This is important, because some of the symptoms and signs may occur in patients who do not have diabetes mellitus. To proceed with a glucose tolerance test when the patient has a normal fasting glucose level is neither appropriate nor cost-effective, except in very specific clinical circumstances. The value of the oral glucose tolerance test has been reviewed by several studies, and the consensus remains that the fasting glucose test is the best.[1,6,9] We believe that this was not emphasized by the Expert Committee.

It is interesting that the WHO criteria[6] are quite different from the NDDG criteria. The Canadian Diabetes Association has accepted the latter but not the former. The key difference between these two internationally recognized sets of criteria is that a larger number of patients are classified as having impaired glucose tolerance and diabetes mellitus by the WHO criteria.[5] There is concern in the laboratory about diagnostic tests or procedures that are associated with a high false-positive rate. The differences between the two sets of criteria have been subject to extensive review;[10] however, the differences have not necessarily meant that patients have suffered, although misclassifications do have positive and negative potential.

We suggest that the diagnostic recommendations should reflect more precisely the NDDG criteria and that serious consideration should be given to the accepted standard of laboratory practice that is consistent with a high quality of medical care and with cost-effectiveness. We also recommend that the expert panels communicate their recommendations in an easily comprehensible and unambiguous format, especially when the primary goal is to assist other specialty and nonspecialty physicians.

It is important that expert opinion and consensus guidelines be established in many areas of medical practice, since it is one of the best ways of evaluating clinical care and communicating the processes of optimum care to practising physicians. It is equally important that during development these practice guidelines be reviewed by appropriate experts, including national medical organizations and occasionally licensing and legislative organizations. More important, the reviewers selected by *CMAJ* should ensure that the relevant and important references are quoted accurately. Unless the recommendations are accurate the brunt of any consequences will be borne by patients. It is unfortunate that a laboratory physician was not included in the formulation of these practice guidelines, which are in need of clarification.

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References

1. National Diabetes Data Group: Classification and diagnosis of diabetes and other categories of glucose intolerance. *Diabetes* 1979; 28: 1039-1057
2. Kahn SE, Schwartz DP Jr, Abrass IB: The glucose intolerance of aging: implications for intervention. *Hosp Prac* 1991; 25 (Apr 30): 29-38
3. Andres R: Aging and diabetes. *Med Clin North Am* 1971; 55: 835-846
4. Jackson RA: Mechanisms of age-related glucose intolerance. *Diabetes Care* 1990; 13 (suppl 2): 9-19
5. Harris MI, Hadden WC, Knowler WC et al: Prevalence of diabetes and impaired glucose tolerance and plasma glucose levels in US population ages 20-74 yr. *Diabetes* 1987; 36: 523-534
6. World Health Organization: Impaired glucose tolerance and diabetes — WHO criteria. *BMJ* 1980; 281: 1512-1513
7. Position statement: office guide to diagnosis and classification of diabetes mellitus and other categories of glucose intolerance. *Diabetes Care* 1992; 15 (suppl 2): 4
8. Committee on Statistics, American Diabetes Association: Standardization of the oral glucose tolerance test. *Diabetes* 1969; 18: 299-307
9. Davidson JK: *Clinical Diabetes Mellitus: a Problem-Oriented Approach*, Thieme-Stratton, New York, 1986: 90-107
10. Harris MI, Hadden WC, Knowler WC et al: International criteria for the diagnosis of diabetes and impaired glucose tolerance. *Diabetes Care* 1985; 8: 562-567

[The authors respond:]

We thank Drs. Rasaiah, Garg and Hoag for bringing to our attention their concerns on the accuracy and potential implications of the statements made on the diagnosis of diabetes.

Rasaiah, Garg and Hoag are correct that no level of venous plasma glucose was given in the original publication of the NDDG.[1] We have confirmed this with Dr. Maureen Harris, co-chair of the NDDG. However, this original omission was subsequently corrected by Harris[2] and by many others.[3,4] We accept a venous plasma glucose level of 11.1 mmol/L or higher without glucose loading to be "unequivocal hyperglycemia" for diagnostic purposes and hence use it. We thought it important to cite the original reference in the guidelines. We agree that age affects the venous plasma glucose level. However, the NDDG felt that with its standards "adjustment in the criteria for age of the subject is not necessary." Rasaiah, Garg and Hoag feel that a random venous plasma glucose level of more than 11.1 mmol/L is too low. This is the same criterion as that adopted by the European Non-Insulin-Dependent Diabetes Mellitus Group.[5]

