

vided that age-dependent glycemic guidelines are considered."

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#### REFERENCES

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## Illegible Fingerprints

Self monitoring of blood glucose has in recent years proved to be a major asset in assessing diabetic control, in improving glycemic levels, and in providing early warning of potential catastrophes that can then be averted. Discussed below is a report believed to be the first about a curious complication of the procedure.

A retired police officer developed hypothyroidism and diabetes in 1985. Diabetic treatment included diet and various oral agents for the next 5 yr until medication was switched to insulin in early 1990 because of unsatisfactory control. At age 62 yr, the patient then began a program of self-monitoring of blood glucose multiple times daily.

Because he wished to keep his gun, the patient had periodically submitted a fingerprint card to renew his firearm license. After some 6 mo of frequent fingerstick glucose determinations, he was notified by the State Division of Licensing that the FBI had rejected his latest fingerprint card because of illegible prints! The fingertips were seen to be distorted with multiple creases and an area of abraded skin. The actual prevalence of illegible fingerprints is unknown because the phenomenon is not usually sought in medical facilities.

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## Classification of Diabetes According to National Diabetic Data Group

It was interesting to read back-to-back articles (1,2) expressing the limited applicability of the classification of diabetes mellitus according to the National Diabetic

Data Group (NDDG; 3) and the need to revisit it. However, they probably did not make waves in the minds of many of the physicians involved in clinical practice of diabetes. It was as far back as March 1982 that a similar misgiving regarding the clinical utility and practical application of such a classification, based in several absolute objective criteria, was voiced (4). It was impractical then and has remained impractical now, despite probably the greater availability of tools to assess  $\beta$ -cell function, HLA typing, and islet cell antibody titers, because these tests fail to accurately classify the patients into types and the heterogeneity of the disorder, detailed in both articles (1,2), renders the task even more difficult. Moreover, with the current crisis of escalating medical costs, the payment for these tests would be almost certainly denied by most regulatory agencies and insurance carriers. Finally, the need for the use of these expensive laboratory tests appears frivolous at best in choosing an appropriate therapeutic option in the management of an individual subject manifesting diabetes mellitus. Thus, insulin administration as an initial therapeutic option would still hinge on the presence of ketosis or ketoacidosis at the onset regardless of the class according to NDDG. It must also be remembered that the insulin concentration is likely to be extremely low, almost undetectable, in most of these situations, because otherwise ketosis would not be present. The only question that remains in this situation is whether the insulin therapy ought to be short lived, such as in a patient with non-insulin-dependent diabetes manifesting ketosis because of accompanying stressful disorder followed by recovering  $\beta$ -cell function, or lifelong as in insulin-dependent diabetic patients with progressive and permanent  $\beta$ -cell destruction. Therefore, the accurate classification often remains retrospective rather than prospective and at best helps minimally in therapy. However, it is unfortunate that several of these non-insulin-dependent diabetic patients with transient ketosis continue to receive insulin therapy and are often being labeled insulin-dependent diabetic mellitus. We are also aware that a group of patients may interchangeably wander from one type to another depending on the prevailing circumstances and also depending on the stage of the disease, as demonstrated by Sims and Calles-Escandon (2).

It is indicated by Abourizk and Dunn (1) that ". . . NDDG states that its classification is not an attempt to deliver guidelines for therapy. . . ." However, this disclaimer obviously has come as "Monday night quarterbacking" and the effort appears to be too little and too late, because several review articles detailing or explaining the classification have appeared in peer-reviewed and other journals involved in clinical practice and in the newsletters of American Diabetes Association after the publication of NDDG classification in 1979. Finally, classification became a part of almost every textbook of clinical practice of almost every medical discipline. Thus, it became almost impossible for it not to be taught to medical students and housestaff and not