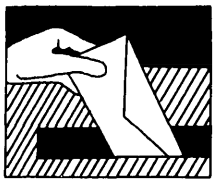
Letters and Comments



Office Care of Newly Diagnosed IDDM

A recent editorial in the *New England Journal of Medicine* discusses diet in the management of diabetes mellitus (1). It concludes that the long-recommended complicated exchange diet is impractical and that the benefits of a specific diabetic diet have not been documented. Many diabetologists who treat patients daily agree. I have always prescribed a simplified diet accommodating the patient's preferences and habits, based on the basic principles of low fat content and proper number of calories, eaten at regular times daily. Complicated diets, as indicated by the authors, are actually a deterrent to cooperation in many patients and are rarely adhered to.

Another custom of questionable value is that of hospitalizing patients with newly diagnosed insulin-dependent diabetes mellitus (IDDM). Many, if not most, physicians hospitalize these patients, and textbooks recommend hospitalization for both children and adults (2–4). This custom persists despite reports from the United States, England, and Canada that hospitalization is unnecessary (5–7). The so-called advantages of hospitalization, e.g., psychological adjustment, nutritional education, and rapid restoration of metabolic equilibrium, are more easily achieved in an outpatient environment. These reports also contend that outpatient management should be attempted only with organized diabetic services or with the availability of a specialist nurse and dietitian or an adequately staffed referral center.

In my experience, organized diabetic services are not required for outpatient care. A knowledgeable physician who has sufficient time is required. I treated newly diagnosed IDDM patients in an academic hospital setting for many years. My office time was limited, and I could not observe the patients closely over a period of 4–5 h. The Glucometer had not been invented, and glycosuria was an unsatisfactory measure of diabetic control. I hospitalized these patients as a convenience, even though the hospital experience was often frustrating; e.g., the food was unappetizing and delivered cold or late, blood glucose levels were improperly measured or unavailable, the nutritionist's advice was not individualized. After discharge, diet and insulin dosage had to be changed and the patient reeducated. In the last 15 yr, I have been in solo practice outside the hospital and have treated these patients in my office. At the first visit, the patient injects his/her own insulin (usually a mixture of 5 U regular and 15 U NPH). The patient receives additional doses of regular insulin as dictated by symptoms and the Glucometer readings. I review the patient's diet and give basic dietary instruction (which takes 25–30 min). The next day the patient returns for reevaluation and adjustment of insulin dosage and diet.

I have not encountered any problems in a wide spectrum of juvenile and adult diabetic patients with blood glucose levels up to 650 mg/dl. Hospitalization is rarely necessary. Any experienced internist or diabetologist can recognize the patient who needs intravenous fluid replacement or intravenous antibiotics. Blood drawn the first day will detect any electrolyte abnormality. Ketonuria is no problem and clears up rapidly. The patient feels better in several hours.

With cost effectiveness and ambulatory care, routine hospitalization of newly diagnosed IDDM patients is an anachronism. Why are a dietitian, specialist nurse, or referral center necessary? With an attentive and knowledgeable physician, the patient receives better care in the office and is controlled faster.

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REFERENCES

1. Wood FC Jr, Berman EL: Is diet the cornerstone in management of diabetes? *N Engl J Med* 315:1224–27, 1986
2. Traisman HS: *Management of Juvenile Diabetes Mellitus.* 3rd ed. St. Louis, MO, Mosby, 1980, p. 88
3. Ellenberg M, Rifkin H (Eds.): *Diabetes Mellitus: Theory and Practice.* 3rd ed. New York, Med. Exam., 1983, p. 519–38
4. Brownlee M (Ed.): *Handbook of Diabetes Mellitus.* Vol. 5. New York, Wiley, 1981, p. 80
5. Schneider AJ: Starting insulin therapy in children with newly diagnosed diabetes: an outpatient approach. *Am J Dis Child* 137:782–86, 1983
6. Whitehouse FW, Whitehouse IJ, Cox MS, Goldman J, Kakkonen DM, Partamian JO, Tamayo RC: Outpatient regulation of the insulin requiring person with diabetes: an alternative to hospitalization. *J Chron Dis* 36:433–38, 1983
7. Wilson RM, Clarke P, Barkes H, Heller SR, Tattersall RB: Starting insulin treatment as an outpatient: report of 100 consecutive patients followed up for at least one year. *JAMA* 256:877–80, 1986

Condylomata Acuminata in IDDM

The late Harvey Knowles believed that condylomata acuminata occurred with a greater frequency in young women with insulin-dependent diabetes mellitus (IDDM) (personal communication, 1983). Many gynecologists, because of their clinical experience, also believe this undocumented and unproven fact. The advent of the use of laser therapy to remove these lesions when they form a large mass in the perineal areas and the need for hospital admission for this procedure gave us the opportunity to study the frequency of diabetes in women with extensive condylomata acuminata admitted to the hospital between 1979 and 1984.

We found that 23 of 173 (13.3%) women requiring hospital admission for treatment of condylomata acuminata were diabetic. Twelve of 68 (17.6%) women aged <30 yr were diabetic, and 6 of 41 (14.6%) aged <20 yr were diabetic. Four of 58 men (6.9%) were diabetic—an incidence matching the prevalence of diabetes in the general population.

Because there is a diabetes center in our university hospital complex, which should result in an increased referral of people with diabetes, and because people with diabetes would be more likely to be treated as inpatients, we decided to compare the frequency of diabetes in women aged <30 yr who were admitted with acute appendicitis with women aged <30 yr who were admitted for treatment of condylomata acuminata. We found that 3.7% (1 of 27) of the women admitted with acute appendicitis were diabetic. Comparing the frequency of diabetes in the two groups with Fisher's exact test gave a *P* value of .059.

From these data, we concluded that there is a statistical (but not statistically significant) trend toward increased frequency of condylomata acuminata in young women with diabetes. We assume that these young women have IDDM.

To establish that there is a significant increase in the frequency of condylomata acuminata in IDDM would require a large, multicenter prospective study of people presenting with condylomata acuminata. We have been unable to locate a registry of people with condylomata acuminata that is detailed enough to distinguish people with diabetes from those without diabetes.

When it is confirmed that condylomata acuminata occur with increased frequency in people with IDDM, both clinical and scientific questions will be raised. Clinically, because women with a history of papillomavirus infections have an increased incidence of carcinoma of the cervix (1), and because the women partners of men with penile condylomata acuminata have an increased incidence of cervical neoplasia (2), increased screening of women with IDDM for cervical carcinoma may be indicated. Scientifically, condylomata acuminata and other genital papillomavirus infections have been shown to occur more frequently in immunosuppressed women (3). This occurs particularly in women with a defect of cell-mediated immunity, such as occurs with antineoplastic or posttransplant therapy. Condylomata acuminata that hypertrophy during pregnancy may regress after delivery (4). This phenomenon has been postulated to be due to the hormonal changes of pregnancy but could be due to the suppressed cell-mediated immunity that occurs during pregnancy. This immune defect, which would allow condylomata acuminata to develop in young women with IDDM and presumably is a defect in cell-mediated immunity, could be related to poor glycemic control or be the same defect that allowed IDDM to develop. This defect might also explain the high incidence of *Candida* vaginitis even in women with very tightly controlled IDDM.

We believe that larger and more sophisticated studies are necessary to document whether there is an increased incidence of condylomata acuminata and other potentially carcinogenic papillomaviruses in young women with IDDM, and if this increased incidence is present, to establish its pathogenesis and evolve strategies for screening, early detection, and treatment of papillomavirus infections.

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