

CORRESPONDENCE

Familial Hypercholesterolemia: Developments in Diagnosis and Treatment

by Prof. Dr. med. Gerald Klose, Prof. Dr. med. Ulrich Laufs, Prof. Dr. med. Winfried März, Prof. Dr. med. Eberhard Windler in issue 31–32/2014

Low-Fat Diet and Exercise Are More Important

While reading this review and the editorial, I stumbled across the many conflicts of interest declared: All but one author of the review received financial contributions from almost all of the companies active in this field.

The group of familial hypercholesterolemias is diverse and certainly there is not one standard regimen that fits all. I have reasonable grounds for rejecting the doctrine of pharmacotherapy. Over the last 20 years, some of my patients with familial hypercholesterolemia have achieved cholesterol levels within the target range only by adhering to a strict vegetarian or even vegan diet, combined with weight reduction to normal weight and exercise.

Physicians are usually very strict with smokers: Patients who continue smoking (rightly!) do not get ProLactin and often no oxygen treatment either. In arteriosclerosis patients, a more conciliatory approach is taken, even though the best therapeutic option for them is to radically stop smoking (as in chronic obstructive pulmonary disease—COPD) and to reduce the dietary intake of animal fats to zero; complemented by pharmacotherapy, where required, and, of course, sports/exercise.

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Conflict of interest statement

The author declares that no conflict of interests exists.

In Reply:

A healthy lifestyle is repeatedly and explicitly mentioned as a first and basic measure to take and described in detail in the Lifestyle Measures section of our review. However, in familial hypercholesterolemia (FH), where it refers to an autosomal dominant hypercholes-

terolemia, the co-dominant transmission of functionally relevant mutations in the LDL (low density lipoprotein) receptor—less frequently apolipoprotein B or PCSK9 (proprotein convertase subtilisin/kexin type 9)—seriously limits the effect of diet on cholesterol levels; in homozygote or combined heterozygote patients, the effect of nutrition is virtually non-existent.

Polygenic hypercholesterolemias with a familial pattern have to be distinguished from FH; they respond much better to dietary changes and presumably explain the very good experiences described. In our review, we have covered the significant phenotypic variability observed in FH. We appreciate that these aspects were highlighted once again. However, we think that it is ethically problematic to refuse treatment in response to poor health behavior.

“Stumbling” across the “many conflicts of interest” reminds us that transparency can also be counterproductive, as a recent discussion in *Deutsches Ärzteblatt* has highlighted: „Apparently doctors give undue importance to the conflict of interest statements,” said Lo. At the same time, they disregard scientific criteria...“ (1).

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Conflict of interest statement

Prof. März is a partner of Synlab Holding GmbH. He has received consultancy fees; reimbursement of conference fees, travel expenses, and accommodation expenses; and fees for preparing continuing medical education events from Amgen Deutschland, Aegerion Pharma, Merck Sharp, Dohme Deutschland, Roche, Sanofi-Aventis, and Pfizer.

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Prof. Laufs has received consultancy fees from Amgen, Sanofi, MSD, and Roche. He has received fees for conference participation and reimbursement of travel and accommodation expenses from MSD.

Prof. Windler declares that no conflict of interests exists.