Evaluation (APACHE II) scores of the patients in their ICU were 16.4±7.5 for 360 patients receiving standard care, 15.7±7.5 for 339 patients receiving SOD, and 16.4±7.7 for 314 patients receiving SDD, with observed inclusion rates of 88%, 91%, and 87% for the three groups, respectively. Their remark that "correction factors were determined afterward" is incorrect, since all variables on case-record forms — which were used throughout the study — were included as covariates.

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Behavioral Management for Anorexia Nervosa

TO THE EDITOR: In their article on behavioral management for anorexia nervosa (Jan. 29 issue),[1] Attia and Walsh state that the Maudsley Method (in which parents take control of refeeding of their child) is the preferred treatment for children and adolescents, but I wonder why they do not recommend it for the 23-year-old woman described in the vignette. For decades, the conventional wisdom was that a "toxic" parent–child relationship caused this disorder. Parents were told to "back off" and were barred from the treatment team.[2] This cruel and inaccurate bias has lingered in psychiatry. Attia and Walsh note that weight restoration is accepted as being paramount for treatment. They also note that inpatient treatment lasts for 18 days, on average, and is associated with a relapse rate of 50% in the first year after hospitalization. When parents are empowered to refeed their child, they do so for as long as it takes, which is usually many months.[3] We await clinical trials using the Maudsley Method in young adults.

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TO THE EDITOR: We agree with the authors that structured multidisciplinary behavioral programs that integrate nutritional and psychological treatments are the most promising approaches in the management of anorexia nervosa. However, their nutritional-support program raises concern. Certainly, priority is given to providing adequate calories,[1] and institutions may opt for different protocols. However, in our experience, patients frequently report considerable difficulties in beginning therapy with such large quantities of solid food (1800 kcal per day); such quantities are probably unrealistic and may be harmful. Patients with anorexia nervosa are at high risk for the refeeding syndrome.[2-4] When similar high-calorie nutritional regimens are enforced, the risk of complications is very high.[1-4] To avoid complications, both current guidelines and expert panels suggest 10 kcal per kilogram of body weight per day for nutritional support during the first 3 days, regardless of the route of administration.[3,4] A cautious increase (by 400 to 500 kcal every 3 days) can then be proposed to obtain a positive energy balance.[1,3] Weight and electrolyte levels should be checked daily to rule out excessive water retention and correct any impairment.

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THE AUTHORS REPLY: In response to Scolnick: we did not recommend a prime role for the family of the 23-year-old patient described in our review because the limited data available suggest that the Maudsley family-based approach is not particularly effective in this age group.[1] However, we concur that it is important to involve the family to the degree that family members are available to help. Controlled trials would be useful to obtain empirical data regarding the usefulness of family members' taking a major role in the refeeding of persons with anorexia nervosa in this age group.

Cereda et al. express concern about the refeeding syndrome. In our review, we recommend careful medical monitoring during initial refeeding. The guidelines of the National Institute for Health and Clinical Excellence[2] suggest starting nutritional support at 10 kcal per kilogram per day in order to avoid the refeeding syndrome. However, this recommendation appears to be overly cautious for most persons with anorexia nervosa, since it is intended to assist in the care of all malnourished persons, including those who may have underlying cardiovascular compromise or who may have suddenly interrupted intake for 15 days or more.[3] The American Psychiatric Association guidelines for the treatment of patients with eating disorders suggest starting refeeding at 30 to 40 kcal per kilogram per day,[4] as do Golden and Meyer in their review of refeeding in anorexia nervosa.[5] In our experience, persons with anorexia nervosa may report a reluctance to eat, but they will commonly tolerate being offered 1800 kcal in solid food, generally consuming this diet successfully within a few days after hospital admission and showing physiological tolerance of this caloric load as well as additional increases needed to achieve consistent weight gain in the weeks that follow.

As mentioned in the review by Mehanna et al.,[3] vitamin supplementation should be started immediately on refeeding, and supplements of potassium, phosphate, calcium, and magnesium should be considered. Lower levels of initial caloric intake may be appropriate for persons with weights that are unusually low (body-mass index [the weight in kilograms divided by the square of the height in meters], ≤14), who have undergone particularly abrupt weight loss before presentation, or who are known to have ingested negligible calories in the previous 2 weeks.

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More on Eculizumab for Congenital Atypical Hemolytic–Uremic Syndrome

TO THE EDITOR: In their letter to the editor about eculizumab for congenital atypical hemolytic–uremic syndrome, Gruppo and Rother (Jan. 29 issue)[1] report that they used eculizumab in an 18-month-old boy at an initial dose of 300 mg and a maintenance dose of 600 mg — half and two thirds of the adult doses (600 mg and 900 mg), respectively.[2] These doses may be relatively high, because this patient weighed only 12 kg, and the body-surface area is approximately 0.5 m^2, which may be less than one third of the adult area. The appropriate dose and the pharmacokinetics of this drug in children or in patients with renal failure have not yet been studied. Therefore, especially in young children, eculizumab should be used cautiously because of the high risk of meningococcal infection[2]; the lowest effective dose of eculizumab should be determined according to the plasma drug level. Because plasma eculizumab levels of more than 35 μg per milliliter are required to block complement activation in adults,[2] the initial dose should be calculated on the basis of body-surface