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Letters to the Editor

In Reply

We thank our Canadian colleagues for their interest in our recent article and, in particular, their observations on the need for the 2-h sample with a 75-g OGTT. We note that 25% of their large cohort of 10 773 women had an abnormal 2-h sample using the IADPSG diagnostic criteria and therefore their understandable caution about missing the diagnosis of gestational diabetes mellitus.

However, their report differs from ours in several respects. Their population had a previous abnormal 50-g glucose challenge test whereas our population had not been previously screened. Our population was selectively screened and we assume their population was universally screened. Also, they used a Serum Separator tube and measured serum glucose after leaving samples to clot for 30 min, whereas we measured plasma glucose after strictly applying the ADA laboratory standards, including the use of a fluoride-EDTA tube placed immediately on an ice-slurry with centrifugation and analysis within 30 min. We are not surprised therefore that there are differences in the incidence of abnormal 2-h measurements.

We are also uncertain how many women in their report had an abnormal fasting and 1-h sample as well as an abnormal 2-h sample? We believe that is the key question because if one of the earlier samples was abnormal, the 2-h becomes unnecessary for diagnosis.

Our article did state that our observations would need to be repeated in larger studies and we welcome this dialogue because it highlights the importance of the need to standardize both the preanalytical and the analytical laboratory standards in evaluating the contribution of abnormal fasting, 1-h and 2-h samples in diagnosing gestational diabetes mellitus.

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