lations and the actual day of the week when dialysis was performed in our study population.

In the U.S. population overall, the variability in mortality is much smaller than we observed among typical patients receiving hemodialysis. For example, among 2,428,343 deaths in 2007, the proportions occurring on Sunday through Saturday were 14.2%, 14.5%, 14.2%, 14.2%, 14.2%, 14.4%, and 14.5%, respectively.1 Within the data set for our primary study report, outcome patterns were similar in the Monday, Wednesday, and Friday (MWF) and Tuesday, Thursday, and Saturday (TTS) populations in the sense that event rates were highest on Mondays in the MWF group and on Tuesdays in the TTS group. For example, in the MWF group, the annualized Sunday through Saturday mortality was 16.1, 21.8, 17.4, 18.8, 17.6, 18.3, and 18.0 per 100 person-years, as compared with 17.0, 22.5, 17.7, 19.8, 19.1, and 18.0 in the TTS group. Corresponding cardiovascular event rates were 23.2, 44.7, 28.4, 33.8, 25.1, 29.7, and 17.1 in the MWF group and 17.7, 33.9, 43.4, 26.1, 30.6, 22.7, and 25.7 in the TTS group. Hence, patterns of mortality appear to be more related to the interdialytic interval than to the actual day of the week.

Only 260 patients (0.8%) in the data set underwent dialysis more frequently than three times per week, and it is difficult to gauge scheduling from the dates of predialysis blood urea levels. Of the 137 deaths observed, the proportions from Sunday through Saturday were 13.1%, 13.9%, 11.0%, 18.3%, 15.3%, 10.2%, and 18.3%. Hence, there was no evidence of a Monday effect in this small subgroup. Variability appears to be less marked in the U.S. population receiving peritoneal dialysis. For example, unpublished data from the United States Renal Data System for 2007 showed that from Sunday to Saturday, the proportions of deaths in the prevalent peritoneal dialysis populations were 13.3%, 14.5%, 14.3%, 14.5%, 14.3%, 14.8%, and 14.3%.

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**Contraception in Primary Care — Embracing the Institute of Medicine Challenge**

**TO THE EDITOR:** On July 19, the Institute of Medicine released a historic report outlining key preventive health services for women to be covered by insurers under the Affordable Care Act (ACA) without consumer cost sharing. Particularly notable was the report’s inclusion of contraception, with the implication that insurers should fully cover the costs for all contraceptive methods approved by the Food and Drug Administration (FDA), as well as for education and counseling.1 These recommendations were accepted by the secretary of health and human services and will be incorporated into the ACA’s minimum package of essential health benefits by August 2012. As Cleland et al. have argued,2 adoption of these recommendations would represent a significant step forward for women’s health, since half of U.S. pregnancies are unintended, and unintended pregnancies carry higher risks for women and children.

Also needed, however, are reforms in medical education and primary care delivery to ensure that women receive safe, effective, and appropriate contraceptive care. Surveys of medical schools, residents, and physicians show that training in contraceptive counseling and provision is insufficient.3,4 A particularly problematic issue is the shortage of providers trained in highly effective, reversible contraceptives, such as intrauterine devices (IUDs) and implants. These methods have been recommended by the American College of Obstetricians and Gynecologists as first-line contraceptives for most women, and experts believe that increased use would dramatically reduce the rate of unintended pregnancies. Despite data supporting their use, however, IUDs or implants...
TO THE EDITOR: Vemurafenib is an inhibitor of the BRAFTV600E mutation and has recently been approved by the Food and Drug Administration (FDA) for treatment of metastatic melanoma in adults in the absence of brain metastases.1-3 Trials are currently under way involving the use of vemurafenib for the treatment of melanoma that has metastasized to the brain. Because of the low incidence of melanoma in children, vemurafenib has not been studied in children, to our knowledge. We present a case of the successful use of vemurafenib therapy in a child with melanoma that metastasized to the brain.

In February 2011, a 16-year-old girl presented to our clinic with rapidly progressing hemorraghic melanoma metastases to the brain after stereotactic radiosurgery. Symptoms included severe headache, somnolence, seizures, nausea, and confusion. A magnetic resonance imaging (MRI) scan of the brain (Fig. 1A and 1B) showed increased size of all known metastases relative to a previous MRI scan, obtained in November 2010. The largest lesion was in the left frontal lobe (5 cm in greatest dimension) (Fig. 1B), with smaller metastases in the left frontal operculum (2.3 cm), the pons (1.8 cm), and the right parietal lobe (0.5 cm). All were associated with substantial vasogenic edema.

The original diagnosis of metastatic melanoma (soft-tissue metastases) was made in March 2010. The patient was treated initially with high-dose interleukin-2 and subsequently with ipilimumab. By November 2010, new systemic and brain metastases had developed. The patient declined cytotoxic chemotherapy and underwent stereotactic radiosurgery for the tumors in the brain. A workup revealed that she had melanoma with the BRAFTV600E mutation. Because of the patient’s rapidly deteriorating neurologic status resulting from progressive melanoma in the brain,