folic acid food fortification. Similar values were found among Ontario women of reproductive age.

We previously showed that plasma total homocysteine levels can be relatively insensitive for detecting vitamin B12 deficiency. A homocysteine concentration at or above 15 µmol/L has positive and negative predictive values of 7.4% and 97.2%, respectively, for the detection of a serum vitamin B12 concentration below 120 pmol/L. For vitamin B12 levels between 120 and 150 pmol/L, the corresponding predictive values are just 6.3% and 94.0%. In Fig. 1 of the article by Robertson and colleagues the mean homocysteine concentration was just 12 µmol/L even in the quartile of patients with the lowest serum vitamin B12 concentrations (below 203 pmol/L). Thus, it is unlikely that vitamin B12 deficiency could be efficiently detected on the basis of a homocysteine measurement equal to or greater than 15 µmol/L.

Their lack of use of a comprehensive and suitable definition of vitamin B12 deficiency leads us to question the authors’ conclusions that “vitamin B12 deficiency is surprisingly common among patients with vascular disease” and that “low serum vitamin B12 levels are a major determinant of elevated homocysteine levels and increased carotid plaque area.” With nearly 50% of patients omitted from their major analysis, could not age and serum creatinine alone have explained some of their findings?

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CORRECTION

A news article concerning the federal government’s decision not to renew funding to the Canadian Network for Vaccines and Immunotherapeutics stated that the network’s early success included the “beginning of the first Canadian clinical trial for a therapeutic HIV vaccine.” Although the final results of this research were presented at a conference organized by the network, the research itself was sponsored by the Canadian HIV Trials Network.

REFERENCE

1. Eggertson L. Vaccine network surprised by funding cut. CMAJ 2005;173(7):741-2.