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Comment on Consistency

A careful reading of the Garber et al. (1) commentary for clinicians leaves me feeling uncomfortable. This stems from several internal inconsistencies that, although acceptable in comparing individual researchers' results, ought not creep into a practical commentary for clinicians.

To take a few notable examples, in Table 1, if a fasting plasma glucose >200 mg/dl is poor or high and 140 mg/dl is normal or desirable, what is a fasting plasma glucose between 141 and 199 mg/dl? Similarly, what is a 2-h postprandial plasma glucose between 200 and 235 mg/dl? More reasonable would be normal or desirable listed as ≤115 and 140 mg/dl, respectively; 115–140 and 140–200 mg/dl as acceptable or borderline, and >140 and >200 mg/dl as poor or high.

This principle is properly applied to the fasting plasma cholesterol values in Table 1 but not to the triglyceride levels, where levels between 150 and 200 mg/dl are in limbo, and the acceptable level is listed at 200–250 mg/dl. Why not 150–250 mg/dl? The plasma LDLs also pose a problem in the range from ≤160 to ≥190 mg/dl—are these acceptable or borderline or are they poor or high? Or are they to be ignored?

Furthermore, after characterizing triglyceride levels of >1.69 mM (150 mg/dl) as "elevated triglycerides" in the text on several occasions, the authors recommend that ". . . in hypertriglyceridemic (>2.82–3.39 mM [250–300 mg/dl]) patients, resins are not effective in lowering total cholesterol and cause increases in triglyceride levels . . ." This definition of hypertriglyceridemia (or isn't hypertriglyceridemia equated with elevated triglycerides?) is a different one than previously given (although presumably the one used in ref. 48).

The bottom line is consistency and practicality. Unfortunately, this commentary may confuse more than it clarifies.

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LDL, LOW-DENSITY LIPOPROTEIN.

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Response to Dr. Matz

We thank Dr. Matz for his comments on our commentary, *Detection and Management of Lipid Disorders in Diabetic Patients.*

With regard to his concerns on the classification of normal, acceptable, and poor values in our Table, "Suggested standards for biochemical indexes of metabolic control," he is correct in that we show a single rather than a range of values for most indexes, including fasting plasma glucose and 2-h postprandial plasma glucose. However, values for these (and other indexes) were taken directly from prior publications and standards of the ADA (as noted in the Table). To reformulate or reclassify these values would be to revise the existing recommendations of the ADA, which was not our intent. The purpose of our commentary was to note that many physicians do not adhere to ADA recommendations and to reiterate for clinicians' benefit, the already published standards for control as they exist in the literature.

His second comment concerned differing values characterizing elevated triglycerides and hypertriglyceridemia, and that in some cases, elevated triglycerides are defined as >150 mg/dl and in other cases >250–300 mg/dl (as in reference 48). Definitions of elevated triglycerides differ between publications and guidelines. A prime example is the discrepancy between the National Cholesterol Education Program (hypertriglyceridemia defined as >250 mg/dl) and the ADA (>150 mg/dl); to complicate matters, the International Committee for the Evaluation of Hypertriglyceridemia as a Vascular Risk Factor considers >200 mg/dl to be elevated. In all cases, we used the original values rather than presuming that hypertriglyceridemia is >150 mg/dl (as in the ADA). While this may have added some confusion, it also adds veracity and authority to the commentary. It reflects existing inconsistencies in the literature.

We suggest that his comments be forwarded to the next American Diabetes Association Consensus Development Conference in this area.

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