

# Letters

CMAJ publishes as many letters as possible. However, since space is limited, choices have to be made, on the basis of content and style; we routinely correspond only with authors of accepted letters. Letters that are clear, concise and convenient to edit (no longer than two double-spaced typescript pages, or 450 words) are more likely to be accepted. Those that are single-spaced, handwritten or longer than 450 words will usually not be published, without comment to the author or return of the letter; nevertheless, we reserve the right to abridge letters that are unduly long or repeat points made in other letters, especially in the same issue, as well as to edit for clarity.

## Managing hypercholesterolemia

The Ontario Task Force on the Use and Provision of Medical Services has recently released a document that includes specific guidelines for treatment of asymptomatic hypercholesterolemia by physicians.<sup>1</sup>

The members of this group, who are principally interested in biostatistics and health administration, have reviewed the current literature on hypercholesterolemia and coronary heart disease (CHD) and come to a decidedly gloomy and negativistic opinion regarding our ability to influence the clinical course of asymptomatic hypercholesterolemia. They appear to have consistently accepted the "worst case scenario" about the results of intervention. That is their right, and I do not object to it.

My objection is that after conducting an "in camera" paper investigation the task force has promulgated policy for physicians. By contrast, the Canadian Consensus Conference on Cholesterol (CCCC) Panel listened carefully to experts in the field and reviewed the published data and the recommendations from three previous consensus conferences before coming to an opinion. That opinion was exposed to a large open meeting attended by people interested in the subject

and then revised before being promulgated.<sup>2</sup>

I am particularly concerned over the position taken by the task force with respect to dietary management of hypercholesterolemia — that no dietary advice be given to individuals with cholesterol levels between 5.2 and 6.2 mmol/L and that dietary therapy be provided for individuals with cholesterol levels between 6.2 and 6.85 mmol/L only if other risk factors are present. These recommendations will leave the majority of individuals at risk unprotected. The National Diet-Heart Study (NDHS), carried out in the United States in the late 1960s, showed that one could obtain an average 10% reduction in cholesterol levels using a diet that approximates the American Heart Association (AHA) level 1 diet.<sup>3</sup> Such a diet would reduce risk in the one-half to one-third of the Canadian population with cholesterol levels above 5.2 mmol/L. Dietary advice is relatively easy to provide with the use of printed materials, and that is what most individuals with cholesterol levels in the range of 5.2 to 6.2 mmol/L require. For those with cholesterol levels in this range and other risk factors or with cholesterol levels above 6.2 mmol/L dietary therapy provided by a physician or a dietitian, or both, is required.

The CCCC did not establish precise cut-off points for drug

treatment, and some Canadian experts feel that the levels advocated by the US National Cholesterol Education Program (NCEP)<sup>4</sup> are too low. This is still under discussion. The recommendations of the Canadian Lipoprotein Conference are now being prepared for publication. For the time being I am advising physicians to use the NCEP cut-off points (4.1 mmol/L of low-density lipoprotein cholesterol for individuals with two risk factors and 4.9 mmol/L for hypercholesterolemia alone).

The Ontario task force's recommendations were arrived at without consultation with Canadian physicians expert in the field and are now being promulgated as policy (at least in Ontario). The result will be to sow confusion in physicians' minds. I find it regrettable that the Ontario Medical Association (OMA), which includes many of the foremost Canadian experts among its membership, has lent its name and authority to these recommendations.

Louis Horlick, MD, FRCP  
Chairman  
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on Cholesterol

## References

1. Toronto Working Group on Cholesterol Policy: *Detection and Management of Asymptomatic Hypercholesterolemia*, Task Force on the Use and Provision of Medical Services, Ontario

Ministry of Health/Ontario Medical Association, Toronto, 1989

2. Canadian Consensus Conference on Cholesterol: Final Report. *Can Med Assoc J* 1988; 139 (11, suppl): 1-8
3. National Diet-Heart Study Research Group: The National Diet-Heart Study final report. *Circulation* 1968; 37 (suppl 1): 1-428
4. National Cholesterol Education Program: Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (NIH publ 88-2925), US Dept of Health and Human Services, Bethesda, Md, 1988

