

be no more than 33% of total energy intake and saturated fat to be no more than 10% of energy intake.¹ An analysis of the results of five major intervention trials involving dietary advice given to individual subjects and applying a step one diet which is rather more severe than that advocated by COMA, showed that a reduction in cholesterol level of only about 2.0% was achieved.² This is similar to that achieved in Buckinghamshire.

The researchers can be satisfied that a reduction in cholesterol level of about 6.2% was achieved by those patients with higher initial cholesterol levels (6.50 mmol l⁻¹ or more) given 'specific lipid lowering dietary advice'. The fact that the overall change in cholesterol level was 'small' cannot be taken as an indication that patients have not changed their diet: in real life, dietary change does not always have the appreciable results that some of its advocates assume it will.²

Meanwhile, of considerable interest is the reported difference in response between men and women. The total cholesterol level of women in the intervention group dropped by only 0.5% compared with 3% for men. There seem to be few studies providing data on women's response to dietary advice, but Knutsen and Knutsen found that in families given advice on diet, the total cholesterol level of men declined by 5.5% but that of their wives increased by 1%.³ In the Scottish heart health study a positive correlation was found between dietary intake of saturated fatty acids and total cholesterol level in men, but not in women.⁴ Indeed, since the National Heart Blood and Lung Institute in the United States of America, in a survey of major risk factor studies, has shown that cardiovascular risk, and indeed overall mortality risk, in women, is not associated with high cholesterol levels,⁵ it seems logical to question the justification for giving lipid lowering advice to women.

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References

1. Committee on Medical Aspects of Food Policy. *Dietary reference values for food energy and nutrients for the United Kingdom*. London: HMSO, 1991.
2. Ramsay LE, Yeo WW, Jackson PR. Dietary reduction of serum cholesterol concentration: time to think again. *BMJ* 1992; **303**: 953-957.
3. Knutsen SR, Knutsen R. The Tromsø survey: the family intervention study — the effect of intervention on some coronary risk factors and dietary habits, a 6-year follow up. *Prev Med* 1991; **20**: 197-212.
4. Bolton-Smith C, Woodward M, Smith WCS, Tunstall-Pedoe H. Dietary and non-dietary predictors of serum total and HDL-cholesterol in men and women: results from the Scottish heart health study. *Int J Epidemiol* 1991; **20**: 95-104.

5. Jacobs D, Blackburn H, Higgins M, *et al*. Report of the conference on low blood cholesterol: mortality associations. *Circulation* 1992; **86**: 1046-1060.

Assessing health needs

Sir,

Dr Gillam's editorial (October *Journal*, p.404) rightly calls for a more coherent and explicit approach to health care needs assessment at practice level. This has been needed since the Leeuwenhorst group stated in 1974 that general practitioners have a professional responsibility to the community as well as to individuals (statement by the working party appointed by the European conference on the teaching of general practice). Moreover, in 1992 the Joint Committee on Postgraduate Training for General Practice stated that general practitioners are expected to be able to assess the health status, needs and expectations of practice populations.¹ A consideration of how this can best be done is timely.

If a basic method could be shown to work, general practitioners could use such a means to familiarize themselves with existing service provision and develop some understanding of the broad health needs of their patients' communities.

The health care team at the Mackenzie medical centre in Edinburgh is currently field testing a method of listening to local voices to hear what the community's perceived health needs are. Although rapid appraisal methodology has been used in an urban setting in the United Kingdom² it has not yet been documented as being effective from a practice base where it may have the greatest potential.

The priorities identified by community members could be compared with patients' general practitioner held medical records at an aggregate level and with their consulting behaviour. This triangulation approach should result in agreed needs and suggest realistic and appropriate interventions to health care planners and community leaders.

A further advantage of a practice based method is that changes and interventions could be facilitated by the practice, although prioritized and monitored by community representatives. General practitioners have a potentially fruitful role in assessing the health needs of their populations and communities.

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References

1. Joint Committee on Postgraduate Training for General Practice. *Training for general practice*. London: Royal College of General Practitioners, 1992.
2. Ong BN, Humphris G, Annette H, Rifkin S. Rapid appraisal in an urban setting — an example from the developed world. *Soc Sci Med* 1991; **32**: 909-915.

Guidelines for management of hyperlipidaemia

Sir,

James McCormick is right (book review, October *Journal*, p.446), there is as yet no consensus on the management of hyperlipidaemia in general practice because we do not have enough evidence on the overall effects of long term interventions, positive or negative, on which any rational consensus could be based. There may be a consensus among hospital-based lipidologists, and they may therefore have a basis for guidelines for management of referred patients, but this is no longer sufficient for rational guidelines for whole population care.

None of the points raised by James McCormick is effectively answered by Colin Waite or Barry Lewis. They concede that neither individual trials nor an overview of all trials shows any reduction in mortality from all-causes following use of cholesterol-lowering drugs. However, they claim that because these trials were designed to detect differences in mortality from coronary heart disease rather than from all causes, it is not known whether even larger trials would have a net positive or negative outcome. However, the onus of proof is on the interventionists. There is no proof of net benefit from any of these trials, but there is consistent and disturbing evidence of increased deaths from suicide, accidents and violence in many of them.

General practitioners in the United Kingdom have been commendably slow to accept mass medication for raised blood cholesterol levels. Despite huge promotional pressure from the pharmaceutical industry, penetration of these drugs into the UK market is still eight times less than in the United States of America.¹ Until we have evidence on which rational policies can be based, the Royal College of General Practitioners should support this cautious approach on behalf of its membership.

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Reference

1. Smith GD, Pekkanen J. Should there be a moratorium on the use of cholesterol lowering drugs? *BMJ* 1992; **304**: 431-434.