

stances after a disaster, the heavy workload, panic, and incomplete patient records.¹ However, despite these drawbacks, crush injuries after the Marmara earthquake, in Turkey, which formed the main basis for our article, were documented in as much detail as possible regarding the fate of the injured persons, their profile, and any nephrologic problems, thanks to the high rate of response to questionnaires that were sent to the reference hospitals immediately after the disaster. This high response rate made it possible to understand the sequence of events after disasters of great magnitude and helped us develop logistic coordination, as presented in the article.

We also agree that rapid evacuation of the victims is important. As we noted in our article, “after a disaster, rapid transport systems should be devised, if feasible, to evacuate injured persons from the epicenter.”

Kettler is correct that the hyperkalemic response to succinylcholine was not mentioned in our article, but it was not our aim to provide a detailed technical description of how to treat persons with crush-related injuries. The primary focus of our article was to provide conceptual information about lifesaving aspects of the medical care that is related to renal rescue, as well as the global and local logistics that are needed to support such action. Hence, owing to space limita-

tions, it was impossible to include all details about the many key interventions required in disaster conditions; this information can be found elsewhere.^{2,3} However, we thank Kettler for emphasizing the importance of hyperkalemia in patients with crush injuries. In one of our articles on the Marmara earthquake, we reported that the risk of fatal hyperkalemia continues even after hospitalization and that early detection and treatment of hyperkalemia may improve the final outcome of disaster victims with renal damage.⁴

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Attendance at Supervised Injecting Facilities and Use of Detoxification Services

TO THE EDITOR: In September 2003, the first safer injecting facility in North America opened in Vancouver, Canada. Here, injection-drug users can inject preobtained illicit drugs under medical supervision.¹ A concern regarding such facilities is that they may lessen the likelihood that injection-drug users will seek addiction-treatment services.^{2,3} Randomized trials are lacking to address this concern. We assessed factors associated with time to entry into a detoxification program at one of the city's three detoxification centers. We used data collected by means of a questionnaire as part of a cohort study (supported by Health Canada) of persons who use supervised injecting facilities, called the Scientific Evaluation of Supervised Injecting (SEOSI) cohort.⁴

Between December 1, 2003, and March 1, 2005,

4764 persons used the facility and 1194 randomly selected repeat attendees were invited to enroll in SEOSI.⁴ The randomization was such that the facility's intake computer alerted the staff to explain the invitation to attendees at their next visit to the program (repeated use was required for enrollment). Of these 1194 persons, 158 (13 percent) either did not return to the supervised injecting facility or declined the invitation, and 5 were considered by study staff to be unable (i.e., mentally ill or too intoxicated) to provide informed consent. Among the 1031 persons (86 percent) enrolled, the median age was 39 years, 29 percent were female, 58 percent used the facility an average of at least weekly, and the median number of visits was 47 during a median of 344 days of follow-up. One hundred eighty-five

Table 1. Univariate and Multivariate Cox Proportional-Hazards Analysis of the Time to Entry into a Detoxification Program among 1031 Users of Injection Drugs after the Opening of a Supervised Injecting Facility (SIF).*

Variable	Unadjusted Relative Hazard (95% CI)	P Value	Adjusted Relative Hazard (95% CI)	P Value
Homelessness (yes vs. no)†	1.43 (1.07–1.91)	0.02	1.42 (1.06–1.90)	0.02
Binge drug use (yes vs. no)†	1.44 (1.05–1.97)	0.02	1.35 (0.98–1.85)	0.06
Ever in treatment (yes vs. no)‡	2.70 (1.56–4.65)	<0.001	2.43 (1.41–4.22)	0.002
Weekly use of SIF (yes vs. no)§	1.84 (1.34–2.52)	<0.001	1.72 (1.25–2.38)	0.001
Addictions counselor (yes vs. no)†§	2.41 (1.55–3.77)	<0.001	1.98 (1.26–3.10)	0.003

* Use of a detoxification service was identified on the basis of database linkage. The model was adjusted for all variables that were significant ($P < 0.05$) in unadjusted analyses, including all variables shown, as well as residence in the neighborhood of the supervised injecting facility (yes vs. no). Time zero was the date of recruitment, and participants who remained persistently out of a detoxification program were censored as of March 1, 2005. CI denotes confidence interval.

† The variable refers to activities during the previous six months.

‡ The “ever in treatment” category refers to current or historical use of addiction-treatment services.

§ Data for the “weekly use of SIF” category were derived from the database of the SIF, and weekly use was determined according to the average use before the censoring or event date.

persons (18 percent) began a detoxification program during follow-up.

In multivariate analyses with the use of Cox regression, an average of at least weekly use of the supervised injecting facility and any contact with the facility’s addictions counselor were both independently associated with more rapid entry into a detoxification program (relative hazards, 1.72 [95 percent confidence interval, 1.25 to 2.38] and 1.98 [95 percent confidence interval, 1.26 to 3.10], respectively) (Table 1).

