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IDDM, insulin-dependent diabetes mellitus; GI, glycemic index; USDA, United States Department of Agriculture; CHO, carbohydrate.



References

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**Response To Wolever**

**W**e would like to thank Dr. Wolever for useful and insightful comments. He concludes that pizza has a higher GI, which results in higher blood glucose levels. However, we are reluctant to attribute the greater, late postprandial rise in plasma glucose, following the pizza meal compared with the control meal, solely to a higher GI for pizza. In most studies, the GI of a food is evaluated by the postprandial rise in

plasma glucose within 2-3 h after ingestion of the food. In our study (1), blood glucose levels were similar for 3 h after both meals. It was only after 5 and 8 h that glucose levels were significantly higher after the pizza meal.

We appreciate Dr. Wolever's interest and expertise in this field and again thank him for his comments.

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**Change of Lipoprotein(a) and Coagulative or Fibrinolytic Parameters in Diabetic Patients with Nephropathy**

**L**p(a) is a plasma lipoprotein of high atherogenicity that competes with plasminogen at the site of plasminogen receptors (1). We know diabetic patients show a hypercoagulable state, which might contribute to diabetic vascular complications. The role of Lp(a) in fibrinolysis in general and in diabetes in

particular is a timely and important issue. In this study, we measured various lipoprotein and coagulative or fibrinolytic parameters in 3 groups of subjects: 1) normal control subjects (n = 51), 2) NIDDM subjects without nephropathy (n = 39, no diabetic retinopathy and <50 mg/g · creatinine of urinary AEI in all subjects, and 3) NIDDM subjects with nephropathy (n = 29, diabetic retinopathy and >200 mg/g · creatinine of AEI in all subjects).

Creatinine was measured by Jaffe's rate assay. Urinary albumin was measured by means of latex turbidimetric immunoassay. TG and total cholesterol were measured by means of enzymatic determination. LDL cholesterol was measured by means of heparin/Ca precipitation method. ApoB100 and apoA-I were measured by a single radial immunodiffusion method. Lp(a) was measured by an ELISA method (Tint Elisa, Bio pool, Sweden). PT, APTT, and fibrinogen were measured by Baxter's kit. TAT and α2PIC were measured by enzyme immunoassay (for the former, Hoext Japan's kit, for the latter, Teijin's kit). D dimer was measured by an ELISA method (Dimertest EIA). The data were analyzed by a Student's t test.

BMI levels were not significantly different among the 3 groups. Fasting blood glucose and HbA<sub>1c</sub> levels were not significantly different between the 2 diabetic groups. Levels of creatinine, TG, total cholesterol, LDL, apoB100, apoA-I, PT, APTT, and fibrinogen were not significantly different (P > 0.05) among the 3 groups; however, the diabetic subjects, in particular those with nephropathy, tended to have higher levels of TAT, α2PIC, and D-dimer as well as Lp(a). A significant positive correlation was detected between Lp(a) and α2PIC (r = 0.4002, P < 0.05) among the diabetic patients. α2PIC showed a significantly positive correlation with TAT (r = 0.6188, P < 0.01) in the diabetic patients, however, this significant correlation was not observed in the normal group. The observation was thought to