

Letters to the Editor

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Is Routine Testing of Vitamin B₁₂ Cost-effective in Workup for Cognitive Impairment?

Original Article: Update on Vitamin B₁₂ Deficiency

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TO THE EDITOR: As a special consideration, the authors of this article mention the current lack of evidence supporting vitamin B₁₂ supplementation for the treatment of Alzheimer disease and other types of dementia. We have also been discouraged by the paucity of studies demonstrating the effectiveness of vitamin supplementation in the treatment of cognitive decline, and thought it pertinent to also raise the point of cost consideration.

The American Academy of Neurology guidelines on cognitive impairment state that screening instruments, such as the Mini-Mental State Examination, may be helpful diagnostic tools.¹ The physician is advised to rule out structural defects, depression, hypothyroidism, and vitamin B₁₂ deficiency as causes of the cognitive impairment. The U.S. Department of Health and Human Services publishes an annual overview of Medicare reimbursement rates for such laboratory tests. It states that measurement of vitamin B₁₂ costs \$21.59, measurement of folate costs \$21.06, and measurement of homocysteine costs \$24.16.²

Although the cost of measuring vitamin B₁₂ is small, given the frequency with which it is performed, there is considerable cost to society. The Geriatric Mental Health Foundation estimates that 360,000 new diagnoses of Alzheimer disease are made each year, and the number of diagnostic examinations performed is expected to triple in the next 50 years as the Baby Boomer generation ages.³ Cost-effective, evidence-based guidelines are needed to direct the evaluation of dementia in an aging population, because

there is a strong trend toward the use of broad diagnostic panels instead of specific tests based on clinical judgment.

Routine measurement of vitamin B₁₂ may not be necessary in the absence of symptoms suggesting pernicious anemia or in the presence of severe malnutrition. Assuming that most diagnostic workups for dementia are paid from Medicare reimbursements, the cost of vitamin investigation would incur a charge of more than \$7 million annually for Alzheimer disease diagnoses. This figure does not include patients tested who ultimately are not diagnosed with Alzheimer disease, and would be expected to increase with the aging population. If examined from the standpoint of cost-benefit ratio to the individual and to society, it would seem that having a fixed "dementia panel" covering many remote possibilities offers very little beyond what can be suspected and detected by an observant physician who obtains an adequate history and performs an adequate physical and mental status examination.

MATTHEW W. WARREN, MD, PhD

MYRON F. WEINER, MD

Dallas, Tex.

E-mail: Myron.weiner@utsouthwestern.edu

Author disclosure: No relevant financial affiliations to disclose.

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IN REPLY: I sincerely appreciate the comments and observations from Drs. Warren and Weiner concerning the not insignificant financial ramifications of the widespread

use of “shotgun” testing, including vitamin B₁₂ testing for dementia. In an era of evidence-based clinical practice guidelines, it is tempting to excuse the nonjudicious use of laboratory and imaging studies as simply following recommendations from reputable sources. As physicians, it is imperative that we listen, examine, and form opinions. Only then should we seek to confirm potential diagnoses with laboratory or imaging studies, rather than substituting a standard array of tests for our interpersonal relationships and clinical skills. We would do well to heed the advice attributed to Sir William Osler: “Listen to the patient. He is telling you the diagnosis.”

ROBERT C. LANGAN, MD
Bethlehem, Pa.
E-mail: LanganR@slhn.org

Author disclosure: No relevant financial affiliations to disclose.

Electrodesiccation and Curettage for Removal of Nongenital Warts

Original Article: Treatment of Nongenital Cutaneous Warts

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TO THE EDITOR: I read this article discussing the treatment of nongenital cutaneous warts, and I appreciate the information shared by the authors. Throughout my 31-year career, I have often removed cutaneous warts by means of electrodesiccation and curettage under local anesthesia. This has proved to be a very effective and well-tolerated technique, which I learned during my residency many years ago. The rate of recurrence has been negligible. I often finish the procedure with the application of bichloroacetic acid to ensure hemostasis, as well as to help eradicate residual human papillomavirus. I would appreciate the perspective of the authors with

regard to the published effectiveness of this technique compared with other methods for removing cutaneous warts.

JONATHAN R. DREAZEN, MD
Reading, Pa.
E-mail: jdreazen@selectmedicalgroup.com

Author disclosure: No relevant financial affiliations to disclose.

IN REPLY: A wide range of therapies has been proposed for treatment of cutaneous warts. When choosing a treatment (especially a first-line treatment) for warts, we need to consider its cost, simplicity, effectiveness, and rate of adverse effects, including pain.

Surgical removal of warts by curettage followed by cautery was an early method that is still widely practiced. Although success rates of 65 to 85 percent have been reported, scarring and recurrence occur in up to 30 percent of patients.¹ However, there are no controlled trials or randomized controlled trials evaluating this approach.

Some experts recommend against surgical excision and cautery as a standard therapy for warts because it can cause pain and scarring that are difficult to treat.² Sharp surgical excision with 1-mm margins also has been described with excellent results and no recurrence in a hand surgery textbook.³ We found no published studies on the use of bichloroacetic acid after curettage.

ELIE MULHEM, MD
Rochester Hills, Mich.
E-mail: EMulhem@beaumont.edu

Author disclosure: No relevant financial affiliations to disclose.

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