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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Effectiveness of Vitamin B_{12} in Treating Recurrent Aphthous Stomatitis: A Randomized, Double-Blind, Placebo-Controlled Trial

To the Editor: We are satisfied to see that not only our last study, but recent research (including your own),[1,2] support the conclusions of our previous observations[3,4] as well. I have some commentaries on your remarks.

In my opinion, your adhering discs as well as sublingual tablets, injections, swallowed tablets, and intranasal sprays could be effective for many conditions (including recurrent aphthous stomatitis [RAS]) in regard to the effect of vitamin (Vit) B_{12} itself. Undoubtedly, the time of response depends on the chosen form of cobalamin (cyanocobalamin, methylcobalamin, or hydroxycobalamin), the mode of use, and individual dosage. For example, according to my own 6 years experience you can receive an adequate response to injections of Vit B_{12} (cyanocobalmin!) in first 2 or 3 wk. Nevertheless, some patients dislike injections and prefer tablets. The largest drawback our study was the issue of participant compliance. RAS is not a life-threatening disease, and therefore some patients even refused sublingual tablets.

The Mechanism of Successful Treatment Is Still Unclear

I disagree with the claim that the positive effect of Vit B_{12} on RAS is related to its local action on the buccal mucosa. How can you explain the response to parenteral treatment? I presume there is a generalized effect of Vit B_{12}, and we hold a "working hypothesis" which, in our opinion, could explain this phenomenon. Vit B_{12} has unique yet obscure and unrecognized function. We assume that there are universal, interchangeable (as required) biologically active substances that regulate different systems of our body and provide homeostasis. We propose that one of these substances is Vit B_{12}. Perhaps Vit B_{12} can correct defects caused by other biological substances. We call this phenomenon the "Master Key effect."[5] In summary, this fascinating and unelucidated topic definitely demands further research to disclose the underlying secrets nature set in this field.

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Re: Postepidural Headache: How Late Can It Occur?

To the Editor: I applaud the author's enthusiasm to contribute to the medical literature; however, a number of issues detract from the validity of the published data and any conclusions that may be drawn from it.[1] Although Dr. Reamy suggests that this is the first case to demonstrate the onset of postdural puncture headache (PDPH) beyond the well-accepted normal range of 1 to 7 days after epidural puncture, a range of 1 to 12 days has previously been reported in at least one case series as well as in editorials and review articles.[2–4]

According to the cited meta-analysis, the incidence of PDPH in an obstetric population is roughly 0.75% and occurs when there is an accidental entry into the intrathecal space while attempting epidural placement.[5] In this case, epidural placement was uneventful—ie, without dural puncture—and thus a mechanism for entry into the intrathecal space is unclear. Furthermore, it is impossible to place an epidural catheter through a 25-gauge needle; this is the instrument most often used to provide intrathecal analgesia.[3] It is unlikely that the patient received analgesia through this route because the duration of action (>4 hours) is beyond the abilities of intrathecal medications at conventional doses. Epidural catheters are typically placed through 16- to 18-gauge Tuohey needles.

Another major issue that is not adequately addressed in this report is the fact that the patient underwent a diagnostic lumbar puncture in the emergency department. Most emergency department lumbar puncture kits include a 20-gauge spinal needle, which carries a 40% risk of PDPH in the obstetric population.[3] Moreover, in the setting of an existing symptomatic dural puncture, further drainage of cerebrospinal fluid exacerbates symptoms. The patient's symptoms were apparently improved with intravenous analgesics, antiemetics, and fluid to the point that she was discharged from the hospital after the diagnostic procedure. Interestingly, the patient's symptoms worsened significantly the day after intervention in

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