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In Reply.—We agree with Dr Wilke that the pathogenesis for the increased risk of ESRD caused by glomerulonephritis among silica-exposed gold miners is unclear. In our article, we described the competing theories of pathogenesis, ie, immunologic injury vs direct toxic effect of silica. Our intent was to give equal attention to these 2 theories. As is the case with silicosis, evidence of immunologic injury has been observed in some, but not all, silica-exposed patients with renal injury.[1]

Therefore, different mechanisms of toxicity may be operating in different patients. In patients with evidence of immunologic abnormality, it is not clear if these abnormalities are directly responsible for renal injury or if they are a response to the direct toxic effect of silica. It is worth noting that there is evidence linking silica exposure to a broad range of autoimmune diseases.[2]

One factor responsible for the variability in the mechanism of silica toxicity may be related to particular properties of silica-dust exposure. For example, the pathologic potential of silica dust is related to the mechanism of dust production.[3,4] Freshly ground silica dusts appear to be more cytotoxic and more inflammatory compared with aged silica dusts.[3,4] In addition, when grinding is conducted without water, the silica dusts produced appear to contain more surface radicals compared with grinding in the presence of water.[3]

Clearly, much remains to be determined about the mechanism of crystalline silica toxicity, and additional study is needed to improve our understanding of the relation between silica exposure and ESRD.

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Assessment of Domestic Violence at the Scene of Domestic Assaults

To the Editor.—We applaud Dr Brookoff and colleagues[1] for looking beyond the medical setting to understand the dynamics of domestic disputes. Clinicians who treat victims of domestic violence know that these are episodic events that we only occasionally glimpse. The participants in this study admitted that they had been victims of abuse over time but had not used medical services as a primary means for seeking assistance. To date, much of the research on domestic violence has myopically focused on the clinical arena and has not stressed the potential lethality of these cases.

Several sources confirm that many victims of domestic violence eventually succumb to homicide.[2] We have had a similar experience with evaluating victims and their use of the 911 emergency system. In a preliminary observational study, we found that of 29 women (aged 13-73 years) who had been murdered in domestic disputes, 17 (59%) had made previous calls to the 911 system from their place of residence within 2 years prior to their death; many victims had made multiple calls (ie, total of 72 calls to 911 from 17 residences). Only 18 of 72 calls resulted in transport of the patient to a health care facility. Of the remaining 54 calls, 7 were for patients found dead on arrival (DOA), only 3 of whom had no prior 911 calls to their place of residence. One of the DOA victims had made 8 prior calls to 911, all of which were cancelled or the patient refused further assistance.

These calls are an opportunity for intervention in potentially life threatening situations. Brookoff and colleagues[1] documented the desperate situation of these individuals at a time of crisis and confirmed that calls to police for help are common during these times.[3] However, by eliminating "repeat calls" Brookoff et al have missed what we believe may be a key factor in the lives of these victims: repeated calls to 911 may be an identifying factor for individuals at greatest risk for severe domestic violence–related injury or death. The authors have not reported the number of repeat calls or the frequency of repeat calls and state only that "most victims had called the police for help during previous assaults" and 78% of victims had never sought help from other sources. Moreover, the sequelae from the victims' previous attempts to get help and the subsequent abuse of these women after the study visit are not reported. Minimal interventions were offered to the victims, but as the authors correctly identify, victims may refuse to accept interventions and refuse to prosecute their assailants for fear of retaliation. This is a well-warranted concern. We would be interested in the results of a follow-up study of the victims, including a search for fatalities through the coroner's office in Memphis, Tenn.

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In Reply.—The data presented by Dr Datner and colleagues reinforce previous studies that show that a crisis due to domestic violence can be a life-threatening event but often is not treated like one.[1] The emergency interventions that they studied, just like the ones that we observed, probably were carried out by police with minimal, if any, involvement by health care workers. Our observations have led us to conclude that a crisis due to domestic violence is as much a health emergency as it is a police emergency. Even though domestic violence typically is a chronic condition punctuated by intermittent crises, developing an effective acute response to the crises may be the first step to generating effective interventions and preventive strategies.[2] This certainly has been the case with other life-threatening conditions such as heart disease and depression.

We have begun to explore novel interventions linked to 911 calls for help such as the use of an on-call crisis intervention team. We also have started taking our medical residents with us to the scenes of domestic assault. While all of these resident physicians have been shocked and saddened by what they have seen, most have expressed hope that they can play a part in addressing this problem and have shared this hope with the victims they have met. Because domestic violence takes place