

Atrophic Gastritis and Vitamin B₁₂ Deficiency

To the Editor—The recent paper by Krasinski et al.¹ describing the utility of serum pepsinogen I and pepsinogen II levels to identify fundic atrophic gastritis in the elderly includes some interesting findings. I believe their conclusion relating atrophic gastritis to vitamin B₁₂ deficiency requires clarification. The data clearly show an increase in the prevalence of low serum vitamin B₁₂ levels with increasing severity of atrophic gastritis as defined by the authors. However, one may not equate vitamin B₁₂ deficiency with a low serum vitamin B₁₂ level given the high false-positive rate of the serum B₁₂ level.²⁻⁴ Thus, further assessment of the 17 subjects with low vitamin B₁₂ levels with respect to: 1) hematologic and neurologic parameters (eg, anemia, macrocytosis, or proprioceptive defects); 2) the presence of B₁₂ malabsorption (Schilling's test); and 3) an indirect measure of "tissue" level of B₁₂ (urine or serum methylmalonic acid determination)^{3,5,6} would be required before a diagnosis of vitamin B₁₂ deficiency could be supported. If this data could be provided for these subjects, the authors' conclusion that atrophic gastritis, as defined by their method, is associated with vitamin B₁₂ deficiency (as well as with low serum vitamin B₁₂ levels) would be valid.

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Intermittent Skin Mottling in Elderly Patients

To the Editor—I am writing this letter to share an observation made at this institution in the past few months. The Hebrew Home & Hospital is a 315-bed, long-term care facility (nursing home) whose patient/residents enjoy a mean age of over 84 years.

On a number of recent occasions I have been asked to see patients because they were found in bed, in no distress, with their skin mottled over various parts of their bodies and their toenails and fingernails cyanotic, but lips pink. There was no accompanying dyspnea or orthopnea and physical examination singularly unremarkable. Electrocardiograms unchanged from prior tracings. Temperature and blood pressures were normal. Measurements of such parameters as arterial blood gases, complete blood counts, and urine analyses were within normal limits. These episodes of skin mottling lasted for approximately 15 to 20 minutes, spontaneously disappeared only, then returned once or twice again anywhere from 30 minutes to hours later. At no time did the patients have any complaints nor did they appear particularly ill.

The unique observation is that all of the patients described above were dead within 24 to 36 hours, having quietly expired in their sleep.

To the best of my knowledge, there is no report of a similar observation in medical literature. It is well-known that sudden and abrupt death occurs only from a massive pulmonary embolus or a hard to document cardiac electrical event such as ventricular fibrillation. It might be useful in the future to immediately place an alive but mottled patient on a Holter monitor to exclude an electrical death.

It has been the purpose of this letter to share an observation about a sign of imminent death (intermittent skin mottling) in elderly patients who, immediately prior to "passing on," could not be considered sick, or having undergone an abrupt clinical deterioration terminating in death. One can only speculate that the described possible "sign" might be the evidence of an irreversibly compromised system ready to "turn off" or getting ready to shut down.

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