were examined separately, BSN programs were significantly more likely to offer clinical experiences in pediatric ($t = -2.05$, $P = 0.04$), community ($t = -9.78$, $P = 0.0001$), and outpatient settings ($t = 3.89$, $P = 0.0001$). ADN programs focused significantly more on acute care experiences ($t = 4.45$, $P = 0.001$).

In terms of faculty characteristics, 69% had recently attended a continuing education program on diabetes, and 86% of subjects indicated an interest in information on other continuing education courses. Fifty-seven percent of faculty stated that they did not use diabetes-specific educational materials in their curriculum. Eighty-one percent of faculty were interested in the development of a diabetes care syllabus as an adjunct to other materials currently in use (e.g., textbooks).

Undergraduate nursing programs lay a basic foundation for the cognitive and clinical understanding of various disease processes. Faculty are faced with developing program curricula designed to prepare a competent general practitioner. These results suggest that most nursing faculty believe there is a need for diabetes materials to supplement current teaching tools. Based on these survey data, the Task Force for the ADA Council of Education will further explore the need to develop diabetes education materials for use by nursing faculty.

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Overnight Versus 24-h Urine Collection in Detection of Microalbuminuria

We read with interest the recent article by Tomaselli et al. (1) comparing albumin excretion rates determined on overnight and 24-h urine collections. We report similar findings, but in the pediatric age-group with assessment of several collections by each method.

Ten patients with insulin-dependent diabetes mellitus (mean ± SD age 14.2 ± 1.6 yr) attending our diabetes clinic and previously shown to have microalbuminuria (MA), defined as an albumin excretion rate (AER) of 15–200 μg/min, performed three 24-h urine collections and three overnight urine collections. Vigorous exercise was avoided during the 24-h collection period.

AERs on the 24-h collections were significantly higher than those obtained on overnight collections, with each of the 10 patients providing three urine collections by each method. The mean ± SD 24-h AER was 47.2 ± 37.7 μg/min (range 16–144 μg/min); mean ± SD overnight AER was 15.8 ± 8.9 μg/min (range 6–28 μg/min, $P = 0.04$). There was no significant correlation between the two methods ($r = -0.25$). The coefficient of variation of the three collections for each individual did not differ between the two methods (40 ± 24% for 24 h, 44 ± 19% for overnight).

When the lower cutoff of 15 μg/min was used to define MA, all 10 patients showed MA on 24-h collections, but only 4 patients showed MA on overnight collections. Our findings add to those of Tomaselli et al. (1), who looked at one collection, given the day-to-day variability in AER. The prognostic importance of patients showing daytime MA related to changes in posture, exercise, and blood pressure requires longer-term follow-up.

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Inhibition of Sleep-Induced Growth Hormone Secretion: No Effect on Diabetic Control

Atiea et al. (1) recently reported that an anticholinergic agent, pirenzepine, given at bedtime suppressed sleep-induced growth hormone secretion and attenuated the dawn phenomenon. Although not noted in their article, we previously made the same observation with oral methscopalamine bromide (Pamine, Upjohn, Kalamazoo, MI), an anticholinergic agent available in the United States (2). We then attempted to evaluate whether chronic use of Pamine (5 mg every night) would improve diabetes control with the following protocol.

Sixteen insulin-requiring (9 type I [insulin-dependent] and 7 type II [non-insulin-dependent]) diabetic patients who were on intensive insulin regimens were recruited. Three used insulin pumps; the remainder were on a