

EDITORIAL

Diagnosis of diabetes mellitus always begins with the discovery of "sugar" in the urine, and there is in the mind of the laity, synonymity between diabetes mellitus and the presence of sugar in the urine. Yet it is as well for doctors to be reminded that there exists a significant number of people who have glycosuria but not the abnormality of blood glucose homeostasis by which diabetes mellitus is clinically characterised. This reminder was amply served by the paper by Cheah and his colleagues in this issue of the S.M.J. In their survey of 28,765 seventeen-year-old male subjects at pre-national service medical examination, 114 cases of glycosuria were discovered. Of these only two were clearly diabetic by the accepted criteria of glucose tolerance test, while ninety-eight subjects (amounting to 86.0% of the total) were not diabetic but exhibiting either renal or alimentary glycosuria. This finding is of obvious practical significance. It means that abnormalities of blood glucose homeostasis must be sought in an adolescent male glycosuric subject before the diagnosis of diabetes mellitus, a life-long and disabling illness, can be made. The applicability of this finding to other groups of the population remains to be defined, but there is evidence that renal threshold tends to rise and that renal glycosuria becomes less frequent with increasing age.¹

In the article by Lim and Khoo, also appearing in this issue of S.M.J., the clinical pattern of new cases of diabetes mellitus was set out in detail. It confirmed the long-held impression that clinical diabetes locally possesses several distinctive characteristics. The low incidence of ketosis and the infrequent need for recourse to insulin are of great practical significance. Other important features include the relatively low prevalence of obesity

and peripheral vascular disease and the somewhat more frequent presence of ischaemic heart disease and peripheral neuropathy, in comparison with parallel experience in the West. The findings on racial distribution among diabetics were particularly interesting when considered in conjunction with the paper by Soong (in this issue of S.M.J.) who found a large proportion of Chinese diabetics in Malaysia firmly adhering to the traditional Chinese concept and treatment of the disease. This would partly explain the finding of a relatively low incidence of Chinese diabetics (as a racial group) in a hospital clinic.

It has not been possible in the last twelve months to discuss the subject of treatment of diabetes without being reminded of the report, from the U.S. of the possible undesirable influence of tolbutamide on cardiovascular complications.² This is particularly pertinent to our diabetics about 80% of whom, according to Lim and Khoo (this issue of S.M.J.) are receiving sulphonylureas. In the present state of uncertainty, until more conclusive evidence is available, it would be judicious to rely as far as possible on dietary measures alone to control hyperglycaemia in the mild and the obese diabetics. But for those who need more than dietary treatment, to abandon sulphonylureas altogether and commit the patients to life-long injections would seem precipitate at this juncture.

REFERENCES

1. Keen, H.: "The Bedford Survey." *Proc. Roy. Soc. Med.* 57, 200, 1964.
2. Prout, T. E. and Goldner, M. G.: "The effects of hypoglycaemic agents on vascular complications in patients with adult-onset diabetes." 3. *Course and mortality. Diabetes*, 19, Suppl., 1, 375, 1970.