vided that age-dependent glycemic guidelines are considered."

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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 catastrophies 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 β-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 β-cell function, or lifelong as in insulin-dependent diabetic patients with progressive and permanent β-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

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to be widely used by clinicians and other clinical professional communities.

Despite the claim that NDDG classification was primarily meant for the purpose of basic and clinical diabetes research, the road has not been easy for researchers either, as shown by both articles (1,2). My own experience in this area confirms this problem. In one of our studies (5), we had to insert the sentence "It is probable that subjects in our study are a distinct, but not yet recognized, atypical subgroup manifesting type I diabetes mellitus" to satisfy the reviewers and the editorial committee.

Finally, is it really going to be fruitful to pursue NDDG II, i.e., arrange another gathering of experts from all over the world to revisit or take a fresh look at current classification? Is it likely to resolve the controversy, especially in the light of the recent data showing the heterogeneity of the disorder? Are financial resources available to organize such a meeting in the current economic crisis, medical or otherwise? These and other similar questions need to be thoroughly discussed before embarking on such an undertaking to avoid another frugal exercise in futility.

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Let's Not Forget IDDM in African-American Children

The 1985 *Report of the Secretary's Task Force on Black and Minority Health* (1) called attention to the role of diabetes mellitus as a contributor to the excess mortality in the African-American population. In response, a conference was held at the National Institutes of Health 8 and 9 September 1988 to discuss the state of knowledge of diabetes in the black population and to suggest direction for future research. Unfortunately, the series of articles published in *Diabetes Care* as a result of this conference focused exclusively on non-insulin-dependent diabetes mellitus (NIDDM; 2). We believe that childhood insulin-dependent diabetes mellitus (IDDM) among African-American children should also have been targeted as a focus of research.

Although NIDDM accounts for the vast majority of diabetes in African Americans (1), the importance of studying the impact of childhood diabetes in African Americans transcends mere numbers of diabetic subjects. In the United States, IDDM appears to be a more malignant disease for African Americans than for whites with the mortality rate of youth-onset IDDM in the African-American population nearly twice that for white children (3). Because of the earlier age at onset and the much higher mortality associated with IDDM than NIDDM, individuals with IDDM experience a greater number of years of life lost than those with NIDDM (3). Of interest for the etiology of IDDM is that the incidence in African-American children is lower than for white U.S. children but considerably higher than for many other countries (4) and apparently greater than that in black African children (5). This has led to the important hypothesis that racial admixture with whites may account for the higher incidence in African Americans relative to African blacks (6).

The role of racial admixture in the development of IDDM among African Americans deserves greater attention. Reitnauer et al. (7) presented evidence that racial admixture with whites contributes to the development of IDDM among African Americans. We also recently reported that white admixture was associated with an increase in risk of developing IDDM among blacks in the U.S. Virgin Islands (8).

Although a genetic marker (HLA-DQ non-Asp positivity) highly correlated with geographic and racial differences in risk has been identified (8), little is known about the genetic environmental interactions that contribute to the etiology of IDDM. African-heritage populations may be ideal for studying these interactions by permitting the comparison of low-risk parent populations in Africa with higher risk racially admixed migrant populations in the western hemisphere to evaluate etiological hypotheses related to admixture, genetic markers, and environmental determinants of IDDM. Our discovery of an apparent epidemic of IDDM in the U.S. Virgin Islands (8) supports the hypothesis of a worldwide pandemic of IDDM in the early 1980s (10) and demonstrates the importance of studying IDDM in black populations to understand not only the contribution of genetic but also environmental factors to disease etiology.

One of the expected accomplishments of the 1988 National Institutes of Health conference on diabetes mellitus in the black population was to define the areas that need additional research. Disappointingly, childhood diabetes was forgotten. Clearly, public health and scientific considerations make it imperative that studies

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