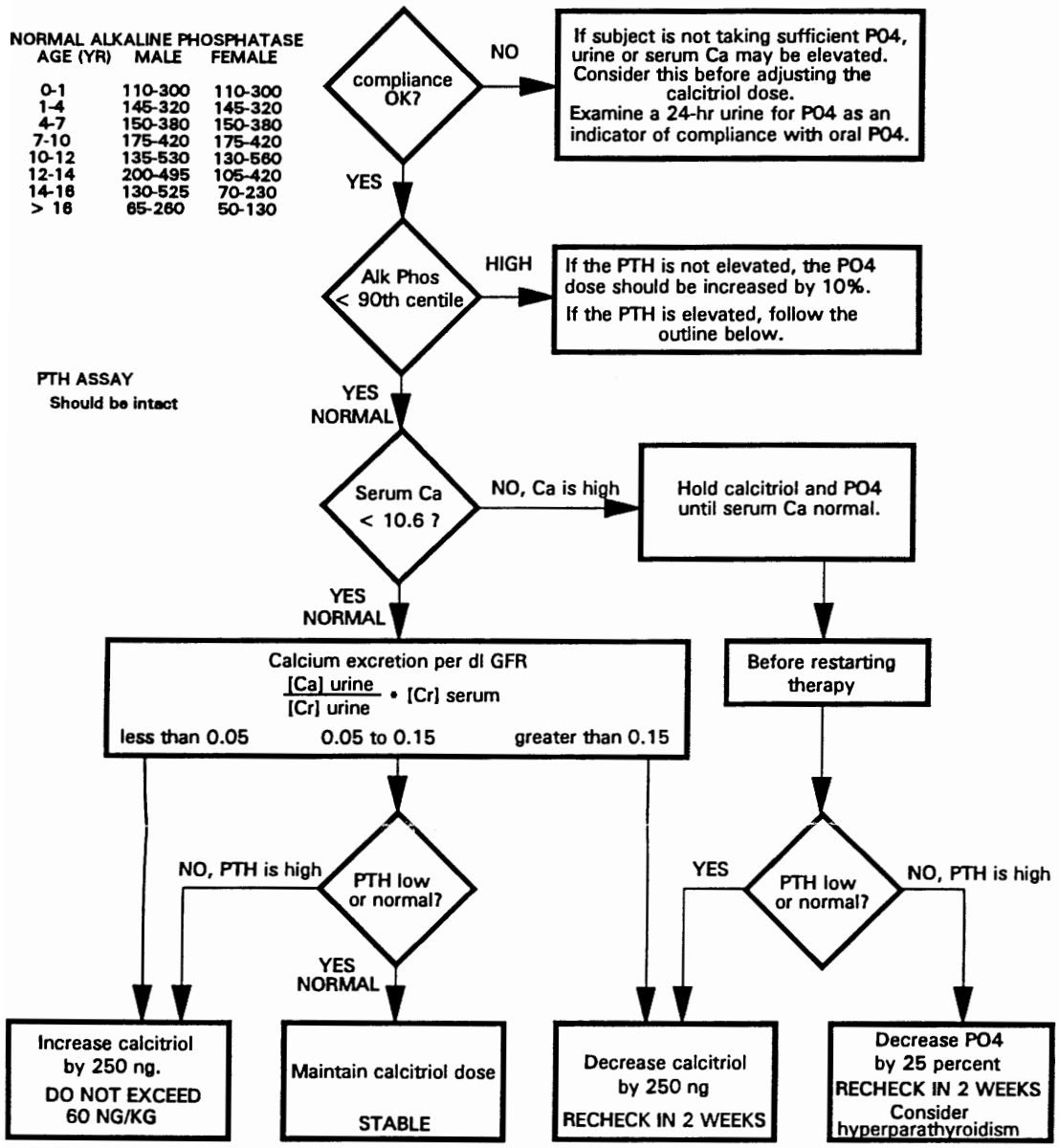

FIGURE 2. Algorithm for the adjustment of therapy in patients with XLH. First, because a significant interaction occurs between calcitriol and phosphate therapy, patients must comply with both drugs. At each visit, compliance with therapy must be assessed as failure to take one or both medications can affect mineral balance. Knowledge of poor compliance may require clinically indicated adjustment in medications that are different than those suggested by the flow chart. Clinical and laboratory information may well dictate more frequent visits. Second, if the subject's case of rickets does not improve (as measured by the alkaline phosphatase), the oral PO_4 dose should be increased if tolerated. Third, if the subject is hypercalcemic ($Ca^{2+} > 10.6$ mg/dl), euparathyroid, and has been taking adequate phosphate (see above), the calcitriol dose should be reduced by 250 ng and the serum calcium remeasured within 7 to 14 d. Fourth, if the subject is normocalcemic, then the excretion of urinary calcium and the serum PTH concentration dictate adjustments in the calcitriol dose. Note the maximum recommended calcitriol dose is 60 ng/kg.

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