*[The task force replies:]*

Criticism of the task force's initiative has focused on the process used. Dr. Horlick feels that there was inadequate consultation with experts in lipid disorders and too little "consensus". We did consult international experts in the field, including Dr. Alan Garber, Dr. Scott Grundy, Dr. Thomas Kottke and, indeed, Dr. Horlick, as chairman of the CCCC. Opinions among these experts differed, so that not all their recommendations could be included in the report. Producing practical guidelines for optimal practice patterns called for a group trained in evaluation of medical data rather than a group of experts in various aspects of lipid metabolism. The guidelines were intended to provide Ontario physicians with a practical guide for deciding who should be tested and who should be treated that is based on the best analysis of the best current scientific evidence.

This exercise represents a major advance in collaborative efforts to develop therapeutic recommendations that are based on impartial and critical review of all scientific evidence available in the hope of reducing inappropriate use of drugs or techniques. The Ontario Ministry of Health must be commended for endorsing the recommendations and accepting the fact that the implementation of these guidelines will substantially increase the costs of the diagnosis and treatment of asymptomatic hypercholesterolemia over present levels. The expected benefit will come from avoidance of the ex-

cessive or unnecessary testing and drug use that might result if not constrained by coherent scientific recommendations.

The OMA also endorsed the guidelines, signalling its willingness to cooperate with government in initiatives aimed at improving the quality of health care. The task force recommendations do advocate some restraint in testing and treatment of hypercholesterolemia, but these are based on clinical considerations that balance the adverse effects of medical intervention with the benefits expected. Like any guidelines supported by the OMA these are voluntary, flexible and subject to immediate modification when new evidence appears.

The members of the task force confirm their support for the policy document, which we believe provides guidance for physicians based on complex data analysis that would be beyond the capabilities of virtually any individual physician. We did not expect that the report would be universally accepted, and we welcome debate both on its scientific conclusions and on the development of better methodology with which to address similar problems in the future.

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*[The working group replies:]*

The mandate of the Toronto Working Group on Cholesterol Policy was to review the evidence concerning the potential benefits, side effects and costs of detecting and treating elevated serum cholesterol levels in the diverse adult subpopulations at risk for CHD. We were also required to weigh the respective roles of community-wide health promotion strategies and individualized medical strategies. These tasks are not within the usual domain of either bench research in lipid biochemistry or sub-

specialty referral practice in lipid disorders.

As case-finding becomes commonplace, testing and treatment of asymptomatic persons for elevated serum cholesterol levels will take place almost exclusively in the offices of those engaged in adult primary care. Indeed, when Blue Cross-Blue Shield in the United States sought an external review of the cholesterol testing conundrum it turned to a group not unlike ours — ambulatory care practitioners with expertise in clinical epidemiology and health economics.<sup>1</sup>

The important point is a willingness to appraise the relevant evidence critically. Dr. Horlick, for example, claims that the NDHS showed an "average 10% reduction in cholesterol levels" with a diet similar to the AHA level 1 recommendations.<sup>2</sup> The treatment group actually followed diets much higher in polyunsaturated fats than recommended for the AHA level 1 diet. The average decreases of 8.4% and 9.3% were observed relative to a control group consuming prepared foods with high saturated fat and low polyunsaturated fat contents. The NDHS subjects were a self-selected volunteer group comprising only 11% of all those asked to participate. More important still, the subjects were randomized to obtaining one of three varieties of all fat-containing foods at *study distribution centres*. The difference in the decrease in cholesterol levels over 1 year between the single cohort randomized to dietary instruction, who obtained their food on the open market, and the "control" group in the same city, who obtained fatty foods at a distribution centre, was less than 4% averaged over the last 40 weeks of the year and 2% at the end of the year. We suggest that such analyses are not "gloomy" but a realistic prerequisite to policy formulation.

Horlick misrepresents the Ontario policy. The poster mailed to Ontario physicians states: "Regardless of whether serum cholesterol is measured, practitioners should encourage all patients to