is the first and sometimes the only measure required for many such diabetics. For those patients who definitely are insulin-dependent insulin is a necessary and logical adjunct to diet therapy. These include 1) the acutely decompensated diabetic (even those above ideal weight) 2) the hyperglycemic maturity onset diabetic at or below ideal weight 3) the hyperglycemic pregnant diabetic and of course 4) the young insulin-dependent diabetic. However, for the overweight diabetic, use of oral agents or insulin is both illogical and unnecessary, if the measures indicatec above can restore metabolic balance.

Many patients enter the health care system too late in the course of their diabetes or of their lives to modify their lifestyle effectively, and the therapeutic options are limited. Our profession should make maximum efforts to reach younger members of high-risk families with education and programs for effective prevention.

If all the above is true, one might indulge in an extrapolation regarding the results of using oral agents in the non-insulin dependent diabetic. Such an extrapolation is obviously highly conjectural since solid data is not yet available, but I believe that it points in the direction of important truth. If we grant that there are approximately 1,500,000 patients reputedly taking oral agents and that 50% are grossly overweight, we have 750,000 patients with diabetes and obesity who are probably also less physically active than they should be. If we assume that 90% of them are not exposed to any vigorous and comprehensive regimen such as that at the Grady Hospital, 675,000 are left with their obesity essentially untreated, and 4 out of 5 are taking an agent which increases their obesity. The taking of oral medication lulls both physician and patient into believing that something worthwhile is being accomplished, while the options which could make a fundamental difference in a patient's life and survival