With regard to plasma versus serum glucose, we used venous plasma glucose in the guidelines because that was used and recommended in the original publication.[1] We know that if the glucose level can be measured shortly after the blood sample is obtained many laboratories use serum so

that the lowering of the glucose level due to glycolysis by the formed blood cells is minimized.[1,3]

Our third recommendation clearly refers to the venous plasma glucose levels of an oral glucose tolerance test and not to those after a meal. We also stated that "a glucose tolerance test is unnecessary if the patient meets either of the other two criteria," and this was italicized for emphasis! In other words, if the patient has a fasting venous plasma glucose level greater than 7.8 mmol/L on two occasions it is unnecessary to do the oral glucose tolerance test; nor is it necessary to do this test if the patient has symptoms of hyperglycemia clinically and a random venous plasma glucose level greater than 11.1 mmol/L. We have thus clearly stated the indication for an oral glucose tolerance test in the diagnosis of diabetes mellitus and followed the guidelines of good patient care. Our recommendation is consistent with those of the NDDG and the American Diabetes Association, both cited by Rasaiah, Garg and Hoag. We agree that it is not cost-effective to repeat this test in an unequivocal case of diabetes mellitus. However, we feel that it is proper to do so in a questionable case, given that the diagnosis of diabetes has so many implications.

We agree that "to proceed with a glucose tolerance test when the patient has a normal fasting glucose level is neither appropriate nor cost-effective, except in very specific clinical circumstances." In developing clinical practice guidelines we have to be concise and clear. We believe that our section on diagnosis meets these expectations and that physicians can follow the guidelines. It was unnecessary to elucidate further.

We are aware of the differences between the diagnostic criteria of the WHO and the NDDG. We did not feel it necessary to discuss this difference since the NDDG criteria are used in North America. In Europe the WHO criteria and not those of the NDDG are used.

We agree that guidelines should be clearly stated. We feel we have communicated our recommendations on diagnosis clearly and concisely. We do not know why Rasaiah, Garg and Hoag find our recommendations and those of the American Diabetes Association confusing.

It is true that clinical practice guidelines should be reviewed by appropriate experts in the formulation process. The Canadian guidelines on diabetes were debated and discussed by the 25-member Expert Committee before they were reviewed by 38 others involved in the care of Canadians affected by diabetes. They were then presented in a public consensus conference, and discussions there led to appropriate modifications before the final version was submitted for publication.

The manuscript submitted for publication was reviewed in detail by two senior members of the *CMAJ* staff, and appropriate changes were made, including an update of the extensive bibliography.

Finally, four members of the Expert Committee have research laboratories and are very familiar with laboratory techniques.

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References

1. National Diabetes Data Group: Classification and diagnosis of diabetes and other categories of glucose intolerance. *Diabetes* 1979; 28: 1039-1057
2. Harris MI: Classification and diagnostic criteria for diabetes and other categories of glucose intolerance. In *Diabetes in America* (NIH publ 85-1486), US Dept of Health and Human Services, Bethesda, Md, 1985: II-1
3. Fajans SS: Classification and diagnosis of diabetes. In Rifkin H, Porte D Jr (eds): *Diabetes Mellitus: Theory and Practice*, 4th ed, Elsevier, New York, 1990: 346
4. Lebovitz H: *Physician's Guide to Non-insulin-Dependent (Type II) Diabetes. Diagnosis and Treatment*, 2nd ed, Am Diabetes Assoc, New York, 1988: 1
5. Alberti KGMM, Gries FA: Management of non-insulin-dependent diabetes mellitus in Europe: a consensus view. *Diabetic Med* 1988; 5: 275-281

Sexual harassment

Susan Thorne's article "Several medical schools have begun to tackle sexual harassment issue" (*Can Med Assoc J* 1992; 147: 1567-1568, 1570-1571) refers to research on abuse of medical students, undertaken by us in 1991 at the University of Toronto. This research was, in fact, greatly assisted by the Office of Undergraduate Affairs, and the assistant dean, Dr. Miriam Rossi, was one of the researchers.

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Is *CMAJ* deteriorating?

Over the years I have witnessed the progressive deterioration of *CMAJ*. I find that after receiving the journal I quickly dispatch it to the recycling heap and lament another tree that died in vain.

It seems that to appear progressive *CMAJ* publishes less research of importance to practising physicians and more submissions by members of the public and