

As mentioned by Myrianthefts et al. and Lima et al., acinetobacter can manifest as wound infections. As we noted, in one series of patients affected by a natural disaster, 20% of wounds were infected with acinetobacter; acinetobacter was also a common cause of infected wounds in the battlefield and burn injuries. Our experience in the greater Chicago area is that acinetobacter detected in wounds more frequently tends to be a contaminant than an actual pathogen. Nevertheless, in the majority of settings, the most common

presentations are respiratory, urinary, and blood infections.

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Does Preventive Care Save Money?

TO THE EDITOR: In the Perspective article by Cohen et al. (Feb. 14 issue),¹ a narrow construction of what constitutes prevention leads to erroneous conclusions about its potential impact and cost-effectiveness. The authors do not address preventive interventions that occur outside the doctor's office. These include basic public health services and many other policies that bear directly on health (e.g., seat-belt laws and smoke-free policies). Health gains achieved through population-based approaches often exceed those that can be accomplished clinically, and these approaches are often cost-saving or highly cost-effective.²

Even if one considers only prevention in clinical settings, many high-value services are substantially underutilized. For example, less than 50% of the target population receives smoking-cessation services, counseling about aspirin use, colorectal-cancer screening, and influenza vaccines. Increasing use of these four services to 90% would save more than 100,000 lives annually.³

Policymakers should support investment in prevention for the right reasons — namely, to improve health at an acceptable cost, even if the services will not reduce overall spending. If reduced spending is the goal, then policymakers should discourage use of low-value services, both therapeutic and preventive.

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THE AUTHORS REPLY: Fielding and colleagues correctly highlight community-based interventions as important preventive strategies to evaluate, but they fail to note that our analysis of 1500 comparisons described in 599 articles drawn from the Tufts Medical Center Cost-Effectiveness Analysis Registry (www.cearegistry.org) did in fact include a number of community-based interventions. Like clinical preventive services, nonclinical interventions are sometimes expensive (e.g., a ban on cell-phone use while people are driving, which costs \$380,000 per quality-adjusted life-year, or QALY¹) and sometimes cost-saving (e.g., folic acid fortification of grains² and condom distribution³). Other interventions cost the health care system more money than they save but generally deliver good value,⁴ meaning that they cost less than commonly recognized benchmarks for cost per QALY.⁵

We also agree that, as we stated in our article, “In addition to determining which preventive measures and treatments are most efficient, it will be necessary to identify those that are not yet fully deployed and those that could serve a large population and bring about substantial aggregate improvements in health at an acceptable cost.”

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Case 4-2008: A Pregnant Woman with a Swollen Left Breast and Dyspnea

TO THE EDITOR: As reported by Shulman et al. (Jan. 31 issue),¹ the first signs of a malignant condition in a young pregnant woman with lymphoma involving the mediastinum and left breast were noted at 26.1 weeks' gestation, and a live-born infant was delivered approximately 5 weeks later. Although the clinicians state that “the baby is well,” it may be too early to tell. There is an average lag time of 4.6 months between birth and the diagnosis of cancer transmitted from a mother to a child,² and although rare, transplacental metastases of maternal leukemias, lymphomas, melanomas, and carcinomas²⁻⁴ have been described. In addition to physical examinations, it may thus seem prudent to obtain computed tomographic (CT) scans of the boy's chest, abdomen, and pelvis, and to continue surveillance with complete blood counts, a comprehensive metabolic panel, and measurement of the serum lactate dehydrogenase level during the first year of his life, especially since the mother had multiple extranodal sites of disease and there has been no documentation of the macroscopic and microscopic examination of the placenta for tumor involvement.

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THE DISCUSSANTS AND A COLLEAGUE REPLY: Tolar and Neglia suggest that imaging and laboratory studies should have been performed in the infant because of the risk of transplacental passage of lymphoma. Although it was not reported in the Case Record, the placenta was examined after birth, and there was no gross or microscopic evidence of lymphoma. The infant's neonatal course was uneventful; routine radiographs and ultrasound studies were normal. The baby was seen by his pediatrician monthly for the first year of life, and there were no physical findings to suggest a malignant condition. At 6 months of age, an intramuscular capillary hemangioma of the abdominal wall was resected. At the last follow-up at 18 months of age, the child was well.

Although placental involvement by maternal lymphoma has been reported, it typically involves the maternal intervillous space, not the fetal circulation or the fetus.¹⁻³ We know of only two reported cases of maternal lymphoma with involvement of the intravillous space and engraftment of the fetus.^{4,5} Thus, the risk to the child of radiation