

THE AUTHOR REPLIES: The importance of gonorrhea, chlamydia, and other sexually transmitted infections with respect to initial screening for HIV infection was noted in the article, as was the importance of the use of condoms both to prevent the acquisition of sexually transmitted infections and to promote secondary prevention of the spread of HIV-1. The list of recommended laboratory tests (which included tests for several other pathogens that can be acquired through sexual contact) did not include screening for gonorrhea and chlamydia, but it certainly could have. The consensus U.S. recommendations¹ referred to by Chin-Hong et al. and these authors' data on

a population of men who have sex with men support data-driven decision making with regard to the optimal testing strategies for sexually transmitted infections in populations at risk.

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1. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *MMWR Recomm Rep* 2003;52(RR-12):1-24. [Erratum, *MMWR Morb Mortal Wkly Rep* 2004;53:744.]

Hurricane Katrina and Disaster Medical Care

TO THE EDITOR: After reading the Perspective articles about Hurricane Katrina (Oct. 13 issue), I would like to offer another perspective. Although the public health work described in the first two articles was admirable,^{1,2} it was irrelevant to most of the people who were evacuated. Only about 50,000 went to shelters. Most of the nearly 1 million displaced people went to hotels or to the homes of family and friends. Among them were the doctors and nurses who normally served this population.

Dr. Cranmer is correct about the disconnect between the needs of the hurricane victims and the aspirations of the volunteers from elsewhere.¹ The doctor she describes was a thoracic surgeon. We didn't need more thoracic surgeons or emergency-medicine physicians. What the displaced people needed from the beginning, and still need today, is access to primary care for chronic illnesses and to the medicines that keep their diabetes and chronic obstructive pulmonary disease under control. Our current medical response to disasters is designed for terrorist attacks. Our current disasters are storms, fires, and earthquakes. Medical care for chronic conditions and acute illnesses should be available to evacuees from the moment they walk into a shelter or arrive on a cousin's doorstep. The only way to provide immedi-

ate care is to use the resources that are already present and functioning. Shelter organizations like the Salvation Army and the Red Cross should enlist the services of organizations such as the American Medical Association, the American Academy of Family Physicians, and the American Hospital Association to establish a medical response as part of our disaster-relief system. We need to stop letting well-intentioned officials and volunteers shoulder aside local resources. We should coordinate the doctors and nurses who are already there to manage the response. Displaced populations in the United States need care providers who know them and their needs, speak their language, and know their culture.

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1. Cranmer HH. Volunteer work — logistics first. *N Engl J Med* 2005;353:1541-4.
2. Greenough PG, Kirsch TD. Public health response — assessing needs. *N Engl J Med* 2005;353:1544-6.

DR. CRANMER REPLIES: Dr. Rathbun is absolutely right. As was noted at the World Conference on Disaster Reduction in January 2005, "While the occurrence of natural events is largely beyond hu-

man control, the consequences are not.”¹ Throughout the world, the disasters that affect people the most are the natural ones — floods, windstorms, epidemics, and earthquakes, in that order.

Our national disaster-response plan stipulates that the affected community should be able to “survive” for at least 48 hours before help arrives. The national plan also federalizes health care personnel to help provide care. We worked with a variety of agencies that enacted this plan, including the Public Health Service, because the local capacity for public health was overwhelmed. The American Red Cross provides food, shelter, and first aid. Because there was a recognized need, we also served a public health function, providing doctors and nurses who offered care beyond first aid by supporting local capacity to address

chronic care needs in the displaced population. It is true that the majority of displaced people were not in shelters, but those who were in shelters were the most vulnerable. They did not have the resources to evacuate, the network of friends and family elsewhere, or the health care they needed for such chronic conditions as hypertension, diabetes, mental illness, and addiction. We should do our best to support local capacity in disaster responses and should plan for such support before the next disaster.

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1. Darcy J. The Indian Ocean tsunami crisis: humanitarian dimensions. (Accessed January 26, 2006, at <http://unpan1.un.org/intradoc/groups/public/documents/APCITY/UNPAN019573.pdf>.)

Seizure Activity and Off-Label Use of Tiagabine

TO THE EDITOR: Thirty-one case reports of new-onset seizures associated with off-label use of tiagabine (Gabitril) have prompted the addition of a boldface warning to the product label.¹ (Tiagabine is approved by the Food and Drug Administration [FDA] solely for adjunctive treatment of partial seizures in adults and children 12 years of age and older.) The mean duration of exposure to tiagabine before the occurrence of a seizure was three to four months, but in some cases seizures occurred within days after the initiation of the drug or an increase in the dose. Although there were no deaths, status epilepticus was reported in seven patients, of whom two had convulsions.

This experience offers several lessons. First, in this case series, many patients were prescribed tiagabine at usual doses for adjunctive therapy for epilepsy, despite the fact that they were not being treated concomitantly with hepatic-enzyme-inducing antiepileptic drugs. During the development of tiagabine as an antiepileptic drug, virtually all patients were also taking at least one hepatic-enzyme inducer. These concomitant treatments decreased the concentration of tiagabine

because they induced the metabolism of tiagabine by cytochrome P-450 3A4. Patients without epilepsy who are not taking concomitant hepatic-enzyme inducers are likely to have increased plasma concentrations of tiagabine because metabolism by the cytochrome P-450 system is not induced. Second, in some cases, because tiagabine is approved for epilepsy, the dose of the drug was increased in an attempt to treat the new-onset seizure. In this setting, physicians may not have expected this paradoxical effect and therefore did not attribute a new-onset seizure to tiagabine. Third, many case reports described the addition of tiagabine to medical regimens that already had the potential to lower the seizure threshold (e.g., antidepressants and, less commonly, antipsychotics).

The FDA is concerned about the risk of seizure with tiagabine particularly because off-label use is increasing. From 1998 to 2004, the proportion of mentions of the use of tiagabine for indications other than epilepsy (i.e., bipolar disorder, anxiety, and neuropathic pain) increased from 20 percent to 94 percent. During the same period, the annual number of dispensed prescrip-