

Letters to the Editor

Diabetes Care and Self-Care

To the Editor:

For me, the highlight of the March/April 2003 issue of the *North Carolina Medical Journal* was to read the commentary, "The Deadly Sins and Diabetes," and to hear a bolder tone than usual in Dr. Francis Neelon's voice. He is absolutely correct, of course about the "collaborative partnership between doctor and patient" and their "shared responsibility." It is time to take off the gloves and deal with patients in a forthright manner. Most of us know (but few will acknowledge) that neither North Carolina nor any other state or country for that matter can afford to practice medicine the way we are currently doing it in the USA. Only personal responsibility, which costs taxpayers and insurance plan members next to nothing, will bring down medical expenditures.

All of the other authors contributing to this issue of the *Journal* make valid points about the relationship between achieving self management (of any chronic disease) and improved long-term outcomes. But they want to do it by creating models that are much more expensive than the doctor saying to the patient, "Just do it!" or "You're not doing what I told you to do." Moreover, it wouldn't hurt for that message to be reinforced by relatives, school teachers, ministers, employers, co-workers, and, yes, even neighbors despite the obstacles of HIPAA. Being a busybody about someone's illness, such as diabetes, may be insensitive, but it sure is an economical method of reinforcement once the doctor and a diabetes educator have delivered their messages. After all, there's collusion going on everywhere—not just in the doctors' offices.

Now that the burden of implied censorship, necessitated by having to be a politically correct editor, has been lifted from Dr. Neelon's voice, perhaps we will read more of his true beliefs!

Harold R. Silberman, MD
The Living Center
2800 CampusWalk Avenue
Durham, NC 27705

To the Editor:

I congratulate you on the vision and excellence of the new *Journal*. However, I was disappointed by your March/April issue, "Improving Diabetes Care in North Carolina," because it failed to note that the most effective therapy for type 2 diabetes today is the gastric bypass operation. The procedure can induce durable, full remission of type 2 diabetes in the morbidly obese.

We first noted the effect at East Carolina University in 1987.¹ By 1995, we were able to report the data shown in the adjoining figure. In a series of 608 morbidly obese patients, we found that 165 were diabetic and another 165 demonstrated impaired glucose tolerance. Following surgery, and after a six-month period for stabilization, 121/146 (83%) of the diabetics and 150/152 of those with impaired glucose tolerance were euglycemic and remained so over the mean observation period of 16 years with a 95% followup.²

In 1997, we were able to show that this was not merely a matter of glucose levels; the operation also reduced the progression and mortality from diabetes.³ Although the groups were not randomized, they do offer a comparison of two matched groups: 154 patients who underwent the surgery and another 78 who were scheduled for surgery but did not undergo the procedures because they changed their minds or because their insurance carriers refused to pay for the procedures. In the group who underwent surgery, 14/154 died within 9 years, or 1% per year. Those who did not, died at a rate of 22/78 within 6.2 years, or 4.5% per year. To our knowledge, no nonoperative therapy has produced such results.

Although we were the first to report the effects of the gastric bypass on diabetes, there have certainly been a number of corroborating series since that time. The most recent was by Schauer and his associates at the University of Pittsburgh,⁴ who reported a series of 1,160 patients who underwent the gastric bypass between 1997 and 2002. Of these, 240 had type 2 diabetes and 192 (80%) were available for followup. Of these, 73% had full resolution, 24% improved significantly, and 3% showed no change, i.e., resolution or improvement occurred in 97%.

The mechanism for this remarkable effect on diabetes and, indeed, on the other comorbidities of morbid obesity remains to be explained. We also do not know whether this

remarkable effect of the operation on the morbidly obese will be achieved in diabetics who weigh less. It is not surprising that this has become one of the most exciting areas of endocrine research.

We still have a lot to learn, but at least we know that diabetes is no longer a hopeless, inexorable disease. It would have been good to include this advance in your otherwise informative issue.

Walter J. Pories, MD, FACS
Professor of Surgery and Biochemistry
East Carolina University
Greenville, NC 27858-4354

-
- 1 Pories WJ et al. The control of diabetes mellitus (NIDDM) in the morbidly obese with the Greenville gastric bypass. *Ann Surg* 1987;206(3):316-23.
 - 2 Pories WJ et al. Who would have thought it: an operation proves to be the most effective therapy for adult-onset diabetes mellitus. *Ann Surg* 1995;222(3):339-52.
 - 3 MacDonald KG et al. The gastric bypass operation reduces the progression and mortality of non-insulin dependent diabetes mellitus. *J Gastrointest Surg* 1997;1:213-20.
 - 4 Schauer PR et al. The effect of laparoscopic roux-en-y gastric bypass on type 2 diabetes mellitus. [Abstract] Reported at the American Surgical Association 123rd Annual Meeting, April 24, 2003, Washington, DC.