Zinc for colds? Yes, but don't swallow whole!

In "Zinc for the common cold—not *if*, but when" (*J Fam Pract.* 2011;60:669-671), authors Rao and Rowland state that physicians should "advise patients to start taking zinc supplements (available as tablets, syrup, or lozenges) within 24 hours of the onset of a cold" and imply that zinc tablets can simply be swallowed. They seem to have based their general recommendation on a Cochrane review in which the authors concluded that "zinc administered within 24 hours of onset of symptoms reduces the duration and severity of the common cold in healthy people."[1]

Both the authors of your article and the Cochrane reviewers generalized too far, apparently forgetting that all the common cold treatment studies used zinc lozenges that dissolved slowly in the mouth, rather than (swallowed) zinc tablets or syrups. This is an extremely important difference, because oral dissolution of throat lozenges over a 20- to 30-minute period allows ionic zinc (which has multiple properties of value in treating colds[2]) to be locally absorbed and transported into the virally infected nose.[3] Swallowed tablets offer no such benefit to the nasal tissues.

In the first study of zinc lozenges for common colds, published in 1984,[4] my colleagues and I showed that it was possible to shorten the duration of colds by 7 days when zinc gluconate tablets (dietary supplements sold over the counter) were slowly dissolved in the mouth every 2 wakeful hours. The reduction in duration, as well as in symptom severity, is highly probable only if the tablets are used as throat lozenges.

Zinc gluconate tablets are available in most pharmacies. However, they have a foul taste and may induce nausea and vomiting. Zinc *acetate* lozenges that are sold without chelating additives do not have an objectionable taste and may be highly useful in combatting common colds.

George Eby, MS
George Eby Research Institute
Austin, Texas

1. Singh M, Das RR. Zinc for the common cold. *Cochrane Database Syst Rev.* 2011;(2):CD001364.
2. Eby GA. Zinc lozenges as cure for the common cold—a review and hypothesis. *Med Hypotheses.* 2010;74:482-492.
3. Sceusa NA, Ehrlich PM. Proof of electro-osmotic drug delivery: a prejudiced clinical trial, delivering from mouth to nose. *Drug Deliv Technol.* 2008;8:50-59.
4. Eby GA, Davis DR, Halcomb WW. Reduction in duration of common colds by zinc gluconate lozenges in a double-blind study. *Antimicrob Agents Chemother.* 1984;25:20-24.

The authors respond

We agree that for the treatment of the common cold, zinc needs to be absorbed in the mouth, as is the case with lozenges, rather than swallowed. Currently available zinc preparations marketed for treatment of the common cold are in lozenge, rather than tablet, form.

Goutham Rao, MD
Kate Rowland, MD
Chicago

CONTINUED

Zinc acetate lozenges that are sold without chelating additives do not have an objectionable taste and may be highly useful in combatting common colds.

One of the major priorities of ACOs is to generate savings by limiting utilization of services—the exact same fiscal incentive used by HMOs in the 1980s.

Accountable care organizations: HMOs by another name?

When accountable care organizations (ACOs) were proposed as part of the Patient Protection and Affordable Care Act in an attempt to reduce health care utilization and costs, the principal thrust was on "team care." The Centers for Medicare and Medicaid Services (CMS) envisioned the integration of a broad spectrum of providers, using a managed care model of sorts. The ACOs would assume both quality and financial responsibilities for patient care and satisfy extensive requirements focused on reducing duplication and improving prevention and wellness through a system that scored performance on 65 quality metrics. The ACOs were slated to begin operations on January 1 of this year.

In November 2011, after receiving comments from well over 1000 stakeholders, CMS issued its final rules.[1] The start date was pushed back to April 1, 2012. (ACOs can also begin on July 1, 2012, or on January 1 of subsequent years.) At the same time, the number of reportable quality measures was cut in half, to 33—in 4 domains, rather than the original 5. Other changes were made to make it easier for providers and hospitals in smaller metropolitan and rural markets to form ACOs.

Despite these changes, physicians face a number of operational challenges. As a retired health care consultant, here are a few that I've identified:

- **Accountability.** What so often gets lost in discussions of ACOs is the patient's role in the accountability equation. Considering that up to 80% of health care costs are related to chronic conditions tied to poor lifestyle behaviors,[2] providers must motivate chronically ill patients to modify the habits that have a negative effect on their health. Indeed, the long-term success or failure of ACOs could well depend on the organizations' ability to establish meaningful partnerships between those who dispense health care and those who utilize it.
- **Leadership.** In general, hospitals that take the leadership role in forming ACOs have some advantages, as they are likely to have greater experience in negotiating with third-party payers and governmental agencies, as well as greater access to capital than many physicians. In my experience, practicing physicians are far less likely to have the ability to form large, well-functioning groups able to agree on clinical guidelines, workload, or equitable ways to distribute revenues.
- **Health IT.** A robust IT structure, often difficult for physicians with solo or small group practices to afford, is a vital component for an ACO. Without a fully functional electronic health record, as well as health information exchange capabilities that make it possible to manage across multiple sites, an ACO has virtually no chance of success.
- **Incentives and cost.** ACOs could eventually anger the public because one of their major priorities is to generate savings by limiting utilization of services—the exact same fiscal incentive used by HMOs in the 1980s. What is equally troublesome is that a major goal of ACOs is to integrate a broader spectrum of providers under one corporate umbrella. Yet in almost all metropolitan areas, further consolidation—which the ACO model seems to support—ends up driving the cost of health care up.
- **The bottom line:** Even with the modifications to the proposed ACO model that are reflected in the final rule, the fiscal rewards for organizing are dependent on providers' ability to reduce Medicare spending. This appears unlikely, considering that most physicians continue to be reimbursed on a fee-for-service basis and a hospital's bottom line generally improves with each admission.

ACOs will fail under their own weight. I believe that in many ways, they are simply a more complicated version of the HMOs of the 1980s. Providers historically have had a dismal record when it comes to reducing costs in a fee-for-service environment, and ACOs do not provide sufficient fiscal rewards to physicians and hospitals that assume the risks.

Thomas P. Weil, PhD
Asheville, NC

1. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Summary of final rule provisions for accountable care organizations under the Medicare Shared Savings Program. October 2011; ICN 907404.
2. Sagar A, Socolar D. *Health Care Costs Absorb One-Quarter of Economic Growth, 2000-2005.* Boston, Mass: Boston University School of Public Health; 2005.