

become the preferred imaging method for staging and restaging of this disease, but first this needs to be demonstrated in larger prospective studies.

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Medicare Drug Benefit

TO THE EDITOR: In one of several Perspective articles in the December 29 issue on the Medicare drug benefit, Bach and McClellan paint a decidedly rosy picture of the new prescription-drug benefit.¹ Their apparent aim was to reassure nervous physicians that this monstrously complex program would not overwhelm either them or their elderly patients. Their statement that “some beneficiaries will have challenging questions and will probably turn to their physicians” is certainly an understatement. A more likely scenario is that large numbers of patients, confused by a daunting array of choices, will deluge physicians’ offices with inquiries.

Although the authors believe that “physicians are uniquely suited to helping their patients . . . to identify plans that provide substantial savings,” I would argue that busy physicians, already overwhelmed by paperwork, are in no such position. Physicians are trained to provide medical care, not to navigate government Web sites and insurance companies’ formularies. The best advice physicians can provide to their patients is to call the offices of their elected officials. Perhaps when these officials are swamped by calls from perplexed seniors, Congress will find a way to fix the mess they have created.

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1. Bach PB, McClellan MB. A prescription for a modern Medicare program. *N Engl J Med* 2005;353:2733-5.

TO THE EDITOR: The series of Perspective articles under the rubric Medicare Drug Benefit is infor-

mative, but the articles fail to communicate the enormous problems confronting Medicare beneficiaries. Having been in practice and involved in research and teaching from graduation from medical school in 1950 until retirement in 1992, I was exposed to the physician’s side of these issues. For several years, I have been a counselor (in the Senior Health Insurance Assistance Program) in Montgomery County, Maryland. The Medicare Part D Prescription Drug Program has generated fear, anxiety, and for many, very limited benefits. Bach and McClellan’s concluding paragraph paints a rosy, unrealistic picture that the frail elderly people who consult our office cannot comprehend. Kravitz and Chang¹ gently point out some of the failures of the program but do not capture the frustrated feelings of a vulnerable population. The mixed and generally limited benefits, coupled with the complexity, lack of standardization of policies, multiple potential loopholes, lack of prescription cost control, and the many unmentioned subsidies to providers of drugs and insurance, contribute to the current low enrollment in this highly acclaimed plan.

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DRS. KRAVITZ AND CHANG REPLY: We appreciate Dr. Lear’s point of view. Although we did point out some of the Byzantine complexities of the Medicare Part D program, the experience of the past few weeks has confirmed some of the critics’ worst

fears. As Dr. Lear states, many beneficiaries (and their providers) are worried, frustrated, and scared. We hope that our guarded optimism will one day seem more prescient than do such fears. At the moment, it appears that patients, doctors, and pharmacists are struggling with information overload and a panoply of poorly understood options.

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Resolution of Recurrent Focal Segmental Glomerulosclerosis Proteinuria after Rituximab Treatment

TO THE EDITOR: Focal segmental glomerulosclerosis recurs in about 30 percent of patients who undergo kidney transplantation for this condition and leads to the nephrotic syndrome and accelerated graft loss.¹ Cyclosporine, cyclophosphamide, plasmapheresis, protein A immunoabsorption, and mycophenolate mofetil have been variably effective.^{1,2}

We report the case of a seven-year-old boy who presented with immediate recurrence of focal segmental glomerulosclerosis after transplantation that subsequently resolved only after rituximab treatment of a transplantation-related lymphoma that occurred five months after the surgery. This child originally had biopsy-proven primary focal segmental glomerulosclerosis with the nephrotic syndrome. After 4.5 years, he progressed to renal failure with a need for dialysis despite therapy with prednisone, cyclophosphamide, and mycophenolate mofetil. Then, 1.25 years after starting dialysis (the patient had anuria), he received a kidney transplant from a deceased adult donor with no HLA-AB matches and one HLA-DR match. His immunosuppressive therapy consisted of tacrolimus, mycophenolate mofetil, corticosteroids at a tapered dose (with discontinuation after seven days), and daclizumab.

Although the initial renal function of the patient was excellent, by two weeks after transplantation, the creatinine level had increased to 2.4 mg per deciliter, and the serum albumin level had fallen to 1.5 mg per deciliter (Fig. 1). Biopsy of the transplant showed minimal pathological changes without evidence of rejection. Electron microscopy was not performed. Recurrent focal segmental glomerulosclerosis was diagnosed; oral corti-

costeroids were resumed, and plasmapheresis with 5 percent albumin replacement, performed three times a week, was begun.

Five months after transplantation, because of fever, enlarged tonsils, and cervical adenopathy, adenotonsillectomy was performed, and a diffuse large-cell lymphoma associated with the Epstein-Barr virus (EBV) that was positive for latent membrane protein and CD20 protein (post-transplantation lymphoproliferative disease [PTLD]) was diagnosed. Six weekly doses of intravenous rituximab were administered (375 mg per square meter of body-surface area; actual dose received, 285 mg), resulting in rapid clearing of circulating CD19-positive B cells (from 9.4 percent [158 cells per microliter] to 0 percent [1 cell per microliter]) and CD20-positive B cells (from 7.5 percent [127 cells per microliter] to 0.2 percent [3 cells per microliter]). At present, the patient is doing well and is receiving cyclosporine (at a dose of 75 mg twice daily) and prednisone (at a dose of 5 mg daily). The ratio of urinary protein to creatinine is 0.5, and the serum albumin level is 3.4 g per deciliter.

This child's proteinuria abated only after treatment of his PTLN with rituximab. Focal segmental glomerulosclerosis has been associated with viral infections,³ but it is unlikely that this case was simply associated with EBV, since the focal segmental glomerulosclerosis recurred immediately after transplantation, antedating the PTLN. The presence of EBV was first determined at the time of adenopathy, some seven months later. Rituximab has been used with increased frequency in various autoimmune diseases, including those that are thought to be primarily mediated