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Editorial Note

Care and cholesterol

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The two papers which follow in this issue of the *International Journal of Risk and Safety in Medicine* look at first sight like the two sides of a coin. On matters of public health debate it is all too common to be partisan and much more difficult to be fair. But Dr Walker and Dr Ødegaard were indeed invited to present these short papers at a WHO meeting [1] in the very hope that they *would* be partisan, thus throwing their topic into perspective for the discussants. The fact that, having prepared their papers quite independently, they did actually agree on a number of fundamental issues is encouraging; it suggests that a basis for consensus must be there somewhere.

Consensus with respect to the treatment of elevated blood lipids essentially exists with respect to two issues. Firstly, it is agreed that there are some people with severely elevated blood lipids whose chance of suffering a severe cardiovascular or other complication will be lessened if the lipids are lowered. Secondly, it is agreed that what needs to be done can be achieved, in a proportion of patients, by dietary means, with drugs kept in reserve for those situations in which dietary instruction, for one reason or another, does not do the trick.

The disagreement, or the opportunity for misunderstanding, unfortunately relates to particular facets of these same two issues. Firstly, it is often not clear which individual patients do need to be treated at all; and secondly, there are differing views as to the best way to provide pharmacological support where it is needed, so as to ensure that it provides more benefit than risk. On matters like that, as Dr Ødegaard reminds us, there will be a need for a great deal more discussion as time passes; and Dr Walker demonstrates the scale on which evidence is likely to reach us which may serve as a basis for our conclusions.

There is in fact a fair basis in pathology and biochemistry for defining the groups of patients in the population who are likely to need to have their lipids reduced. The discussion crystallized out a decade ago with the discussion around the risks apparently created by clofibrate, and the principles have been further developed since then. Hyperlipidaemias symptomatic of a specific disorder, obesity or alcoholism will generally respond nicely to treatment of that condition. Of the five population groups with specific hyperlipidaemias, several (types I, III and V)

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cause little excitement because they are relatively small groups and many of the people concerned react well to diet. The battle rages primarily around the larger groups IIa, IIb and IV, not so much because they are helpless to date (many of these two will respond to diet and to fairly innocent things like nicotinic acid or the ion exchange resins) but because there are so many of them; they are a mass, and a mass is a market. The art of selling in such a situation, if one may be impolite about it, is to respect the broad lines of the truth but set aside the troublesome things in parentheses; one will sell simplicity, convenience and reassurance. Shall we lower our cholesterol, like the neighbours do, without a dismal diet or an unappetising resin? Naturally we shall, and the things in brackets like age, sex and threshold severity [2] are better forgotten because they make the tale so complicated. It is the old elixir story all over again.

It is entirely clear that some thin have happened (and go on happening) in this field for which there really should be no place in medicine [3]. Where an honest attempt to inform and educate slips across the delicate borderline of the permissible so as to create concern and even alarm something is very wrong; this is very akin to what Vance Packard in the 'sixties identified as "want creation" of the less pleasant type [4]; will my husband continue to desire me if I do not use XYZ deodorant? Shall I drop dead if I do not do something about my lipids?

It is much to the credit of some experienced pharmaceutical companies in this field that they have not succumbed to this type of technique. They have contented themselves with a little of the hyperbole which gives colour to life and their products have settled down to give fairly quiet and useful service. But the door to excess is still open for others to rush through, even if angels fear to tread there. The trouble is that, with uncertainties on all sides, they may well be rushing headlong into the unknown, and taking a large part of society with them. Even some very sensible regulatory bodies, which have for a time kept the matter reasonably in hand, seem to be succumbing to pressure from the manufacturers [5], and from those whom the manufacturers seem to have processed carefully to share their views. Only considerations of sheer expense (and a few very sober cost/benefit analyses) now seem to be holding back the flood [6].

In fact something can be done to keep the matter in hand if society really cares enough. The community, pleading if necessary its financial limitations but thereby conserving a health-orientated ideal, can insist that the indications for the newest generation of lipid-lowering agents are defined, respected and understood. Even a critically selected fraction of the hyperlipidaemic population, comprising only those who truly do not respond adequately to anything else, will still be large enough to provide an impressive study population in which more can be learnt. The food manufacturers can be further encouraged to mass-produce tasty foods with a low cholesterol content. The bulk of the population are unlikely to become much healthier as a result, but the minority with a lipid problem will be more successful at adhering to a healthy diet (and dietary non-compliance is one of the great reasons for drug use) for the simple reason that they will no longer experience it as a restrictive diet at all [7]. And finally: some part of the vast amount of money which the community seems to be resigned to paying for a new

generation of lipid-lowering drugs could be diverted into building up a better network of dieticians and nutritionists.

Society has once before in drug history rushed headlong into the unknown; it happened with the oral contraceptives around 1960; with only the bare bones of their clinical properties defined they were avidly seized upon by millions of healthy women for chronic ingestion. Happily, they did virtually no serious harm, but there was no knowing. The HMG-CoA inhibitors may be equally blessed; they may prove to be the best and safest medicines in creation; we shall hope and trust that they are; but for a long time we shall have to go on reminding ourselves that we, in truth, do not know. We shall need to keep our eyes and our ears open for the unexpected, for it may well be, just as was the case with the oral contraceptives, that the risks and opportunities which emerge as time passes are not those which have been predicted either in animals or in man.

References

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