Table. Patient Nutritional Delivery Over 10 Days

	Total (n = 63)	Type of Nutrition Received		
		Parenteral Only (n = 4)	Enteral and Parenteral (n = 5)	Enteral Only (n = 54)
Mean (95% CI)				
Protein, g/kg of IBW	6.7 (5.3-8.2)	2.3 (0.72-3.8)	4.2 (2.2-6.3)	7.3 (5.7-8.9)
Calories, kcal/kg of IBW	158.4 (143.9-172.9)	194.3 (45.7-342.9)	142.6 (92.6-192.5)	157.2 (141.9-172.6)
Median (range), d				
Initiation of feeding	1 (1-4)	1 (1-2)	2 (1-4)	1 (1-4)
Full feeding regime	2 (1-10)	2 (1-9)	5 (2-8)	2 (1-10)
No nutrition delivered	1 (0-6)	1 (0-5)	1 (0-6)	1 (0-6)

Abbreviation: IBW, ideal body weight.

Day correctly identified some errors of transcription that affect neither the results nor the discussion. These have been corrected online, and we apologize to the readers. However, certain confidence intervals crossed zero appropriately (eg, those for muscle wasting in patients with single organ failure, who do not show significant muscle loss). The confidence interval for change in muscle atrophy factor crossed zero but was statistically significant because these data were nonnormally distributed using the 2-tailed Wilcoxon signed rank test. In addition, $\log_{10}$-transformed values yielded a value of 0.03 (2-tailed paired *t* test) for 7-day change in muscle atrophy factor.

Predicting muscle loss was not our study's primary aim. Because it was unique in design, no expert body of evidence could guide variable selection for multivariable analysis. We thus sought a parsimonious model (with the attendant concerns noted by Day) for hypothesis generation for future studies with larger numbers.

Nevertheless, a model controlling for age, sex, organ failure, Acute Physiology and Chronic Health Evaluation II score, insulin received, protein received, total calories received, serum C-reactive protein, calcium, bicarbonate, and ratio of Pao_2 to fraction of inspired oxygen (Fio_2) confirms the importance of variables found by stepwise regression (odds ratios [ORs] are per unit variable change for 10% loss in rectus femoris cross-sectional area by day 10). There was an OR of 0.904 (95% CI, 0.818-1.000; $P = .045$) for ratio of Pao_2 to Fio_2, an OR of 1.001 (95% CI, 0.999-1.003; $P = .10$) for C-reactive protein, and an OR of 0.666 (95% CI, 0.453-0.978; $P = .03$) for bicarbonate; c statistic, 0.949 (95% CI, 0.861-0.989), Hosmer-Lemeshow goodness-of-fit test, $P = .61$.

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Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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Fetal Outcomes Associated With Metoclopramide Use in Pregnancy

To the Editor In the study on the use of metoclopramide during pregnancy and the risk of congenital malformations and fetal death,[1] explicit details as to the dosage of metoclopramide were not reported. The only stratification made was women receiving 1 prescription vs 2 or more.

Specifically, information was lacking on the dose and the total amount of metoclopramide to which the fetuses were exposed, along with the duration of exposure and the form of administration. Because these factors can affect the molar concentration and the bioavailability of the drug,[2] provision of this information is important to evaluate the actual exposure of the fetuses.

The teratogenic effect of many drugs used during pregnancy has been reported as being dependent on dose.[3] The analysis of metoclopramide exposure should consider a dose-dependent risk for congenital malformations.

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In Reply Dr Vrachnis and colleagues claim that our study does not account for dosage with sufficient detail. We do not agree.

First, they state that dosage was not reported in the article. However, the number of dispensed doses was reported as a median of 40 doses (interquartile range, 30-40 doses). The number of dispensed doses corresponds to units of the drug, which in Denmark includes tablets containing 10 mg and suppositories containing 20 mg, 2 formulations of metoclopramide that are considered equipotent.

Second, Vrachnis and colleagues suggest the need for dose-response analyses. Given the narrow distribution of the number of doses received in our study, dose-response analyses are not feasible.

The sensitivity analyses according to the number of received prescriptions (1 and 2 or more) were not intended as dose-response analyses. Rather, they were conducted on the assumption that women refilling prescriptions are more likely to have taken the drug.

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Geographic Differences in US Health Care Spending

To the Editor In their Viewpoint regarding the Institute of Medicine (IOM) report on geographic variation in health care spending, Drs Newhouse and Garber[1] indicated the spending data were adjusted for geographically different input prices.

Use of a flawed input price-adjustment method leaves many of the IOM report's conclusions in doubt. The input price adjustment did not use the actual dollars spent on physician work but used geographic practice cost index (GPCI) adjusters to change the spending figures to reflect local differences in input price.[2]

The problem is that the GPCI does not use real data on physician labor prices for determining the adjustment but instead uses the wages of other professionals by region to set the price of physician labor. The GPCI adjustments have never used actual physician compensation figures, and there has never been proof of a relationship between the wages of other professionals and physicians by region.

The Medicare Payment Advisory Commission has stated "the current GPCI is flawed in concept and implementation" and urged Congress to "direct the Secretary to develop an adjuster to replace it."[3]

Even though the GPCI input price adjustment of Medicare data may be useful to determine differences in use, adjusting private insurance data are even more unreliable due in large part to the variation in physician supply and demand that drives even greater variation in the regional price of physician labor.

Using the actual dollars paid to physicians rather than adjusting spending data using flawed input prices based on the wages of other professionals might lead to different conclusions.

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In Reply Dr Kitchell provides us an opportunity to explain the methods used in the IOM report on geographic variation more fully. The report used Medicare's GPCI to adjust physician spending for geographic variation in input prices. We know of no serious concerns about the measurement of the price of the nonphysician inputs in the GPCI, such as the wages of billing clerks.

Questions about the GPCI center on the weight given to its physician work component and how well the geographic units it uses approximate local labor markets. Fortunately, the effects of inaccuracies in these 2 dimensions are necessarily limited. Physician work accounts for about half of physician costs (slightly more or less depending on the year), but by statute it is only given a weight of one-quarter of that amount in the actual index.[1]

Whether one-quarter is the proper weight does not much matter for our purposes because spending on physician and clinical services accounts for only 24% of total medical spending and 22% of Medicare spending.[2] Consequently, any misweighting of the work component of the GPCI affects at most about one-eighth of the input price index used to adjust both