

treated with oral melphalan plus high-dose oral dexamethasone, the 3-year overall survival rate was 80%, showing that they were actually “good risk” patients. With censoring of data for patients who died early and patients who could not receive their assigned treatment, the results of the landmark analysis strongly argued against the superiority of high-dose melphalan, even in groups with 0% treatment-related mortality and 100% treatment feasibility. This probably resulted from the very similar hematologic response rates in the two treatment groups, in a disease in which a clonal response is mandatory for improved survival.

Our 24% rate of treatment-related mortality with high-dose melphalan is in keeping with the results of several other multicenter studies and can be considered as representative of the results with high-dose melphalan when used outside some tertiary referral centers. The better results obtained in these referral centers probably reflect not only better management of the disease but also better selection of candidates for high-dose melphalan. Both were likely factors in the impressive

results reported by Comenzo et al. Studies comparing new standard-dose regimens with (optimized) high-dose treatments should now be performed in tertiary referral centers. In our opinion, further improvements in the survival of patients with AL amyloidosis are likely to result from the use of new drugs and innovative therapeutic approaches.

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Early Thimerosal Exposure and Neuropsychological Outcomes

TO THE EDITOR: Thompson et al. (Sept. 27 issue)¹ report the results of a study investigating the neuropsychological outcomes of early exposure to thimerosal. As a dissenting member of the panel of external consultants for this study, I object to the authors' conclusion that there is no causal association between thimerosal and children's brain function. The sample comprised children who were least likely to exhibit neuropsychological impairments. Specifically, children with congenital problems, those from multiple births, those of low birth weight, and those not living with their biological mother were excluded. The sample was skewed toward higher socioeconomic status and maternal education — factors that are associated with lower rates of neurobehavioral problems and higher intervention rates and that were not measured. The sampling frame included only children enrolled from birth in the health maintenance organization (HMO) and still enrolled after 7 to 10 years, excluding children in higher-mobility families, who tend to have lower academic and behavioral function.² Children with neurobehavioral

problems may have been less likely to remain with the HMO. Only 30% of families selected for recruitment participated, a low rate for scientific research. Among the families selected for recruitment, 26% refused to participate. Another 28% “could not be located,” which included families that did not respond to multiple recruitment attempts (internal documentation from the study contractor, Abt Associates) — another form of refusal.

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TO THE EDITOR: Recently, I summarized several nutritional factors that are likely to play a large