

1. National statement on ethical conduct in research involving humans. Canberra: National Health and Medical Research Council, 1999. <http://www.nhmrc.gov.au/publications/pdf/e35.pdf>. □

Loane L C Skene

Professor, Faculty of Law, University of Melbourne, Parkville, VIC 3052. l.skene@law.unimelb.edu.au

COMMENT: As I understand Carapetis et al's study, the researchers determine who has a group A streptococcal infection from the laboratory that performs the test (as this infection is not a notifiable disease,¹ there is no central source of information). The laboratory may be independent or in a public or private hospital, and may be situated anywhere in Victoria. The laboratory tells them who requested the test and the patient's name and infection status. The researchers then seek assistance from the hospital or doctor requesting the test in obtaining "individual informed consent" from the patient to release clinical information to the researchers. Each institution has required that its own human research ethics committee approve the project, as well as the Department of Human Services (DHS) Ethics Committee, before the laboratory releases information. This accords with the law, but the additional bureaucracy and costs involved will deter much important public health research.

The law: In Victoria, public and private hospitals and their employees have a statutory duty of confidentiality under section 141 of the *Health Services Act 1988* (Vic). There is an exception when the patient consents (s 141(3)(a)), but, in Carapetis et al's study, patients cannot be approached until the laboratory gives identifying information. Information may be divulged for medical research without patient consent if an ethics committee "established under the by-laws of the agency" has approved "the use to which the information will be put and the research methodology" (s 141(3)(g)). The giving of information must also accord with Health Privacy Principle (HPP) 2.2(g) in the *Health Records Act 2001* (Vic): it must be necessary and "in the public interest"; it is impracticable to seek consent; identifying information is needed; identifying information will not be published; and it must conform with the Guidelines of the Health Services Commissioner.² The federal *Privacy Act 1988* (Cwlth) contains similar provisions.³

Options for change: The Health Services Commissioner has power to issue guidelines varying the subparagraphs of HPP 2, and even to lessen the level of privacy protection, if it is in the public interest to do so.⁴

However, guidelines cannot override the requirement in the Health Services Act that projects must be approved by the ethics committee "established under the by-laws of [each] agency". There are four options for change:

■ The Health Services Act could be amended so that approval of *one* human research ethics committee is sufficient.

■ The Secretary of the DHS could prescribe more diseases as notifiable,¹ so that information is available centrally, and access could be authorised by the DHS Ethics Committee.

■ The Secretary could request information from pathology laboratories for public health research and supply that to the researchers (laboratories would be protected under section 137 of the *Health Act 1958* [Vic]).

■ Institutions could amend their by-laws — or ethics committees could adopt a policy — that the institution will follow the approval of the DHS Ethics Committee in public health research.⁵

The last seems the simplest option, but historically this approach has not been favoured in multicentre trials in Australia.

1. Health (Infectious Diseases) Regulations 2001 (Vic) reg 6, scheds 3, 6.
2. *Health Records Act 2001* (Vic) s 141(3)(g)(iii). Sched 1, Health Privacy Principle (HPP) 2.2(g).
3. National Health and Medical Research Council. Guidelines approved under Section 95A of the *Privacy Act 1988*. Canberra: NHMRC, 2001. Available at <<http://www.nhmrc.gov.au/publications/synopses/e43syn.htm>>
4. *Health Records Act 2001* (Vic) s 22(1)(a)(5).
5. Tully J, Ninis N, Booy R, Viner R. The new system of review by multicentre research ethics committees: prospective study. *BMJ* 2000; 320: 1179-1182. □

Opportunistic screening for type 2 diabetes mellitus in public hospitals

Anthony T Zimmermann,* Stephen N Stranks,† Sally L Gall,‡ Geoffrey S Hebbard§

*Physician Trainee, Division of Medicine; †Director of Endocrinology; ‡Gastroenterology Nurse, Repatriation General Hospital, Daws Road, Daw Park, SA 5041. §Director of Gastroenterology, The Royal Melbourne Hospital, Parkville, VIC. atzimm@ausdoctors.net

TO THE EDITOR: Diabetes is a leading cause of morbidity and mortality in Australia, with 50% of cases remaining undiagnosed.¹ Consequently, the Australian National Diabetes Strategy has early detection of diabetes as a key priority.² We undertook a study to determine the prevalence of abnormal glucose metabolism (impaired fasting glycaemia [IFG] and diabetes) in patients presenting in the fasted state for endoscopy or colonoscopy at a metropolitan teaching hospital. We used the

Results of fasting plasma glucose tests in 224 patients presenting for gastroenterological procedures

Fasting plasma glucose level

Normal (<6.1 mmol/L)	172 (77%)
Impaired fasting glycaemia (≥6.1 mmol/L, <7.0 mmol/L)	22 (10%)*
Diabetes (≥7.0 mmol/L)	6 (3%) [†]
Not tested (known diabetes)	24 (11%)

*Diabetes was confirmed on subsequent oral glucose tolerance test (OGTT) in nine of these patients (four refused further testing).

