

## Diabetes type and endogenous insulin

### To the editor:

In the July 2005 issue (“What is the best way to distinguish type 1 and 2 diabetes,” *J Fam Pract* 2005; 54:630–633), Vincent Lo asserts in his clinical commentary that “distinguishing between type 1 and type 2 diabetes is neither clinically helpful nor cost effective.” In their recent Position Statement, the American Diabetes Association states that labeling the type of diabetes is less important than knowing the pathogenesis of the hyperglycemia.<sup>1</sup> We think we may lose this knowledge of pathogenesis if we never attempt to identify patients who do not produce endogenous insulin.

As an example from our practice, a 60-year-old obese woman with coronary artery disease was admitted with diabetic ketoacidosis. Her C-peptide was undetectable. On subsequent hospital admissions, it is essential that her exogenous insulin be continued to prevent iatrogenic diabetic ketoacidosis, and this information must be conveyed to the team caring for this patient. A patient who does not produce endogenous insulin needs to have basal insulin replacement at all times to prevent iatrogenic diabetic ketoacidosis.<sup>2</sup> In these patients, management with only an insulin sliding scale can have severe complications.

While the assertion that distinguishing between type 1 and 2 diabetes may be correct in most outpatient situations, in the inpatient setting managing patients who do not produce endogenous insulin is often quite different from managing those who do.

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### Dr Lo responds:

*The comments of Dr. Spencer and Dr. Miller were appreciated. While knowing the pathogenesis of the hyperglycemia is important, checking insulin C-peptide remains not always helpful and cost-effective.*

*In the example of a 60-year-old obese woman admitted with diabetic ketoacidosis, it was clinically obvious that the patient would require exogenous insulin replacement therapy. It is often a misguided practice for physicians to use sliding scale insulin coverage to address hyperglycemia in hospitalized patients. Sliding scale insulin is often not adequate and appropriate for long-term management of patients with diabetes who are insulin-dependent.*

*I agreed that it is critical to address the need for basal insulin requirement for both hospitalized and outpatient patients who required exogenous insulin replacement.*

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## Tegaserod for chronic constipation

### To the editor:

In a recent supplement in the *Journal of Family Practice*, the benefit of tegaserod for chronic constipation is overstated.<sup>1</sup> I am concerned that this publication is marketing “spin” from the manufacturer of tegaserod, Novartis Pharmaceuticals.

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**In the inpatient setting, managing patients who do not produce endogenous insulin is quite different from managing those who do**

The authors give tegaserod a strength of recommendation rating (SOR) of “A” based on 2 recent studies.<sup>2,3</sup> The primary outcome measure used in both studies is percentage of patients labeled “responders” to the medication. A “responder” has a mean increase of >1 complete spontaneous bowel movement (CSBM) per week. Using absolute numbers of “responders,” the number needed to treat with 6 mg bid of tegaserod is 7.<sup>2</sup> Additionally, modest gains are noted in numerous constipation symptoms rated by patients on 5-point ordinal scales. Mean increase in CSBM is technically patient-oriented evidence, as are symptoms of constipation, and many of the findings achieve statistical significance compared with placebo. However, I do not believe that most of these differences are clinically significant, and I doubt the value of this expensive medication to most of my patients with chronic constipation.

The supplement is not an unbiased source of clinical information. It is “supported by a grant from Novartis Pharmaceuticals.” Two of the 6 members of the consensus panel receive compensation from Novartis, either as a consultant or as a member of a speakers’ bureau. The 2 referenced trials were funded by Novartis, and all authors of 1 study are either an employee of or a paid consultant to Novartis.<sup>2</sup>

I am concerned that your journal published this supplement and emphasized the article with a red box labeled “Clinical Update.” The busy clinician is unlikely to recognize this for what it is: pharmaceutical industry marketing.

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3. Johanson JF, Walk A, Tougas G, et al. Effect of tegaserod in chronic constipation: a randomized, double-blind, controlled trial. *Clin Gastroenterol Hepatol* 2004; 2:796-805.

## Family Medicine: Aiming higher

### To the editor:

We read with interest your editorial in the July 2005 edition of the *Journal of Family Practice*. We found the title provocative but disagree with your basic assumptions and conclusions.

First, our patients are not our “financial” customers. In the last 20 years in the US, the paying customers for healthcare have become governmental programs, insurance companies, and large corporations. The decision to base the US health system upon specialty care was made by our “real” financial customers, not by the patients we see in our clinics and offices. Many medical specialty associations understand this fact and spend considerable time lobbying to maintain high reimbursement procedures within the scope of practice of their specialty. On the other hand, many Family Medicine leaders spend time arguing that FPs should not be trained to do profitable procedures that are needed by their patients. This argument is bad for patients and bad for the specialty.

Second, for a third-party payor, utilizing an FP only to be an “expert in outpatient care” is a waste of money. Capitalism values rapid, predictable, effective, economic results on investment. A provider who can assess patient needs and then effectively and efficiently eliminate a medical problem is a provider that the payor will attempt to retain (some might call this the specialty model of medical care). Someone who merely specializes in the chronic, never-ending treatment of insoluble medical problems is essentially viewed as a “loss leader” by the payor (ie, always needing more resources, never “solving” the problem). If FPs are only “outpatient experts,” as you suggest, the people who pay for health care will always see us as a “losing” investment.