Because our study design was observational, it is possible that other factors may explain the observed associations; for example, greater concern for one’s health or a tendency to “comply” might lead to greater use of the supervised injecting facility, as well as more ready acceptance of detoxification. In this regard, we have previously shown that greater use of the supervised injecting facility is associated with markers traditionally associated with reduced access to care, including a higher intensity of drug use and homelessness.⁵ In addition, contact with the addictions counselor was among the strongest independent predictors of more rapid entry into a detoxification program. Our findings provide reassurance that supervised injection facilities (Fig. 1) are unlikely to result in reduced use of addiction-treatment services.

(The views expressed in this letter are those of the authors and do not necessarily represent the official policies of Health Canada.)



Figure 1. Supervised Injecting Facility.

Courtesy of Will Small.

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Alemtuzumab for Refractory Celiac Disease in a Patient at Risk for Enteropathy-Associated T-Cell Lymphoma

TO THE EDITOR: A 56-year-old woman had a two-year history of refractory celiac disease for which she had taken prednisone (20 mg per day) for the previous six months, during which time her condition had worsened despite a gluten-free diet. Duodenal biopsy showed severe atrophy with crypt hyperplasia and increased intraepithelial lymphocyte counts. On immunohistochemical analysis, the cytoplasm was positive for CD3 and negative for CD4 and CD8 (Fig. 1). Flow-cytometric analysis of intraepithelial lymphocytes showed that more than 50 percent of the cells expressed T-cell receptor $\gamma\delta$ (TCR $\gamma\delta$). In addition, we identified a second aberrant population of intraepithelial lymphocytes,

which stained negative for surface CD3, CD16/56, and CD19. Polymerase-chain-reaction analysis of DNA extracted from duodenal mucosa and peripheral blood showed oligoclonality of TCR $\gamma\delta$. Computed tomography of the abdomen, an intestinal barium study, colonoscopy, and enteroscopy did not show any evidence of enteropathy-associated T-cell lymphoma.

After a discussion of the risks and benefits, the patient decided to undergo immunotherapy with alemtuzumab, an anti-CD52 monoclonal antibody. Alemtuzumab was administered according to the conventional therapeutic schedule used in cases of chronic lymphocytic leukemia that is

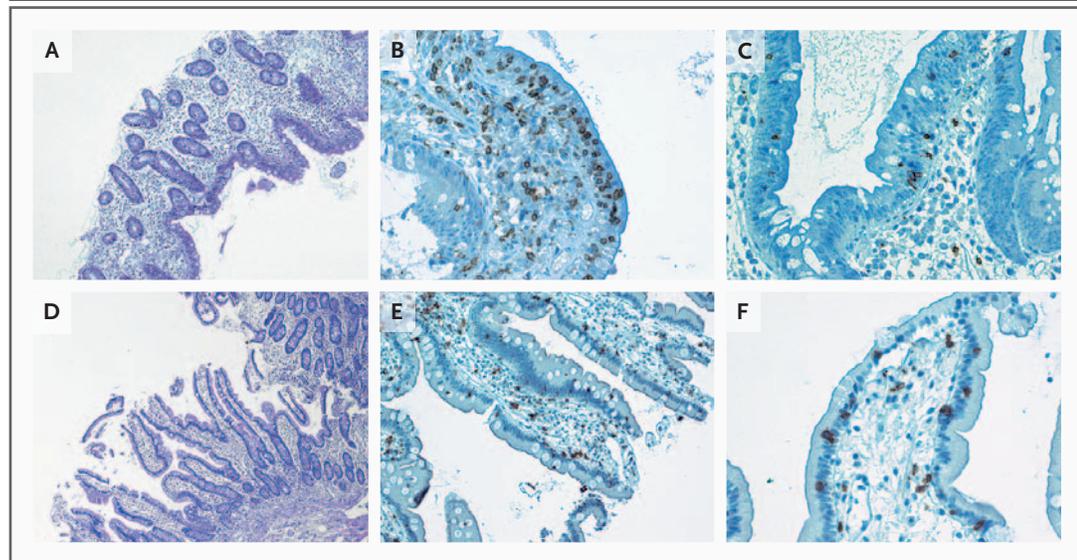


Figure 1. Duodenal-Biopsy Specimens before and after Alemtuzumab Therapy.

Panel A shows total villous atrophy with crypt hyperplasia and elevated intraepithelial lymphocytes in a specimen obtained before therapy. Immunohistochemical staining for CD3 antibody is shown in Panel B. In Panel C, immunohistochemical staining for CD8 is negative, revealing that the ratio of CD3+ to CD8+ lymphocytes is greater than 1. Panel D shows the recovery of mucosal structure after nine months of alemtuzumab treatment. Panel E shows the decrease in the number of intraepithelial lymphocytes, and Panel F a specimen in which the CD3+:CD8+ ratio of 1:1 is restored after therapy.