[†]Diabetes was confirmed on subsequent OGTT in all six patients.

definitions of abnormal glucose metabolism outlined by the World Health Organization in 1999³ and published in a position statement in the *Journal* in April 1999.⁴

Two hundred and twenty-four patients gave informed consent and participated in the study, comprising 126 men and 98 women. Mean age (SD) was 75.1 years (6.9) for men and 60.9 years (17.6) for women. Twenty-four participants (11%) had known diabetes. The remaining 200 patients had fasting venous plasma glucose levels determined (Box). Patients with abnormal glucose metabolism (fasting plasma glucose level >6.1 mmol/L) were offered further testing with a 2-hour oral glucose tolerance test (OGTT) after a 75 g glucose load. Nine patients initially classified with IFG had diabetes based on OGTT results. No patient classified with diabetes on initial testing was subsequently classified as not having diabetes by the OGTT. The overall prevalence of undiagnosed diabetes was 7% (15 patients).

We demonstrated a high prevalence of abnormal glucose metabolism in a group of predominantly elderly patients presenting for gastroenterological procedures. Furthermore, subsequent investigation of these patients revealed that a substantial proportion who were classified with IFG on initial screening were classified with diabetes based on 2-hour OGTT results, highlighting the importance of this test in diagnosing diabetes.

It is likely that we underestimated the prevalence of abnormal glucose metabolism, as OGTT was not performed in all patients. This is supported by results of the AusDiab study that revealed a high prevalence of abnormal glucose metabolism in older patients — 37% of those aged 55–64 years, 47% of those 65–74 years, and 53% of those 75 years and over.¹ National Health and Medical Research Council guidelines suggest that all patients with a fasting plasma glucose level of 5.5–6.9 mmol/L be

referred for OGTT.⁵ Based on this suggestion, an additional 28 patients in our study group would have had an OGTT.

Measurement of fasting venous plasma glucose level is safe, relatively simple and inexpensive. Patient presentations in the fasted state for investigations and procedures provide an ideal opportunity for screening with this test. Patients with abnormal results should be referred for further testing with repeat fasting glucose determination or OGTT. This process may be facilitated by involving patients' general practitioners.

Competing interests: None identified.

1. Dunstan DW, Zimmet PZ, Welborn TA, et al. The rising prevalence of diabetes and impaired glucose tolerance: The Australian Diabetes, Obesity and Lifestyle Study. *Diabetes Care* 2002; 25: 829-834.
2. Colagiuri S, Colagiuri R, Ward J. National diabetes strategy and implementation plan. Canberra: Diabetes Australia, 1998.
3. World Health Organization. Definition, diagnosis and classification of diabetes mellitus and its complications; Part 1: Diagnosis and classification of diabetes mellitus. Geneva: Department of Noncommunicable Disease Surveillance, WHO, 1999.
4. Colman PG, Thomas DW, Zimmet PZ, et al. New classification and criteria for diagnosis of diabetes mellitus. *Med J Aust* 1999; 170: 375-378.
5. Colagiuri S, Zimmet PZ, Hepburn A, Colagiuri R. Evidence-based guidelines for type 2 diabetes: case detection and diagnosis. Canberra: Diabetes Australia and National Health and Medical Research Council, 2002. □

Is breastfeeding best practice?

Sandra L Neate

Emergency Physician, Emergency Department, St Vincent's Hospital, Victoria Parade, Fitzroy, VIC 3065
neates@svhm.org.au

TO THE EDITOR: Thank you to McVeagh¹ for highlighting some more of the amazing scientific evidence regarding the benefits of breastfeeding. It is extremely important to continue to emphasise the benefits to mother and child in order to strengthen the individual's resolve and the community's support for breastfeeding.

However, my concern is whether the question "Is breastfeeding best practice?" should ever be posed in the first place. Do our natural physiological processes now need to be supported by an evidence base and scrutinised in terms of whether they conform to notions of "best practice"? And should the question about choice between breastfeeding and artificial feeding continue to be asked?