Many physicians will be upset by this analysis because they feel that it ignores the

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great value of preventative medicine. We agree with them that chronic care management is very important to the public health. However, a capitalist economy devalues long-term planning. If you doubt, explain why we have a multi-billion dollar automotive and petrochemical economy, when we know that fossil fuels are limited and exhaustible, vehicle accidents kill tens of thousands of people per year, and combustion engines cause pollution that may permanently poison our environment.

Although everyone realizes that many medical problems can't be solved, no payor with an eye on the bottom line can afford to "maximize the use" of providers who can only deal with these chronic problems. If Family Medicine is to survive as a specialty we must prove ourselves in the marketplace by offering an efficient, effective service valued by a third-party payor, not by creating providers who never solve insoluble problems and cost huge amounts of money in the process. We should be much more than just "outpatient experts."

Currently in the US there are not enough specialists to provide all of the care that patients need. For example, every gastroenterologist in the US could do colonoscopies all day long and still not accomplish all of the indicated screening procedures. If ERs required 100% board-certified ER physicians, most would close. There are nationwide shortages in obstetricians, general surgeons, general pediatricians, and many other specialties, especially in rural areas. The health system and the third-party payors cannot possibly afford the cost to train sufficient specialists to provide all of the common specialty care that is needed in this country. In fact, even if we could afford it, the system of care would be hampered by the fact that most specialists prefer not to focus their practices upon the most common medical issues seen in their field. Ob-Gyn doctors are giving up obstetrics and pregnancy termination care. Few surgeons make an entire practice treating hernias and surgical skin problems; instead, they tend to specialize. Many orthopedists are refusing to take emergency calls and

prefer not to care for simple traumatic fractures. The list goes on and on.

FPs can provide these and many other common medical services in a safe and effective manner. Indeed, FPs can provide this care very cost-efficiently. Therefore, we should be talking about training our residents to do more, not less. We should train them, as one of our mentors used to say, "to do the common things, uncommonly well." That means we must actively train residents to compete with specialists for common procedures (ie, hospital care, colonoscopies, obstetrics, HIV care, orthopedics, allergy care, ER care, low-tech surgery). We should consider expanding the curriculum to 4, perhaps 5 years. Require rigorous documentation of competency and quality outcomes. Hire the best, most experienced, most talented faculty available. Set high expectations and we will have high-quality graduate physicians. When the bar is set high, we will attract the best.

We should not train FP residents to believe they are less capable of learning than specialty residents. We should not train them to believe that 4 years of medical school and a full residency only qualify them to be an "expert in outpatient care"—essentially an expensive mid-level practitioner. We should train them to care for patients, with common medical problems, better than a specialist can. Better, because we have a comprehensive perspective on the patient's care. Better, because we are flexible and multiply skilled. Better, because we have been well trained and can prove our competency. We should expect to train the best students, in the best residencies, to provide the best medical care—comprehensive primary care.

If we aim for less, why waste our time?

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## We should not train FP residents to believe they are less capable of learning than specialty residents

## COPD and antibiotics

### To the editor:

We have read with interest the suggestions for treatment of respiratory tract infections in *JFP*.<sup>1</sup> We congratulate the authors on the clarity of the message conveyed. Indications for antibiotics can vary according to each country due to differing degrees of resistance of the most frequently isolated respiratory germs. But we agree with the authors that the most important item is whether the patient requires an antibiotic.

The literature has shown that antibiotics are slightly more effective than placebo in the treatment of exacerbations of moderate-severe chronic obstructive pulmonary disease (COPD) and should be recommended when at least 2 of the Anthonisen criteria are presented.<sup>2</sup> Among all the placebo-controlled studies performed, that published by Anthonisen et al in 1987 continues to be the reference study.<sup>3</sup> They reported that 55% of the exacerbations of COPD in the placebo group resolved spontaneously. This study included moderate-severe patients.

One of the problems that general practitioners have is to know whether a determined exacerbation is due to a bacterial agent or not, and thus, whether antimicrobial treatment is necessary. Few clinical studies have evaluated the role of antibiotic therapy in mild COPD and none of the studies undertaken have demonstrated that antibiotics are indeed beneficial in exacerbations of this disease. It may be stated that the microbiologic studies which have analyzed the frequency of isolating suspicious pathogens only find 50% of the exacerbations, even in patients requiring hospitalization, and the more severe the patient the greater the frequency of isolation, being arguable in patients with mild COPD.<sup>4</sup> In these cases the effectiveness of sputum cultures is poor and in many cases potentially pathogenic microorganisms are not isolated, in contrast with the finding of pathogenic microorganisms in patients with advanced disease.<sup>5</sup>

The benefits of antibacterial treatment has only been demonstrated in patients with moderate-severe COPD in whom potentially pathogenic microorganisms are isolated. We think that the indications for the antibiotics in chronic bronchitis can lead to misunderstandings; probably it would be more useful to classify these patients according to the severity of their condition. COPD in those who have a forced expiratory volume in 1 second of 60% of predicted or more behave similarly to those with acute bronchitis with a mainly viral cause, cases in which the use of antibiotics is not recommended.<sup>6</sup> Taking the microbiological basis of uncomplicated acute bronchitis into account, it is not surprising that in the few studies that evaluated the role of antibiotics in exacerbations of mild COPD, no benefits have been observed. While there are no other studies in this subgroup of patients with limitations in air flow, antibiotics should not, initially, be prescribed and bronchodilator medication, hydration and natural measures should be used as in cases of acute bronchitis. For this reason we should recommend the use of spirometry to be able to treat these patients adequately.

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**We think the indications for antibiotics in chronic bronchitis are misleading; it would be more useful to classify these patients by severity**