milieu and correcting the metabolic defects in women with PCOS (2–4). Vaughan and Bell's case and ours suggest that the combined use of metformin and a glitazone agent may prove to be an attractive combination to tackle the infertility of women with PCOS; however, this will need to be tested by randomized controlled trials.

Though Vaughan and Bell have rightly pointed out the need to exercise caution in the use of this combination therapy and to fully counsel such women for the possibility of unexpected conception, we feel that only a randomized controlled trial will prove such safety.

Finally, such a combination may also provide some help to tackle other metabolic abnormalities of PCOS, like hirsutism and glucose intolerance (5,6).

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COMMENTS AND RESPONSES

Triple Therapy in Type 2 Diabetes: Insulin Glargine or Rosiglitazone Added to Combination Therapy of Sulfonylurea Plus Metformin in Insulin-Naïve Patients

Response to Rosenstock et al.

Rosenstock et al. (1) reported on the safety and efficacy of add-on insulin glargine versus rosiglitazone for patients with type 2 diabetes not adequately controlled on dual oral therapy with sulfonylurea plus metformin. The main finding of the study was similar glycemic control in both groups. About 50% of participants in both groups achieved an HbA_{1c} of <7%. However, the authors comment on two positive aspects that favor the use of glargine over rosiglitazone therapy.

First, an improved lipid profile was reported with the glargine therapy. There was an increase in total cholesterol from 196 to 215 mg/dl in the rosiglitazone group versus a decrease from 196 to 186 mg/dl in the glargine group (+10.1 vs. −4.4%, respectively; $P = 0.0001$) as well as an increase in LDL levels from 106 to 120 mg/dl vs. 117 to 115 mg/dl (+13.1 vs. −1.4%, respectively; $P = 0.0004$). A similar difference was found with triglyceride levels, which increased from 241 to 252 mg/dl in the rosiglitazone group and decreased from 217 to 176 mg/dl in the glargine group (+4.6 vs. −19%, respectively; $P = 0.0011$). We question whether this degree of cholesterol and triglyceride reduction translates into better clinical outcomes and would like the authors to comment about any ongoing outcome studies. It should be noted that the increase in LDL levels with rosiglitazone may not be clinically detrimental, as it may reflect an increase in larger, less atherogenic LDL particles previously reported with thiazolidinediones (2–4).

The other finding of the study that favors glargine therapy, according to the authors, was a better cost profile, which is an important consideration. However, the estimated cost of glargine was $216 for 24 weeks, yet the average monthly cost of a vial is $70 (5). This results in a total cost of glargine therapy of $420 for 24 weeks. We would like the authors to comment on how they accounted for the cost of glargine.

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