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Letters to the editor

Poor predicting values in obtaining non-insulin requiring remission using proinsulin/C-peptide ratios

Dear Sir,

Herewith we would like to comment on the article of O. Snorgaard et al., [1]. In their discussion the authors suggest that a high (above 0.024) proinsulin/C-peptide ratio may be of value in predicting the induction of remission on cyclosporin. A further specification of this conclusion is warranted; first it is shown in Figure 3 that although proinsulin/C-peptide ratios are lower in the cyclosporin-treated group vs. the placebo group, this effect is independent of non-insulin-requiring remission (NIR). From the data given in Table 3 we calculated the positive and negative predictive value (PPV and NPV) of the ratio above and below 0.024. Predicting for NIR in the cyclosporin treated and placebo group, the values were respectively: cyclosporin PPV 64% and NPV 58%, placebo PPV 28% and NPV 66%. From these data it is clear that although the PPV is considerably higher in the cyclosporin group, the NPV is higher in the placebo group. We feel that considerable caution is indicated before the proinsulin/C-peptide ratio can be applied as a predictor of outcome on a large scale.

Yours sincerely,
H.E. Brussaard and B. Bravenboer

References

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Drs. H.E. Brussaard
and B. Bravenboer
Utrecht University Hospital
P.O. Box 85500
NL-3508 GA Utrecht
The Netherlands

Effect of protein kinase C modulators on the leucocyte Na^+/H^+ antiport in Type 1 (insulin-dependent) diabetic subjects with albuminuria

Dear Sir,

Recently L.L. Ng et al. reported an elevated leucocyte Na^+/H^+ antiport activity in Type 1 (insulin-dependent) diabetic subjects with albuminuria as compared to patients without albuminuria [1]. The patients were defined as albuminuric if the average of three early morning urine albumin/creatinine ratios were above 2.0 mg/mmol [2]. The predictive value of this cut off level is 35% for identification of an overnight urinary albumin excretion rate > 30 μg/min [2]. Thus, 65% of the patients will have an overnight urinary albumin excretion rate below 30 μg/min (false positives). Overt and incipient diabetic nephropathy should be defined by quantitative tests according to general accepted criteria [3].

Yours sincerely,
H.-H. Parving

References

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Dr. H.-H. Parving
Hvidøre Hospital
Emiliekildevej 1
DK-2930 Klampenborg
Denmark

Repeatability of the oral glucose tolerance test for the diagnosis of impaired glucose tolerance and diabetes mellitus

Dear Sir,

The recent paper by Eriksson and Lindgärde [1] presented a survey of 45–47 year old men, which aimed to identify both impaired glucose tolerant (IGT) and diabetic subjects. They performed an oral glucose tolerance test (OGTT) with a glucose load of 30 g/m^2 and selected a group of 889 subjects who were considered to have abnormal glucose tolerance, those with a 2 h glucose concentration greater than 6.7 mmol/l. One month later, a second OGTT was performed.

They commented on the 'individual wide fluctuation', and 'that only 31% of those originally meeting the WHO criterion of IGT [2] had a comparable test outcome' on the second OGTT and that 'reproducibility was highest in the diabetic group'. The low reproducibility of 45% in the group diagnosed diabetic at the first examination is of even more concern than the poor reproducibility of the IGT di-