I. PROPER LABELING OF THE ORAL HYPOGLYCEMIC DRUGS IN THE LIGHT OF RECENT STUDIES

I believe that the intense preoccupation with the increase in cardiovascular mortality from use of the oral agents has drawn attention away from matters of even greater importance in the management of the non-insulin-dependent diabetic. These include the facts that 1) Obesity is now recognized to be a predisposing factor for diabetes in a person genetically susceptible. 2) Insulin, in addition to its well-known function of lowering blood glucose, is a storage hormone and its use and the use of oral agents which promote release of insulin promote obesity. 3) Lifestyle changes in eating and in physical activity are essential components of good management of non-insulin-dependent diabetes and of cardiovascular disease as well. These changes are often sufficient in themselves to restore near normal function.

We should not classify diabetes into juvenile and maturity onset, since the correlation of types with age is poor. Diabetes occurs in two forms, each requiring entirely different management: i. e. insulin dependent, usually lean and hungry, and non-insulin-dependent, usually obese and also insulin resistant. Our studies in Vermont have shown that normal volunteers who deliberately gain 20 to 30 per cent above their basal weight develop insulin resistance similar to that seen in the spontaneously obese. They also had a diminished ability of muscle and fat cells to utilize glucose. Their fat cells enlarged, but did not increase in number, again similar to those who spontaneously develop obesity in adult years. These results suggest that in the naturally obese patient at least a part of the insulin resistance that places a stress upon the pancreatic reserve of insulin is secondary to weight gain and is reversible.

The UGDP investigators chose their five treatment regimens because