

heritage Indians<sup>3-6</sup>. A regional survey of Oklahoma Indians, however, suggested the prevalence of IDDM may be forty times greater (7.9%) than previously reported<sup>7</sup>.

In 1980 West reported an overall prevalence of diabetic retinopathy of 24.4% among a group of Oklahoma Indian patients with NIDDM<sup>8</sup>. His study included 973 diabetic Indian patients from 25 tribes. A regional study in 1987 reported an overall prevalence of 49.3%<sup>7</sup>. West's original cohort was reexamined by Kingsley's group from 1987 to 1989 at which time the overall prevalence of retinopathy had increased to 67%<sup>1</sup>. Since the population studied by West and Kingsley was selected for long term follow-up, an increased prevalence of disease with time is expected. Some of the increase may also be explained by improved methods of examination used in the later studies. Conversely, these improved methods and longer follow-up provide more accurate data.

In Kingsley's report, over 90% of patients with proliferative retinopathy, requiring panretinal photocoagulation, had been treated. However, only 6% of those with clinically significant macular edema had received treatment<sup>1</sup>. The increased prevalence of IDDM reported by Newell and co-workers<sup>7</sup> suggests the prevalence of proliferative diabetic retinopathy, more common in IDDM than NIDDM, may be higher than previously thought.

Prospective studies sponsored by the National Institutes of Health have clearly demonstrated that the risk of severe and ongoing visual loss in proliferative diabetic retinopathy and clinically significant macular edema is reduced by 50% with appropriate laser photocoagulation<sup>9,10</sup>. Furthermore, the benefit of laser therapy must