LETTERS

Insulin Resistance Linked to Diet

Dr. Alfonso Torquati was quoted as saying, "We think that bariatric surgery is metabolic. It bypasses the duodenum and changes the way that glucose and lipid metabolism work" ("Gastric Bypass Halves Framingham Risk Score," March 2007, p. 32).

He says later in the article that the same changes in insulin resistance improvement are not seen with gastric banding, again suggesting that the metabolic changes are somehow linked to duodenal bypass.

I would suggest that if Dr. Torquati were to evaluate the metabolic changes that occur within the first week of beginning a strict rice diet, he would appreciate a drop in insulin resistance, and the ability to stop most oral hypoglycemics within that time frame. It is therefore not intuitive to conclude that duodenal bypass has anything to do with decreasing insulin resistance.

It is more likely that the bypass patients are severely restricted in what they can and do eat in the immediate postoperative period. Gastric banding limits oral intake to a lesser degree, and patients can still eat some of the same foods they had eaten preoperatively, only in smaller portions.

Douglas Jay Sprung, M.D.
Maitland, Fla.

Dr. Torquati replies:

We thank Dr. Sprung for highlighting the importance of caloric restriction in the management of type 2 diabetes. We agree that any intervention that limits the daily amount of calories results in decreased insulin resistance. However, more important is the magnitude of change in insulin sensitivity and maintaining this effect over time. There is much evidence that gastric bypass surgery induces and maintains the greatest change in insulin sensitivity in individuals with class II and III obesity. In our recent trial we observed 12 months after gastric bypass a decrease in hemoglobin A_{1c} of 1.7 ± 1.1% from baseline (J. Gastrointest. Surg. 2005;9:1112-6 and 1117-8). Another study showed a reduction in HbA_{1c} of 0.6 ± 0.3 % after 12 months of combined therapy with sibutramine and a low-calorie diet similar to a post–gastric bypass regimen (900-1,300 kcal daily) (Diabetes Care 2003;26:2505-11).

What are the reasons for this significant difference? We think that a restrictive procedure such as the gastric bypass that limits its caloric intake and has a malabsorptive component is the most effective treatment for subjects with type 2 diabetes and class II and III obesity. There is evidence that bypassing the duodenum and the proximal jejunum in addition to caloric restriction decreases insulin resistance more than does a simple restrictive procedure (i.e., gastric banding). A study of meal-stimulated responses of insulin, ghrelin, peptide YY, glucagon-like-peptide-1, and pancreatic polypeptide in humans and rodents following different bariatric surgical techniques found that gastric bypass patients had early and exaggerated insulin responses, potentially mediating the improved glycemic control in patients with diabetes (Ann. Surg. 2006;243:108-14). None of these effects were observed in patients losing similar weight through gastric banding, suggesting that the hormonal changes are not secondary to weight loss alone.

This evidence and more, omitted for the sake of brevity, shows that the duodenal-jejunal bypass component of the gastric bypass is a major contributor to the improvement and resolution of obesity-related comorbidities observed after gastric bypass surgery.

Health Insurance According to Need

Dr. Kevin Grumbach would have us emulate the Canadian health system, but fails to list the long waits for most surgeries and imaging studies—waits which most U.S. citizens would find unacceptable ("What is the best way to reform the U.S. health care system?" Point/Counterpoint, December 2006, p. 28).

Indeed, the numbers of Canadians who avoid the wait by obtaining care in the United States is impressive, but that factor also is ignored by Dr. Grumbach.

Dr. Robert Moffit's views are pertinent and accurate. In addition, we need to recognize that the "mandates" imposed by a majority of states make the cost of individual health insurance policies excessively high; therefore, this is a significant cause of many going uninsured. Health insurance policies should be like homeowners' policies, where the buyer contracts for the type of coverage that is needed and affordable. Mandates primarily are a response to demands by special interest groups who benefit from forcing the buyers of policies to include what they may neither need nor want and often cannot afford.

A federal law that would allow national sales of health insurance, like national sales of life insurance, would help, as would a federal law that would require that states accepting federal Medicaid funds be prohibited from forcing mandated benefits on private buyers of health insurance policies.

