the level of methodologic rigor in our study was considerable, including a randomized trial with an intention-to-treat approach and the use of state birth records to document birth outcomes. Second, both clinical trials[3,4] and nonexperimental studies[5,6] support the notion that home visitation can effectively reduce the rate of LBW. Third, we disagree with their assertion that "Many of the factors that lead to poor birth outcomes are not known or amenable to modification during pregnancy. Smoking is the exception." Several research studies have shown links between LBW and a variety of psychosocial factors such as social support,[4,7] stress,[8,9] engagement of the fathers,[10] and improved access to services.[11] Finally, given that more than 75% of the women in our sample were nonsmokers, a prenatal intervention focused exclusively on smoking cessation would be of no benefit to the majority of women served by HFNY.[1,12]

We do agree on the need for additional research studies that from the outset are designed to examine the mechanisms through which reductions in rates of LBW are achieved. In the interim, however, there are plenty of examples in medicine (e.g., penicillin) where interventions have been recommended and used prior to understanding the operating cause, especially if the potential benefits outweigh the risks associated with withholding the intervention. We thus stand by our conclusion that "a prenatal home visitation program . . . holds promise for reducing LBW deliveries among at-risk women and adolescents."[1]

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Saved by the Carbon Monoxide Alarm

To the Editor: As an individual very interested in the epidemiology of carbon monoxide (CO) poisoning, I read with interest the article by Weaver and Deru[1] describing acute, severe CO poisoning occurring in hotels, motels, and resorts. Prior to that publication, it had not occurred to me that I was at increased risk for CO poisoning in those environments. Because the paper pointed out the general lack of CO alarms in public lodging facilities, I purchased and began to carry in my computer satchel a personal CO monitor designed for industrial applications (Lumidor Minimax XT, Honeywell).

I recently traveled to a luxury fishing resort in Alaska for a week-long vacation. The lodge building itself had one lower-level guest room adjacent to the utility room. Two guest rooms were on the center floor, and a communal kitchen/lounge was on the top floor. Room heating and kitchen cooking were electric. Water heating was by a natural gas boiler.

While unpacking my suitcase in my room on the center floor, I heard a beeping noise that I first thought was an alarm clock. I then realized that it was coming from my computer bag. My CO monitor was in full alarm, reading 26 ppm CO. Well aware of the significance of this reading, I knew that I had time to track down the source. As I went downstairs, the monitor reading continued to rise, reaching 80 ppm in the basement bedroom. Upon entering the utility room, the level jumped to 106 ppm and the alarm entered Phase 2 of severity. The only fuel-burning appliance in the room was the water heater. I turned off the gas supply, and CO levels throughout the building dropped precipitously.

A plumber subsequently discovered improper venting of the water heater. Once the heater was repaired, the CO level in my room measured 0 ppm. The lodge owner was sufficiently impressed by this demonstration; he installed CO alarms in all sleeping units of the resort, even though they are not mandated by federal law at this time.

I went away thinking that Dr. Weaver's article may have saved many individuals, including myself, from chronic brain injury or even death.

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