need for universal screening and over the usefulness of treatment in preventing the effects of gestational diabetes — larger babies and a higher-than-usual risk of toxemia and cesarean section. However, identifying gestational diabetes has

another benefit.

"Pregnancy amounts to a 'metabolic stress test' to find women who are at higher risk long term for diabetes," Naylor says. At least in theory, women with diagnosed gestational diabetes can receive care after pregnancy to lower body mass and modify other risk factors. However, Naylor cautions that research into the benefits of postpartum intervention to prevent diabetes is needed.

In the study, conducted at Women's College Hospital, the Toronto Hospital-General Division and Mount Sinai Hospital, more than 3000 pregnant women were given both the screening test and the oral glucose-tolerance test. Study data were then randomly divided. In one group, various demographic factors were examined to see which ones predicted gestational diabetes. The second group was used to validate the findings from the first group. The result was a variety of screening strategies based on age, body mass index (BMI) before pregnancy, and race.

The authors recommend that family physicians and obstetricians who currently conduct universal screening instead refer pregnant women for the screening test *unless* they are black or white *and* under

35 years old *and* have a BMI of 22 kg/m² or less before pregnancy.

Some of the strategies involve a lower blood-glucose level threshold than now recommended for women at high risk of gestational diabetes. Naylor suggests that physicians who wish to adopt the revised thresholds build them into test requisition sheets. — *C.J. Brown*

In the news . . .

Ankle bone connected to the knee bone

From the people who brought you the Ottawa ankle rules comes the Ottawa knee rule (*JAMA* 1997;278:2075-9), a prospectively validated guideline that saves time and money when physicians request radiographs for acute knee injuries. The guideline recommends requesting a knee radiograph only for patients who are 55 or older, have isolated tenderness of the kneecap, have tenderness at the head of the calf bone, cannot flex the knee 90° or cannot bear weight. After physicians in the study learned the rule, their ordering of knee radiographs fell 26.4%, and no fractures were missed as a result.