confusion, irritability, auditory and visual hallucinations, and paranoia. She had multiple brief (few minutes) episodes of worsening of auditory/visual hallucinations, fluttering her eyes, and moving her lips. Results of a laboratory examination, LP, brain MRI, and EEG were normal. All medications were discontinued, but she remained psychotic for 3 more days. Her symptoms then resolved over 48 hours without treatment and she was discharged to home with mild residual irritability. Two weeks later she came to the clinic reporting irritability and occasional racing/disorganized thoughts that were not improved after 3 days on risperidone 0.5 mg/day. Her irritability and thought process completely normalized when a steroid inhaler prescribed after her discharge was discontinued.

These observations have several methodological limitations. Because the patients were taking different cold preparations combined with other medications, it is not possible to separate the individual effect of each drug in the development of psychosis. In case 3 steroids probably contributed to the development of psychotic symptoms. Despite the limitations inherent in case reports, the clinical picture in these 3 girls was very similar, with acute onset of severe psychosis associated with the use of cold preparations, and met *DSM-IV* criteria for substance-induced brief psychotic reaction. These patients required several days of medical hospitalization, extensive/invasive medical evaluations, and consultations with neurologists, infectious disease specialists, toxicologists, and psychiatrists. Ephedrine/pseudoephedrine and dextromethorphan should be used with caution in children and adolescents. Intoxication by this class of drugs should be included in the differential diagnosis of new-onset psychosis.

Cesar A. Soutullo, M.D.
Division of Child and Adolescent Psychiatry
Children's Hospital Medical Center, Cincinnati
Department of Psychiatry
Biological Psychiatry Program
University of Cincinnati
Elizabeth M. Cottingham, M.D.
Division of Child and Adolescent Psychiatry
Children's Hospital Medical Center, Cincinnati
Paul E. Keck, Jr., M.D.
Division of Child and Adolescent Psychiatry
Children's Hospital Medical Center, Cincinnati
Department of Psychiatry
Biological Psychiatry Program
University of Cincinnati

Milgrom H, Bender B (1995), Behavioral side effects of medications used to treat asthma and allergic rhinitis. *Pediatr Rev* 16:333–335

Polles A, Griffith JL (1996), Dextromethorphan-induced mania. *Psychosomatics* 37:71–74

Sauder KL, Brady WJ, Hennes H (1997), Visual hallucinations in a toddler: accidental ingestion of sympathomimetic over-the-counter nasal decongestant. *Am J Emerg Med* 15:521–526

FLUOXETINE IN CHILDREN WITH AUTISM

To the Editor:

A multidimensional approach should be considered in the treatment of children with autistic disorder. Pharmacological treatment could help to improve some symptoms in these children and could increase the effectiveness of other types of therapies and improve the quality of life for autistic children and their families. Serotonin reuptake inhibitors have shown efficacy in improving some symptoms in children with autism.

We report here a 6-month, open-label trial with fluoxetine in 6 patients (4 to 7 years and 4 months old) with autistic disorder who were in treatment in a day hospital for children with psychiatric disorders. The Clinical Global Impression (CGI) scale was used to assess the severity and the improvement of symptoms. Improvement of individual symptoms was assessed by both parents and therapists. Tolerance was assessed by collecting spontaneous adverse events. The fluoxetine (liquid formulation) dose was titrated in all patients from 1.2 mL/day (5 mg/day) to reach a final dose of 5 mL/day (20 mg/day) in 4 weeks in 5 children and 3.6 mL/day (15 mg/day) in 1 child. This final dosage was maintained until the end of the study. The efficacy and safety of the drug were assessed weekly for the first 2 months, then monthly until the end of the study.

Baseline severity of the disorder was assessed as a score at least of 5 (markedly ill) on the CGI. Five children completed the 6-month period of treatment; 1 child withdrew because of a severe adverse event. Children experienced a moderate or marked improvement assessed by the CGI (final score 3 [mildly ill] or 2 [borderline ill]). Regarding individual symptoms, there was improvement in ritualistic behaviors, improvement in motor stereotypies, and above all, improvement of social functioning and increased interest in the environment in all the children as assessed by parents and therapists. Once achieved, the improvement was maintained throughout the evaluation period (6 months). This improvement increased the effectiveness of other therapies.

