

Correspondence

Re: A Lifestyle Intervention Study in Patients with Diabetes or Impaired Glucose Tolerance: Translation of a Research Intervention into Practice

To the Editor: I read with interest the research article by Matvienko and Hoehns.¹ The overarching goal of the study was timely and consistent with the recent paradigm shift toward translational science; furthermore, the authors used a collaborative approach with local health care providers to assist with participant recruitment. I applaud their efforts to connect science with the real world. Although I commend the authors I must comment on their methodology. First, translational science must always be cognizant of the intent of the original science. The specific aim of the Diabetes Prevention Program was to reduce the incidence of diabetes²; therefore the current authors' inclusion of known diabetics into a diabetic prevention program negates the intent of the original trial. Also weight gain, which oftentimes is secondary to the diabetic's pharmacotherapy,³ potentially is a confounding variable. Alternatively the authors may consider conducting a comparison study which includes 2 groups: one consisting of diabetics and another that does not include diabetics. A design such as this may contribute to the body of literature regarding the effectiveness of the diabetes prevention program in changing anthropometric and physiologic measures in both groups.

Second, the authors stated that they wanted to translate research into a real world practice setting. My conceptualization of a real world setting is one wherein the participant frequents as part of their daily lives. Settings such as recreation departments, community centers, or faith-based environments come to mind. However, the authors conducted the intervention within an academic institution and used trained graduate students to deliver the sessions. Using interventionists who are trained in the intervention is imperative in translational science, because training increases fidelity maintenance. Yet, I don't accept the academic setting as a "real world" translation. Furthermore the academic setting is privy to resources that are not as easily attainable in community settings, such as grant funding. I suggest the use of a more community-based participatory model in which the academic institution partners with the community, trains the community partners, and empowers them to deliver the intervention. Although communities may not be privy to the resources of the academic center, they have their own unique resources. For example, they have community leaders who can be instrumental in providing access to the target population as well as people who are vested in the community and may unselfishly promote health behavior change in their own communities. Oftentimes these individuals are nurses, physicians, educa-

tors, and other public/health professionals whose health background enable them to easily grasp the material. Interventions which are conducted using these real world resources are likely to provide the community with sustainable programs that outlast the researchers funding period(s).

In conclusion, the translation of evidenced-based interventions which target obesity are much needed within community settings. Researchers must be ever mindful of the intent of the original research and equally mindful of the sustainability of resultant successful interventions.

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References

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: A Lifestyle Intervention Study in Patients with Diabetes or Impaired Glucose Tolerance: Translation of a Research Intervention Into Practice

To the Editor: We appreciate the interest and comments from Ms. Williams¹ regarding our research article.² She expressed some concern about our adaptation of the Diabetes Prevention Program (DPP)³ for a study group that included patients with prediabetes and diabetes. Unlike the Diabetes Prevention Program study, we enrolled patients *with* diabetes. However, for those patients, enrollment was limited to individuals who were in the early stages of diabetes (diagnosis within the past 5 years) and who had never used insulin. Although including both types of patients somewhat increased the heterogeneity of the study group, we felt that doing so would not unduly compromise the objectives of the study.

It is correctly noted that differences in pharmacotherapy regimens for patients with diabetes can influence patient weight. Five participants started or discontinued