However, when unfortunate circumstances coincide, one may lead to the other.

My most important point is that hypoglycaemia unawareness increases the risk of serious and sometimes even fatal consequences of the ensuing hypoglycaemia. During hypoglycaemia unawareness, there will be no autonomic or adrenergic warning symptoms of falling blood glucose concentrations.[1] Autonomic symptoms are more difficult to recognise while supine, even without hypoglycaemia unawareness.[2] Increasing evidence has shown that hypoglycaemic episodes precede the development of hypoglycaemia unawareness.[1] Hypoglycaemic unawareness will raise the risk of having severe hypoglycaemia five-fold to six-fold,[1] and is more common among those having severe hypoglycaemias.[2,3]

After an undetected overdose of short-acting insulin, there is an obvious risk that the patient with hypoglycaemia unawareness will not wake up and there will be no signs of sweating or struggling. If the patient wakes up when blood glucose is very low, neuroglycopenic symptoms will make it very difficult to take appropriate action. Electroencephalographic changes will occur when the blood glucose falls below about 2 mmol/L,[4] and unconsciousness happens at a blood glucose of about 1 mmol/L. QT-interval prolongation and hypokalaemia have been recorded during nocturnal hypoglycaemia of less than 3 mmol/L.[5] Seizures do not always accompany very low blood glucose. Death may be caused by arrhythmia secondary to exaggerated potassium disturbances. However, if the patient discovers the accidental injection, appropriate action can be taken and no serious consequences will occur.

I certainly agree with the comment that an undetected accidental overdose of short-acting insulin as a result of taking the wrong type of bedtime insulin is not always the cause of the dead-in-bed syndrome. However, it may very well be the explanation for some of these cases, and since it is avoidable by using different designs of pens or different sizes of bottles for daytime and bedtime insulin. I certainly advocate that we make our patients aware of this risk.

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New treatments and azathioprine in multiple sclerosis

SIR—Jackie Palace and Peter Rothwell (July 26, p 261)[1] drew attention to the use of azathioprine in multiple sclerosis (MS) patients. We are currently following 571 MS patients in our centre. 106 MS patients had had at least two relapses of neurological symptoms before starting treatment with azathioprine (100–250 mg daily) and prednisone (7·5–15 mg daily). 76 have been continuously treated with azathioprine for more than 3 years. Six of these patients have died (two accidental deaths, one after status epilepticus, one of myocardial infarction, one of bronchopneumonia, and one suicide) and four have been lost for follow-up. 24 (36%) of the remaining 66 patients have improved and have remained mobile for 5–15 years (median 9 years and 8 months). The condition of four (6%) has not worsened. 14 (21%) showed progressive motor deficits mainly affecting the legs, in which there was muscle weakness without neurological symptoms. Liver-function tests and blood counts were done every 2–3 months. In one MS patient azathioprine was stopped because of agranulocytosis.

I am unable to compare results in these MS patients treated with azathioprine for at least 3 years with those in 121 patients treated at this centre with interferon β (INFβ). INFβ-1a has been available for only 18 months and only three of 13 MS patients treated with INFβ-1b have been taking this drug for more than 3 years.

Azathioprine treatment is a sixth of the cost of INFβ. I believe that azathioprine should be used to treat MS patients with progressive neurological symptoms provided that the potential side-effects of continuous immunosuppression are monitored.

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Selective serotonin reuptake inhibitors in anorexia nervosa

SIR—We have previously reported that the bodyweight of patients with anorexia nervosa dropped by 5·4 kg and that the patients attained an alarmingly low body-mass index (12·2 [range 10·6–16·7] kg per m^2) when treated with a selective serotonin reuptake inhibitor (SSRI).[1] This effect was not surprising because serotonin inhibits food intake. For this reason, serotoninergic agonists are used to reduce bodyweight in the obese.[1]

So we were surprised that David Collier and colleagues (Aug 9, p 412)[2] refer to preliminary evidence that SSRIs are "effective" in increasing bodyweight in anorexic patients. Less surprising, Per Björntorp (p 423)[3] repeats that serotoninergic agonists are used in obesity in the same issue. Perhaps the rationale for using SRRIs in anorexia nervosa should be explained to readers of *The Lancet*

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Authors' reply

SIR—We agree that the treatment of anorexia nervosa with selective serotonin reuptake inhibitors (SSRIs) is controversial. In the limited space of a letter we were unable to address this argument in detail.

There have been two published reports of open trials of fluoxetine for anorexia nervosa. Kaye and colleagues[1] treated patients who had undergone inpatient weight restoration with fluoxetine and found that 29 of 31 patients maintained their weight at or above 85% of average bodyweight. Gwirtsman and co-workers[2] reported a series of six patients with chronic refractory anorexia who were treated with fluoxetine, and all gained weight. Case reports have described similar findings.[3,4] Taken together, these reports suggest that in at least some cases of anorexia nervosa, SSRIs may be a successful treatment. Indeed, the preliminary results of a double-blind, placebo-controlled clinical trial by