References


To the Editor:

Regarding the editorial in Circulation in October 1993, Stamler et al1 seem to imply that the 50% reduction in coronary and cardiovascular disease death since the 1960s is significantly related to health policies, including reduced cholesterol, more physical activity, etc. In the same issue, however, Kaplan and Keil2 document the increasingly apparent relation between cardiovascular disease and socioeconomic factors, including income, education, and occupation. Blue collar work, low income, lower education level, and high psychological stress relate to cardiovascular mortality. Since the 1960s, per capita income in the developed world has continued its phenomenal ascent, with the standard of living 3 times its level 60 years ago in the United States, 7 times in Germany, and 10 times in Japan. This has been accompanied by a relative reduction in blue collar jobs as well as a widespread increase in education levels. Kaplan et al cite the work of Williams et al3 who report a 5-year survival independent of all baseline invasive and noninvasive medical prognostic factors of 0.91 for patients with coronary artery disease and an annual household income of $40 000 or more as compared with a 5-year survival of 0.76 in patients with incomes of $10 000 or less.

It would seem plausible from the above that the 50% reduction in coronary and cardiovascular disease death since the 1960s in the developed world is most likely predominantly a result of the increasing wealth and accompanying lifestyle modifications resulting from this wealth rather than predominantly a result of more enlightened health policies, although such policies may well have made some contribution, as Stamler et al suggest.

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References


Reply

Our Circulation editorial emphasized that the cornerstone of US national health policy on serum cholesterol is a population-wide strategy to achieve dietary means a downward shift in serum cholesterol level, first and foremost for the primary prevention of epidemic coronary heart disease (CHD).3 It concluded: “The present national policy . . . has provided the added merit that the recommended healthful eating patterns can be beneficial in preventing or controlling other chronic diseases as well as coronary disease. There is no sound evidence that justifies a withdrawal from this policy. On the contrary, we need to expand and intensify efforts to achieve its goals.”

Our editorial assessed as unfounded all three concerns set down in the prior editorial by Hulley et al.2 In the first paragraph of their letter above, Hulley et al note this and restate the three concerns but make no effort to reply to our reasons for concluding that concerns No. 1 and No. 2 were unsound. They focus solely on concern No. 3, related to meta-analyses of data from randomized controlled trials (RCTs) of cholesterol lowering. Olson and Ravnskov also rely heavily on these meta-analyses as a basis for their critiques of our editorial and of US national policy on serum cholesterol.

Altogether, their three letters cite findings in 8 such meta-analyses (of 6 to 35 trials).1-10 However, the fact is that all these meta-analyses are at best irrelevant or at worst misleading in regard to the recommended dietary approaches for CHD primary prevention. Specifically, of the cited unifactorial trials on CHD primary prevention, only two were dietary trials. All others were drug trials, hence by definition unrelated to the main thrust, that is, the nutritional emphasis, of US national policy. Lumpying diet and drug RCTs together is a flawed use of the meta-analysis method, and citing overall findings from such meta-analyses is inappropriate when the primary issue under discussion is national nutritional policy. Moreover, combining all these RCTs results in ignoring the details of their nature, design, procedure, and outcome that are critical for assessment of their soundness and policy relevance.

As to specifics, first on the two unifactorial diet trials:3,12 both were actually combined primary and secondary prevention trials. Both had design features that make their findings uninformative in regard to public policy on reduction of coronary and all-cause mortality rates by population-wide improved nutrition. First, they
Doing the right thing: stop worrying about cholesterol.
G Kessler

Circulation. 1994;90:2573
doi: 10.1161/01.CIR.90.5.2573
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 1994 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/90/5/2573.citation

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