Alan W. Feld, M.D.
Las Vegas

We'd Lose Under Single-Payer System

Dr. Kevin Grumbach made several points in defense of his argument for a single payer system of health care, and he made a glib comment—"physicians in Canada do very well"—to quell the worry that this system does not adequately reward physicians ("What is the best way to reform the U.S. health care system?" December 2006, p. 28).

The facts say otherwise. According to recent statistics from the Johns Hopkins Bloomberg School of Public Health, the average income for a U.S. physician is $180,000, while in Canada it is $100,000. Given the real estate market in San Francisco where Dr. Grumbach practices, I imagine the next generation of physicians there will be camping out in the city's Tenderloin district if we adopt the Canadian model.

Rand L. Werbitt, M.D.
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Bills to Fix Medicare Rates, Reauthorize SCHIP Are Likely

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — The 110th Congress is fertile ground for health care legislation, from expanding coverage to fixing physician pay, according to Capitol Hill insiders and observers speaking at a conference sponsored by AcademyHealth.

"You can feel it in the air, not just in Washington but all across the country. The season is changing," said Sen. Max Baucus (D-Mont.), chairman of the Senate Finance Committee. "The season is for real debate on health-care reform. And it is long overdue."

"Having run vigorously against a 'do-nothing' Congress, Democrats … now have to show that they are the do-something Congress," said Dr. Norman J. Ornstein, a resident scholar at the American Enterprise Institute, a conservative think tank in Washington.

There is also a sense that America's employers are ready to support health care reform, said Sen. Ron Wyden (D-Ore.). "In 1994, the business community said, 'We can't afford health care reform.' In 2007, the business community is saying, 'We can't afford not to fix American health care,' " he said.

Democrats' first focus has been and still is on covering the uninsured, said Sen. Wyden.

"You cannot fix American health care unless you get everybody covered," he said. "And the reason that's so important is not only is it morally the right thing to do, which it clearly is, but if you don't get everybody covered, what we all know is the costs of people who don't have coverage get passed on to people who do."

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"What we have done is target our efforts on children. And trying to make sure that we improve on the coverage that is there today and certainly try to find those children who would qualify for the public programs that we have and who yet aren't enrolled," said a Democratic congressional staffer speaking at the briefing.

About 25% of children in the United States have health coverage through either Medicaid or the State Children's Health Insurance Program (SCHIP). However, 9 million children currently have no health insurance, and two-thirds of those are actually eligible for public coverage. States have been increasing their outreach efforts, but they have been stymied by shortfalls in federal matching funds for SCHIP. This year, 14 states are expected to run out of federal funds by May.

As Congress considers the reauthorization of SCHIP this year—its mandate expires Sept. 30—some Democrats have suggested it's time to make the program an entitlement. (SCHIP currently is funded on a pay-as-you-go basis, meaning that any increased funding must be offset by a cut somewhere else in the federal budget.)

When it comes to decreasing physician pay under the sustainable growth rate formula, both Democrats and Republicans have expressed interest in finding a solution. However, no one has come up with a remedy that fits into the current budget outlook.

"In order to get the physicians back to zero, we're talking costs of probably approximately $22 billion. And that isn't addressing the longer-term problem that Medicare's current payment formula is going to call for cuts for an additional 5 years beyond that," the Republican congressional staffer said.

Recent proposals to fix the SGR have ranged in cost from $4 billion in the short-term to $250 billion in the long term.

Democrats speaking at the conference said they hope to make refinements to the Medicare Part D drug benefit, such as improvements in the low-income subsidies and a reassessment of the higher payments that Medicare Advantage plans currently receive. Several proposals have already been introduced to allow the government to negotiate drug prices.

Republicans are expected to oppose significant changes to the program. "From our perspective this program has been wildly successful beyond any estimation that we could have made back in 2003 when we passed the Medicare Modernization Act. [In light of this], why are we talking about making fundamental changes to this program?" said the Republican congressional staffer.

While action on these and other health care issues seem likely this year, there is a short window of opportunity to complete them before election politics come into play, said Dr. Ornstein.

"The conventional wisdom is that in a presidential election year where there's an open contest in the final 2 years of a two-term president, you have about an 8-month window to move things along. That doesn't mean you have to finish everything, but … you better be pretty close to field goal range at the end of that 8 months," he said. That seems likely to hold true now this year given that at least 26 members of Congress have announced or are considering announcing a run for the White House, he said. ■