McVeagh also posed the question, "Is there justification in the argument that women are being pushed too hard to breastfeed?" Can there ever be too much encouragement given to women to provide nutrition and nurturing hand-in-hand to their baby?

We must keep emphasising that breastfeeding is not only about good nutrition,

reduction in childhood obesity and other measurable health outcomes. Surely there must remain some areas in our lives that do not require evidence and scientific support. Breastfeeding is about loving and nurturing a baby. It is about human relationships. When one experiences a newborn latching on to feed, the clearly felt surge of hormones from breast to brain, the physical expression of these hormones as a palpable "let-down" reflex and the incredible sight of milk rushing from the breast on demand, we do not need science to tell us that this is one of life's most amazing and wonderful experiences, nor to confirm what breastfeeding mothers innately know to be best practice.

1. McVeagh P. Is breastfeeding best practice [editorial]? *Med J Aust* 2002; 177: 128-129. □

Patricia McVeagh

Paediatrician, 116 Artarmon Road, Artarmon, NSW 2064.
pmcveagh@ozemail.com.au

IN REPLY: I thank Neate for her comments and for challenging the need to ask "Is breastfeeding best practice?". I appreciate her sentiment that there is more to infant feeding than nutrition and health.

However,

- while there are mothers who don't find breastfeeding pleasurable or easy and are deciding how long to persist;
- while there are mothers who opt not to exclusively breastfeed for six months or to wean before a year of age;
- while mothers' advisors prescribe solids or complementary feeds or weaning for myriad problems without evidence for effectiveness beyond a placebo effect;
- while some believe that the disadvantages of not breastfeeding only apply to infants in developing countries;
- while there are commercial interests promoting products that undermine exclusive breastfeeding;
- while the Australian government has not fully implemented the recommendations of the World Health Organization Code and subsequent resolutions;¹
- while health professionals are receiving "educational material" implying that a new additive makes commercial infant formula more like human milk; and
- while the scientifically minded among us just need to satisfy our curiosity,

we need to know to what extent it matters if an infant is breastfed at all, breastfed exclusively, or breastfed for longer periods.

Thank you for challenging the question. The weight of the evidence is such that the

real question is not "Is breastfeeding best practice" but "By how much?"

1. International Code of Marketing of Breast-milk substitutes. Geneva: World Health Organization, 1981, and subsequent resolutions. Available at: <http://www.who.int/nut/documents/code_english.PDF>. Accessed 24 September 2002. □

Chronic fatigue syndrome clinical practice guidelines: psychological factors

James D Hundertmark

Consultation-Liaison Psychiatrist, Flinders Medical Centre, Bedford Park, SA 5042.
james.hundertmark@fmc.sa.gov.au

TO THE EDITOR: The working group responsible for the recent chronic fatigue syndrome (CFS) guidelines needs to be congratulated for producing a sensible and well balanced document in a most controversial area.¹ Larkins and Molesworth have contributed a somewhat predictable response.² Some sufferers of CFS can be characterised by their capacity to react strongly to the suggestion that psychological factors may be involved in the pathogenesis of their condition.³

From the perspective of the consultation-liaison psychiatrist, their response can be written with the comments on physical and psychological issues substituted for one another. Hence it can read (1) there is no current evidence that the syndrome has a specific physical origin, and (2) there is evidence that a range of psychological issues occur in people with CFS, although it remains unclear whether these changes are primary or secondary.

The mental health movement has worked hard in recent times to reduce the stigma associated with psychiatric conditions. The sufferers of chronic physical illness now accept the importance of looking after their emotional health as well as their physical well-being. Enlightened CFS sufferers and support groups accept the links between physical and psychological morbidity and do not mindlessly exclude the latter. There is ample evidence that cognitive-behavioural strategies and graded exercise programs assist those with CFS, and psychiatrists are skilled in providing these treatments.⁴

1. Chronic fatigue syndrome clinical practice guidelines - 2002. *Med J Aust* 2002; 176 Suppl: S17-S55.
2. Larkins RG, Molesworth SR. Chronic fatigue syndrome clinical practice guidelines [letter]. *Med J Aust* 2002; 177: 51-52.
3. White PD. Discomfort of patient power: power sharing is not a takeover bid. *BMJ* 2002; 324: 1214.
4. Whiting P, Bagnall A, Sowden AJ et al. Interventions for the treatment and management of chronic fatigue syndrome: a systematic review. *JAMA* 2001; 286: 1360-1368. □