

specific treatments, it is accepted by all with a specialist interest in this field that the mainstay of emergency management is the immediate institution of effective offloading, preferably in a total contact cast. Offloading results in protection of the bones and joints of the foot, as well as amelioration of the underlying inflammatory process.

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Acute Neuropathic Joint Disease: A Medical Emergency?

Response to Jeffcoate et al.

We thank Jeffcoate et al. (1) for their comments on our article (2). To summarize, they agree that neuropathic joint disease (NJD) is in-

deed a medical emergency, but they disagree that bisphosphonates are of proven efficacy. One of the major problems for clinicians at the moment is the failure to recognize early NJD based on several considerations, including other possible diagnosis at presentation, the presence of pain, normal radiographs, and patients presenting to nonendocrinological specialists. Therefore, at the time of initiation of therapy, damage may already be well established and, furthermore, joint offloading with prolonged casting has several drawbacks (3).

It was not the intention of our article to convey the idea that the very early initiation of bisphosphonate therapy before radiographic damage would definitely halt disease. We agree with Jeffcoate et al. that further work needs to be done in this regard. However, given the data from trials in NJD, the safety profile and costs of bisphosphonate therapy, and ease of administration, it would seem reasonable to prescribe these.

It is interesting to note that bisphosphonates may have some structural modification properties in the more common garden variety of osteoarthritis (4) and also some evidence of symptom control (4,5). However, based on the magnetic resonance imaging (MRI) observations that the earliest stages of NJD is strikingly associated with bone edema, which is also a predictor of progressive osteoarthritis joint deterioration in other sites (6), besides the ankle and foot, then it would seem prudent that attempts to inhibit osteoclast function may be of use.

To summarize, we feel that the MRI features of early NJD will allow for early intervention, including those suggested by the authors, at a stage before irreversible joint damage to see whether ultimately progressive joint damage can be prevented. We feel that the MRI observations in early disease have broad implications for raising awareness of the potential for early NJD diagnosis and for monitoring potential therapies.

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Resistance to Insulin Therapy Among Patients and Providers: Results of the Cross-National Diabetes Attitudes, Wishes, and Needs (DAWN) Study

Response to Peyrot et al.

The recent article by Peyrot et al. (1) concerning the attitudes of both patients and providers with respect to insulin therapy raises some potentially important issues about barriers to an important treatment in diabetes. However, their statement that “U.S. physicians were significantly more disposed to delay insulin therapy than physicians in all other countries . . .” (1) appears to contradict

differences in cited prescribing patterns between type 2 diabetic patients in America, Australia, and Europe. For example, results from the National Health and Nutrition Examination Survey 1999–2000 cohort (2,3) and a large western U.S. study (4) are consistent in finding that ~34% of type 2 diabetic patients on medication are using insulin. However, a more recent study (5) in the Canadian primary care setting reported only a 14% use of insulin, while two independent Australian studies (6,7) and our own results show an insulin prevalence of 16–18%. Studies in Denmark (8) and France (9) establish an insulin prescription rate of 24 and 17%, respectively. It therefore appears that physicians in U.S. are more likely to initiate insulin therapy for type 2 diabetic patients than their colleagues in other Western countries. The discrepancy between physicians' attitudes, as reported by Peyrot et al. (1), and actual practice may represent a lack of generalizability of their findings or that the such "attitudes" are not the principal determinants of prescribing behavior.

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Resistance to Insulin Therapy Among Patients and Providers: Results of the Cross-National Diabetes Attitudes, Wishes, and Needs (DAWN) Study

Response to Phillipov and Phillips

Phillipov and Phillips (1) suggest that our finding (2) that U.S. physicians were significantly more disposed to delay insulin therapy than were physicians in all other countries surveyed contradicted reports from other studies of the proportion of patients with type 2 diabetes taking insulin in the U.S., Australia, and some European countries. Phillipov and Phillips conclude that either our findings cannot be generalized or that attitudes are not the key determinant of prescribing behavior.

We thank Phillipov and Phillips for providing additional information regarding international differences in insulin-prescribing attitudes and behaviors. We agree that attitudes alone do not deter-

mine physician prescribing behavior. Also important is the level of perceived need for insulin. The relevance of the attitude identified in our study depends explicitly on the level of perceived need for insulin treatment (delay of insulin “until it is absolutely essential”). If the need is perceived as greater in the U.S. than in other countries, U.S. physicians might be more likely to prescribe insulin even if are they have a higher threshold for making that choice. The level of perceived need might itself be a function of attitudes or it could be a result of actual differences in need, e.g., higher BMI, worse glycemic control, patient unwillingness to change lifestyles, etc.

We believe that finding out how all of these factors combine to influence physicians' insulin-prescribing behaviors would be a major contribution to the field. We hope that others will continue the study of this issue.

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