The most common adverse events were a worsening of impulsivity and restlessness, sleep disturbances, and lost of appetite (Riddle et al., 1990/1991). Two children needed concomitant medication with carbamazepine and one with levopromazine. One child who was taking carbamazepine suffered a Steven-Johnson syndrome and had to be withdrawn, but he recovered totally.

Previous studies conducted with fluoxetine have also reported an improvement in ritualistic behaviors and reaction to changes in routine (Tood, 1991; Cook et al., 1992), whereas its efficacy in social functioning remains unclear (Mehlinger et al., 1990; DeLong et al., 1998). In this work, we found that all patients improved their social functioning, which could be caused by a primary improvement of the rituals, stereotypies, and repetitive thoughts.

A multidimensional approach to therapy for autistic disorder should be considered. Fluoxetine at doses of 20 mg/day could minimize behavior disturbances in some cases and increase the effectiveness of integrated therapies in these patients.

Marta Peral, M.D.
Department of Child Psychiatry
Hospital Niño Jesus, Madrid
Margarita Alcamí, M.D.
Department of Psychiatry
SS Mental Vallecas, Madrid
Inmaculada Gilaberte, M.D.
Clinical Research Department, Lilly
Madrid

Cook EH, Rowlett R, Jaselkis C, Leventhal BL (1992), Fluoxetine treatment of children and adults with autistic disorder and mental retardation. *J Am Acad Child Adolesc Psychiatry* 31:739–745

DeLong GR, Teague LA, McSwain Kamran M (1998), Effects of fluoxetine treatment in young children with idiopathic autism. *Dev Med Child Neurol* 40:551–562

Mehlinger R, Scheftner W, Poznanski E (1990), Fluoxetine and autism (letter). *J Am Acad Child Adolesc Psychiatry* 29:985

Riddle MA, King RA, Hardin MT et al. (1990/1991), Behavorial side effects of fluoxetine in children and adolescents. *J Child Adolesc Psychopharmacol* 1:193–198

Tood R (1991), Fluoxetine in autism. *Am J Psychiatry* 148:8

The Letters column is a corner of the *Journal* that encourages opinion, controversy, and preliminary ideas. We especially invite reader comments on the articles we publish as well as issues or interests of concern to child and adolescent psychiatry. The Editor reserves the right to solicit responses and publish replies. All statements expressed in this column are those of the authors and do not reflect opinions of the *Journal.* Letters should not exceed 750 words, including a maximum of 5 references. **They must be signed, typed double-spaced, and submitted in duplicate.** All letters are subject to editing and shortening. They will be considered for publication but may not necessarily be published nor will their receipt be acknowledged. Please direct your letters to Mina K. Dulcan, M.D., Editor, Journal of the AACAP Editorial Office, Children's Memorial Hospital, 2300 Children's Plaza #156, Chicago, IL 60614-3394.

Insurance Reimbursement for the Treatment of Obesity in Children. Andrew M. Tershakovec, MD, Miriam H. Watson, MS, RD, William J. Wenner, Jr, MD, Alison L. Marx, MBA

Objective: Although the prevalence of obesity among children in the United States is rapidly increasing, third party payer reimbursement for evaluation and management may be limited. The purpose of this analysis is to evaluate third party payer reimbursement rates for a pediatric weight management program for obese children and associations among child characteristics (eg, degree of obesity), insurance policy type, and reimbursement rates. *Study Design:* Cross-sectional survey in a tertiary care pediatric medical center. Reimbursement rate of charges for initial evaluation and management and patient characteristics were evaluated for children 2 years or older enrolled in the Children's Hospital Weight Management Program. *Results:* From October 17, 1995, to December 23, 1997, 191 children were evaluated in the Children's Hospital Weight Management Program. The children were on average 10.1 ± 0.3 years old, with a mean body mass index z-score of 4.9 ± 0.2; 46% were black, and 65% were female. The median reimbursement rate was 11% and varied widely (0% to 100%). Reimbursement rates differed significantly among policy types. Reimbursement rates did not differ between boys and girls or white and black children, nor were reimbursement rates associated with the degree of obesity. *Conclusions:* Despite the need for weight management services for obese children, these low reimbursement rates preclude the long-term financial viability of such programs without external support or a significant proportion of patients who can pay "out-of-pocket." **J Pediatr** 1999;134:573–578. Reproduced with permission from Mosby-Year Book, Inc.

Abstracts selected by Michael J. Maloney, M.D., Assistant Editor.