

a background in mental health and the product is a pragmatic report by an informed visitor who has a particular knowledge of the research field. Although the book does not provide an empirical evaluation of services, it gives a view of how they operate in a way that most research studies do not. Where applicable, prevention in general practice is referred to, for example, the detection of psychiatric symptoms by the doctor and the use of mental health professionals attached to general practice.

Although interesting and informative, it is not completely clear for whom this book is intended. Perhaps it will serve best as a guide to good practice for people who already work in community services. General practice is increasingly seen as a major resource for prevention but little has been achieved in the area of mental health. Perhaps this book will indicate the directions in which the field may develop.

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GUIDELINES FOR THE MANAGEMENT OF HYPERLIPIDAEMIA IN GENERAL PRACTICE

Occasional paper 55

Royal College of General Practitioners, London (1992)
15 pages. Price £6.00

When knowledge is established beyond reasonable doubt, or has advanced sufficiently to be a secure basis for action there is no need for guidelines or consensus statements. The problem with these guidelines on the management of hyperlipidaemia in general practice, published by the Royal College of General Practitioners, is that they portray a view of the problem and a proper response which is open to debate. In a sense they provide an *ex cathedra* statement. A thorough and comprehensive critique would be lengthy, so what follows is a brief summary of some of the problems which these guidelines pose.

My first cavil concerns the guidelines' dismissal of the reality that controlled trials of reducing cholesterol levels by drugs show, on the whole, a deleterious effect on total mortality. This is a consistent finding, and while the causes of the mortality in the treated groups are various and include violence, they cannot be dismissed because they are not understood.

The results of the lipid research clinics trial (*JAMA* 1984; 251: 351-364) are adduced as evidence for action in the form of treatment with cholestyramine. The results of this trial were reported as showing a 24% reduction in deaths that definitely resulted from coronary heart disease — over the course of seven years there were 38 deaths in the control group of 1900 subjects and 30 deaths in the group of 1906 subjects treated with cholestyramine. The total number of deaths in the two groups were 71 and 68 respectively: the 95% confidence interval of this difference expressed as a percentage, is minus 23% to plus 30%.

Obesity is defined in the occasional paper as a body mass index greater than 25 yet there is no evidence that plump people suffer a worse prognosis than thin people, they may even live longer. The ill effects of fatness only became apparent at body mass indices greater than 29, and by taking a limit of 25 many people will be made unnecessarily conscious of their weight as a problem, and will presumably begin to worry about their diet.

In the economic justification which is presented, much is made of the cost of coronary heart disease. However, no reference is made to the cost of alternative modes of death. Not dying of

coronary heart disease allows the possibility of dying of cancer or experiencing the slow protracted death of senescence.

The concluding sentence of these guidelines reads, 'In looking at the economic considerations relating to an opportunistic programme of cholesterol testing, it is important to look at cost-benefit ratios and not total costs'. I agree but am distressed that in calculating the cost-benefit no reference is made to the possibility of inducing an unhealthy preoccupation with the risk of dying of coronary heart disease. If these guidelines are to be followed by general practice in the British Isles, all those people whose serum cholesterol concentrations lie above 5.2 mmol l⁻¹, that is most of us, are in real danger of having our health diminished by being labelled as unhealthy to no useful purpose.

These guidelines also raise the important question as to whether the RCGP should attach its imprimatur to advice which is still *sub judice*. By so doing the College lends a powerful and influential voice to something which in time may turn out to be an error and as a result may do harm to large numbers of as yet unidentified individuals.

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Owing to the controversial nature of the subject covered by Guidelines for the management of hyperlipidaemia in general practice, we sent a copy of Professor McCormick's review to the authors of Occasional paper 55 and their response to the review is given below.

We wish to reply to the points raised by the reviewer. We regard the case for risk factor reduction to be beyond reasonable doubt. Despite the complexity of the subject and its unfamiliarity to some doctors, we were justified in drawing up these guidelines.

Controlled trials to reduce cholesterol levels by drugs, and for that matter by diet, show neither a deleterious nor a favourable effect on total mortality. No trial has been completed in which the design permits valid conclusions to be drawn on this issue, though it is desirable that suitably large trials be undertaken.

The lipid research clinics trial of cholestyramine is one of 23 trials of the effect of lipid lowering on coronary heart disease using clinical endpoints. An overview of these trials shows the outcome of the lipid research clinics trial to be representative in indicating benefit in the context of a well designed trial. In clinical use the effect is likely to be considerably more favourable because of selection of patients at high risk of coronary heart disease for treatment, intervention against all remediable risk factors and not only one, and the probability of fuller compliance in a clinical setting. In the lipid research clinics trial, coronary heart disease events decreased by 39% in a relatively short period in those who took most or all of the recommended dosage.

The 30 year follow-up data from the Framington study indicate a considerable excess in total mortality in men whose relative body weight was 10% or more above the desirable range.

The main cause of death in a population in which coronary risk factors have been reduced will remain coronary heart disease, but it will tend to occur later, that is, the age-specific mortality in middle age will decrease.

We would share the reviewer's distress at the induction of an 'unhealthy preoccupation with the risk of dying of coronary heart disease' if he had provided evidence that this outcome occurred with significant frequency. Smoking cessation programmes have not diminished health by preoccupying people with fear of lung cancer.

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