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reshaping dialysis and renal transplantation programmes to improve efficiency, effectiveness and quality. GIS permits the elaboration of scenarios supporting more effective planning for dialysis as well as for transplantation services. For governance assessment, GIS may contribute to the assurance of ongoing evaluation and critical review of dialysis or transplantation programmes based on analysis of health status and service utilization data.

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Reply

Sir,
MacGregor *et al.* give an interesting example of the utility of Geographical Information Systems (GIS) in the planning of dialysis facility provisions. In effect, GIS permits decision-making for health programmes at local, state and governance assessment levels [United States National Public Health Performance Standards Program <http://www.phppo.cdc.gov/nphpsp/EssentialPublicHealthServices.asp>]. For local assessment, GIS demonstrates accessibility and quality of services delivered and the effectiveness of personal and population-based programmes provided. This level provides information necessary for allocating resources and reshaping programmes. For state assessment, GIS may contribute to the evaluation of patients' health status and service utilization data, helping to assess programme effectiveness and to provide information necessary for allocating resources and

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Short-term rosiglitazone treatment in renal transplant recipients

Sir,

We read with great interest the article by Voytovich *et al.* [1], demonstrating the beneficial effect of a new insulin sensitizer, rosiglitazone, in renal transplant recipients. They concluded that short-term treatment with rosiglitazone improves glucose tolerance, insulin sensitivity and endothelial function in this group of patients.

The treatment modalities for diabetes mellitus and glucose intolerance include lifestyle modification, diet, exercise and pharmacologic intervention [2]. In this study, the authors did not give any information on dietary intervention, which is the mean predictor of the blood glucose level in diabetic and glucose-intolerant patients. Although this was not a crossover study, as the authors reported in the limitations section of the study, it might have been better to give a 4 week study period with a standard diet for all patients, in order to exclude the effect of nutritional factors. Also, seven patients were determined as post-transplant diabetes mellitus (PTDM) according to oral glucose tolerance test (two of them were previously known PTDM), but the authors did not give any information on the patients' glycohaemoglobin or fructosamine levels, which could be more valuable parameters (not influenced by acute changes in blood glucose) before and after the rosiglitazone, even in a 4 week period. Fructosamine seems to be a more suitable measure in this study design, because it is a more sensitive marker for abnormal glucose tolerance and it reflects 3–4 weeks' blood glucose control [3].

The main immunosuppressive agents responsible for PTDM are calcineurin inhibitors and steroids. Current evidence shows greater diabetogenicity of tacrolimus in multi-centre studies [4]. Therefore, it would be interesting to see if there is any correlation in insulin resistance and the response to the rosiglitazone between the patients on cyclosporin or tacrolimus.