Letters to the Editor (from page 6)

trol groups on IQ at intake. As for demonstrating the effectiveness of operant conditioning, all we can say is that the treatment did include a number of important factors (e.g., early intervention, treatment in home environment, mainstreaming, etc.), and at this time it is not possible to determine how much any single component contributed to the final outcome.

3. Outcome measures: We agree that IQ scores and school placement at the age of seven years do not tell the whole story. Yet, Dr. Schopler seems to have missed that these children were *not simply enrolled* in normal classes but were functioning successfully with no one aware that they had any history of special problems, and were *passed* from grade to grade based on satisfactory performance and using the same criteria applied to all other children in the classes. We have been collecting additional follow-up data, including a blind evaluation of the most successful outcome cases at an average age of 13. This study, soon to be published, showed that on measures of cognitive, adaptive, social and personality functioning, eight of the experimental subjects were virtually indistinguishable from the normal control subjects, while two others showed some adjustment problems but still had IQs in the normal range and were passing in normal classes.

Dr. Schopler and others have taken us to task for calling special education classes the "kiss of death" for autistic children. This statement was, regrettably, taken out of context by the *New York Times* writer. We believe that for many autistic children, particularly those who do not recover during intensive treatment, placement in special classes for autistic children may well be the best available option. However, we believe that for the children who eventually recovered it was crucial not to be grouped with other disturbed children; thererefore we sought to expose them only to appropriate peer modeling.

A more detailed written response is available on request from the address below:

Ivar Lovaas, Ph.D.
UCLA Department of Psychology
Los Angeles, California 90024.

To the editor:

In your article, "Rett Syndrome: Diagnostic guidelines offered" (Vol. 1, No. 2), you write: "A major achievement in recent years has been the subdividing of the population labeled 'autistic' into smaller subgroups, such as fragile X autism, lyase deficiency autism, purine autism and Rett syndrome."

While we agree that Rett syndrome should be presented in a review of research in the field of autism and related disorders, we object to Rett syndrome being described as one of these subgroups.

We think it is important that physicians know that the presence of an autistic behavioral syndrome is not an obligatory condition for the diagnosis of Rett syndrome.

A large percentage of the children with Rett syndrome age 0-6 months or older than 3-5 years are not autistic. There are even children with this syndrome who are the oppostie of autistic, and contact with people seems to be their greatest pleasure.

Sincerely,

Bo Olsson, Ph.D.
Prof. Andreas Rett, M.D.

Editor's response: Drs. Olsson and Rett make an important and valid point. I was not aware that so many Rett syndrome girls would not be classified as autistic. On the other hand, there are undoubtedly many Rett cases who have been diagnosed as autistic whose caretakers may be unaware that Rett syndrome exists. One problem is that we do not know what proportion of Rett cases have been labeled autistic, nor what percentage of autistic girls are in fact Rett cases. The situation is quite analogous to that found with the fragile X syndrome, except that in fragile X we do know that about 8% of diagnosed autistics are fragile X cases, and about 20% of fragile X cases are diagnosable as autistic.

We have been developing, in collaboration with Dr. Loretta Leon, a diagnostic checklist to help delineate the Rett/autism relationship. Interested parents and professionals may send a stamped, self-addressed envelope to this Institute for a draft copy of this experimental checklist.

Fenfluramine (from p. 2)

The risk of neurotoxicity also concerns Gerald August and fellow researchers who have conducted two studies on the efficacy of fenfluramine. While the researchers found that the drug led to a reduction in hyperactivity and motor symptoms, improved attention, and possibly improved social awareness (an effect seen only in higher-functioning subjects), they found "no indication that short-term administration of fenfluramine enhances intellectual functioning or promotes more appropriate verbal and nonverbal communication." In their opinion, fenfluramine "remains an investigative agent with rather discouraging results concerning its efficacy"; they caution that "if indeed fenfluramine produces irreversible changes in serotonin neurons, future use of the drug should weigh the apparent symptomatic benefits from its use with the potential adverse effects from long-term administration."

Fenfluramine is a potent drug which should not be used without close medical supervision. Twelve cases of fenfluramine toxicity due to overdoses have been reported, and three of these were fatal.

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A list of the 25 references cited in this article is available from the ARRI. In addition, a chart listing the 15 studies summarized in this article, tabulating the numbers of subjects in each study who experienced good and adverse effects, and listing the specific effects seen, is available upon request. Please send a self-addressed, stamped envelope to ARRI, 4182 Adams Avenue, San Diego, CA 92116, and specify that you are requesting the chart and/or references for the article on fenfluramine.

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