

term fenofibrate therapy on cardiovascular events in 9795 people with type 2 diabetes mellitus (the FIELD study): randomised controlled trial. *Lancet* 2005;366:1849-61.

7. Rothman RL, Elasy TA. Can diabetes management programs create sustained improvements in disease outcomes? [editorial]. *CMAJ* 2005;173:1467-8.

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[Two of the authors respond:]

Eddie Vos questions the use of fibrates for patients with type 2 diabetes mellitus. In our trial,¹ 9 patients were given fibrates, in accordance with recommendations of the Canadian Diabetes Association (CDA).

Use of statins or fibrates has been the subject of debate for some time. Statin trials in patients with diabetes have provided convincing evidence of a substantial benefit stemming from this class of drugs. Trials have been conducted with gemfibrozil,^{2,3} bezafibrate,⁴ clofibrate⁵ and fenofibrate.⁶ Some of these had positive results in terms of primary prevention (Helsinki Heart Study² and a World Health Organization study⁵) and secondary prevention (Veterans Affairs High-Density Lipoprotein Cholesterol Intervention Trial [VA-HIT]³). However, the results of the Bezafibrate Infarction Prevention (BIP) trial⁴ and the FIELD trial⁶ were mixed: positive outcomes were observed only in certain subgroups, raising reservations related to an increase in noncardiovascular mortality. Reasons for the differences in outcomes were not immediately apparent.

It emerged in post hoc subgroup analyses of data from the Helsinki Heart Study,⁷ the VA-HIT⁸ and the BIP study⁹ that fibrate-induced reductions in cardiovascular events were especially pronounced (on the order of 30%–50%) in subjects with evidence of insulin resistance or other features of metabolic syndrome, such as dyslipidemia and increased body weight, or in people with both diabetes and preexisting cardiovascular disease. These results were not found in the FIELD study.

The observation that the cardioprotective effects of gemfibrozil were substantially greater than those of other fibrates may be no more than fortuitous or may reflect differences in the populations studied. However, it is also possi-

ble that gemfibrozil has either protective properties that are lacking in other fibrates, or that other fibrates have adverse properties not shared by gemfibrozil.

Accordingly, the debate continues, more research is needed, and whether or not diabetes associations will alter their clinical recommendations is an open question. At present, the FIELD study has introduced doubts but not enough evidence to change the current guidelines.

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The “Editor’s Take” on the article by Julie Ménard and associates¹ about intensive multitherapy for patients with

diabetes was both discouraging and baffling. Russell Rothman and Tom Elasy, in their accompanying commentary,² correctly state that “Ménard and colleagues ... demonstrate again that an intensive disease management program can improve glycemic control and cardiovascular risk factors in patients with poorly controlled diabetes.” The fact that patients were unable to sustain these improvements when intensive therapy was stopped is hardly surprising. This small trial is best seen as a proof-of-concept study that adds to the literature showing that intensive multifactorial and interdisciplinary treatment improves patient outcomes.³⁻⁵ Rather than pointing to the need to establish health care teams and systems of care that are sustainable over the long term, the Editor advises that, “physicians should expect few of their patients to attain CDA goals and even fewer to maintain the goals over extended periods.”

The Editor also questions whether CDA guideline targets are realistic. It is important to note that the CDA metabolic and blood pressure targets are based on evidence and reflect thresholds for improved patient outcomes. These are clinical goals for best practice. Even if targets are not achieved, the evidence also points to the benefits of incremental improvements in blood glucose levels, blood pressure and lipids.

The defeatist attitude reflected in the Editor’s comments does little to motivate physicians to advance diabetes care in this country. Physicians should continue to strive to achieve evidence-based targets, as the literature has clearly demonstrated that the serious complications of diabetes can be delayed or averted by this clinical approach. Our patients deserve nothing less.

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Editor's note: We acknowledge the concern expressed by Dr. Harris that a statement in the "Editor's Take" was interpretable as being unnecessarily pessimistic, whereas it was intended to provide a realistic caution regarding the limited application of the findings of this study.

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