

appropriately to ensure comfort, safety, and a well-balanced, nutritious diet.

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Social Events at ADA Meetings

Readers may have noted reprimands directed to the pharmaceutical industry by our respected colleagues Ron Arky (1) and Phil Raskin (2) caviling the entertainment and refreshments provided at the Annual Meeting of the American Diabetes Association. Indeed, the rhetoric used in their commentaries is intensely hyperbolic, with allusions to orgiastic meetings, gargantuan feasts, Hollywood spectaculars, and the like. A more reasonable judgment should be addressed in describing each of the affairs as an "open house," the beneficiaries of which are mostly junior faculty members, house staff, young investigators, nurses, dietitians, and affiliate personnel who attend the annual meetings on limited budgets. These social events provide a proper opportunity for meeting old friends, discussing new ideas and concepts, and engaging in other professionally oriented interchange in an informal and pleasant atmosphere. For those with limited funds, a refreshing interlude is made available to relieve the pressures of the scientific meetings in a convivial setting not otherwise available to the participants. Contrary to the comments of the critics, there have been no significant efforts by the representatives of industry to influence health-care providers. The annual meetings have been of the highest quality in scientific content and organizational format; extracurricular activities are in good taste and afford a suitable social medium for members and guests.

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2. Raskin P: Goodbye, Columbus revisited. *Clin Diabetes* 3:98, 1985

Bah, Humbug

Each of the last 10 yr I have looked forward to attending the Annual Meeting of the American Diabetes Association because it provided an excellent mix of work (editorial board

and study-group meetings), scholarship (scientific sessions), and fun (social events other than the banquet). On the other hand, Drs. Raskin and Arky have recently decried what they perceive as ever-growing excesses of the drug-company-sponsored social activities (1,2). We must be attending different meetings, because the overall social calendar has changed very little since I have gone to the Scientific Sessions: two large receptions followed by hospitality suites.

Dr. Raskin seemed to be particularly offended by the receptions. He was put off by the herd of people scrambling for a few morsels of food at these gatherings. However, has he examined who attends the receptions? Most are young people on limited travel budgets. Cutting back or cancelling the receptions will have much greater impact on these individuals than on senior investigators and clinicians who are squired off to civilized dinners at 4-star restaurants.

Perhaps the hospitality suites are the culprits. The most popular of these involve a group of people standing around a piano singing show, popular, and patriotic tunes. One might complain about the quality of the music produced but would be hard pressed to describe them as "orgies" (2). Even my 73-yr-old mother, who wanted me to take piano lessons, would enjoy these evenings.

While excesses must be avoided at the ADA meetings, I do not think we have reached this point. I am more concerned that a wave of moralistic fervor will make us try to fix something that ain't broke. It would be a shame to have our meeting reduced to the pristine boredom of some of the other research meetings, because fewer people would want to come. Even Scrooge came to realize that 2 days off for Christmas was not all that bad.

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Factitious Hypoglycemia Mimicking Insulinoma

The diagnosis of insulinoma relies on the detection of nonsuppressible hyperinsulinemia and an often very small pancreatic tumor (1). Factitious hypoglycemia induced by hidden sulfonyleurea intake can mimic both clinical and biological features of an insulinoma (2,3).

A 26-yr-old psychiatric nurse was referred to us for severe

TABLE 1
Simultaneous measurement of blood glucose, insulinemia, and C-peptide during hypoglycemic episodes

| | Episode | | | | | |
|---------------------------|---------|-----|-----|-----|------|------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Blood glucose (mg/dl) | 34 | 37 | 19 | 36 | 37 | 43 |
| Insulinemia (μ U/ml) | 25 | 16 | 40 | 26 | 29 | 40 |
| C-peptide (pM) | 866 | 532 | 800 | 933 | 1330 | 2130 |

recurring hypoglycemia with loss of consciousness. The episodes had been recurring for several months, showing no particular pattern; no weight gain had been noted. During these episodes (Table 1), blood glucose was constantly low, whereas insulinemia and C-peptide reactivity were elevated. The amended insulinemia/blood glucose ratio was very high, >150 [insulinemia (μ U/ml) \times 100 \div blood glucose (mg/dl) - 30] (4).

During the insulin suppression test, which was done with 0.1 U/kg body wt Actrapid (Novo, Copenhagen) as an intravenous bolus, the decline of C-peptide was impaired, reaching only 80% of the basal level. In our laboratory, this test, slightly different from the usual one with continuous insulin infusion (5-8), was used in 21 healthy controls. C-peptide levels reached $28 \pm 14\%$ of basal values (mean \pm SD, range 6-57%) at 45 min.

Anti-insulin antibodies and the qualitative urinary assessment of sulfonylureas were negative. The subject was concluded to be normal after the psychiatric interview.

Because an insulinoma was suspected, abdominal computerized tomography scan and selective pancreatic arteriography were performed and found to be normal. Treatment with diazoxide (600 mg/day) reduced both the number and severity of hypoglycemic episodes with noticeable side effects (edema, hirsutism). Six months later, on persistent hypoglycemia and hyperinsulinism, a second arteriography showed a suspicious 20-mm blush in the cranial pancreas. Percutaneous transhepatic catheterization of the pancreatic veins yielded levels of insulinemia higher at the caudal pancreatic level (62-120 μ U/ml) than in peripancreatic veins (13 μ U/ml) (Dr. A. Roche, Bicêtre, Paris). Laparotomy was under discussion when we were able to diagnose factitious hypoglycemia, because two blood samples contained therapeutic levels of glyburide (45 and 65 ng/ml, respectively) (Dr. C. Spriet-Pourra, Hoechst, Puteaux, France). The patient finally admitted that she had been taking glyburide stolen at work.

The well-known characteristics of factitious disease can be noted in this case (9). The subjects aim at obtaining the "sick" status. They have often been considered normal by the interviewing psychiatrist. They may accept invasive procedures, even laparotomy (2), sometimes with resection of the pancreas (5). Our case confirms that the C-peptide

suppression test cannot adequately distinguish between insulinoma and factitious hypoglycemia induced by sulfonylureas (2,5) and can even lead to useless invasive procedures and surgery. The assessment of plasma levels of sulfonylureas should be done in every case of hyperinsulinemic hypoglycemia, a fortiori if the patient is likely to have access to the medication at work or in the family (5,9-12).

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