# Correspondence

*We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a quarterly journal where continuity of comment and redress is difficult to achieve. When the redress appears 3 months after the comment, 6 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.*

### Nonsteroidals in Elderly

*To the Editor:* I believe that publication of the article "Office-Based Evaluation Of Renal Function In Elderly Patients Receiving Nonsteroidal Anti-Inflammatory Drugs" by Cummings, et al. (April–June 1988 issue) was premature and misleading. The content of the report presumes to show that ibuprofen 400 mg qid had no more effect on renal function than aspirin 650 mg qid in an elderly population for a 6-week test period and that neither drug caused progressive renal impairment. The authors admit that relatively insensitive measures were used due to procedural difficulties. The title of the article suggests that it is about office-based methods of assessing renal function, not an attempt to prove that ibuprofen is safe. This and the fact that the study was supported by the Upjohn Company, a major manufacturer of ibuprofen, further brings this study into question. In the very least, the data should not have been accepted for the publication until a longer study had been done with a placebo group and a greater sample size and with more sensitive measures of renal function employed.

Robert A. Weissberg, M.D.
Schenectady, NY

*Editor's Note*

This letter is deeply appreciated by the editors. This article or any article published is subject to thoughtful criticism. It is the willingness to point out perceived shortcomings of manuscripts and editors that is needed to maintain and improve the quality of the publication.

### Gestational Diabetes

*To the Editor:* Zoller, et al. are to be commended for their study on "Screening for Gestational Diabetes."[1] With a prospective trial, they showed that traditional risk factors for diabetes are not sensitive or reliable in predicting which pregnant women will have a positive glucose tolerance test. They also showed that the 1-hour, 50-gram glucose challenge test is a highly sensitive and cost-effective screening test for detecting those with gestational diabetes and recommended its universal application in prenatal care.

The study by Zoller, et al. validates current recommendations in the screening for gestational diabetes.[2] If one accepts this approach as optimal care, there is no problem. However, I have questions and concerns about the impact on normal women with the universal application of glucose challenge testing.

As in previous studies, Zoller, et al. had a high false-positive rate with glucose challenge testing (15 percent of the study group were positive, and about 5 out of 6 women who were positive were not diabetic by the glucose tolerance test). Because the standardized oral glucose tolerance test is such an unpleasant experience for pregnant women (many vomit the solution), there is a real tendency in practice to omit the test and make the diagnosis of gestational diabetes simply on the basis of a positive screening test.[3] Such practice would result in massive overdiagnosis of gestational diabetes and seriously compromise the ability of many women to have a normal spontaneous delivery without medical intervention. Even with the proper diagnostic approach, I have seen women with positive screening tests label themselves as possibly diabetic, and they are considered as such by health care providers.

Is there a better and more practical approach for the screening and diagnosis of gestational diabetes? With the widespread availability of immediate fingerstick blood glucose, this test can easily be performed during prenatal visits. Fasting and post-meal blood glucoses could be obtained strategically during prenatal visits, and if they are high by standard criteria, more standardized post-prandial testing could be done. At least one study in England showed random blood glucose testing in pregnancy to be reliable and cost effective.[4]

Why do we rely on the oral glucose tolerance test as the "gold standard" for the diagnosis of gestational diabetes? Much of medicine has largely abandoned this test in favor of more physiologic fasting and post-meal testing.

Are all pregnant women with a positive glucose tolerance test at risk for the complications usually associated with diabetes in pregnancy? It is difficult to compare our current gestational diabetic population with that of O'Sullivan in the 1950s and 1960s when many more diabetics were not previously diagnosed. More current studies suggest that the only consistent risk factor for women with mildly elevated glucose is that their babies are larger (I refuse to label babies with a birth weight of 3808 g as macrosomic).[5]

The universal screening of pregnant women with a glucose challenge test seems like an example of a "maximum strategy in modern obstetrics" well described by Brody and Thompson.[6] Normal- or low-risk women can easily be victimized by an approach preoccupied



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