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CORRESPONDENCE

Correspondents are asked to be brief

Prevention of Coronary Deaths

SIR,—Once again in the *B.M.J.* (9 October, pp. 64 and 65) there are references to the problems of preventing coronary heart disease. Nevertheless, in Britain at the present time very little is being done about it. In your leading article on "Coronary Deaths" you state correctly that there is no conclusive proof (with the implication, that is, when started in middle age) that available preventive measures are effective. However, you do not state that the probability of their being beneficial is very high indeed and consequently appropriate action should be taken now whilst individual trials continue.

The facts are clear. The prevalence of coronary heart disease, especially in middle-aged and younger men, is high and the incidence is increasing. The situation will *not* improve spontaneously and the majority of deaths occur before medical help is available. Previously most patients have apparently been well.

Some coronary risk factors have been identified in prospective epidemiological studies. A very important point to be emphasized is that, despite the absence, as yet, of conclusive evidence that coronary deaths can be prevented or delayed, most of the factors are in any case injurious to health in measurable ways or treatment will in any case be beneficial. The risk factors are mainly environmental.

The evidence in relation to smoking is now accepted but ways and means must be found to improve motivation against this habit which is the only socially acceptable form of drug addiction. Smoking must become as unacceptable as spitting. It is far more dangerous.

Obesity itself, that is to say, in the absence of other commonly associated adverse features may not be a strong risk factor. However, all insurance statistics show that obesity reduces life expectancy, mainly from premature cardiovascular disease, and also that reduction of obesity is beneficial from the point of view of the insurance risk.

Though reduction of hypertension has not been shown to improve prognosis as regards coronary heart disease, it has been conclusively shown that it greatly reduces the risks of hypertensive cerebrovascular disease. It should therefore be treated, even if mild, but not necessarily by drugs.

All that need be said about hyperlipidaemia at the present time is that it is highly probable that reduction at a relatively young age would be beneficial. From the practical point of view, since most patients at risk are obese and reduction of obesity also reduces hyperlipidaemia, there is no difficulty, as our experience has clearly shown,[1] in modifying the quality of the diet apart from the reduction in calories to reduce hyperlipidaemia further.

As regards exercise there can be no question but in coronary patients and the coronary-prone, as in healthy individuals, exercise tolerance is improved. The general physical and psychological benefits are considerable and, in addition, there are other measurable benefits in relation to myocardial function, hyperlipidaemia, fibrinolysis, and platelet function. The adverse effects of catecholamine secretion, whether produced by certain types of emotional stress or by cigarette smoking, are numerous in relation to atherogenesis, thrombogenesis, and myocardial function, and much can be done about this. Hyperglycaemia is another factor which is almost certainly important for a number of reasons, and this, too, can be treated.

Coronary heart disease is multifactorial in origin and it has been clearly established that risk factors are additive in their effects. It is reasonable to conclude that treatment must also be multifactorial and the modification of only one factor is likely to be relatively ineffective. Any measures likely to be of value against coronary heart disease should also be beneficial against other forms of atherosclerotic and hypertensive disease. Associated benefits as regards other unrelated disorders, as in women, would be considerable.—We are, etc.,

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1 Turner, R. W. D., and Illingworth, D. G., Paper given to Scottish Society of Physicians, Aberdeen, September 1971.

Rehabilitation and Faculty of Community Medicine

SIR,—In the letter (9 October, p 117) by the presidents of the respective Royal Colleges of Physicians of Edinburgh, Glasgow, and London, intimating the inaugural meeting of the new faculty of community medicine, they define community medicine as concerned with populations or groups rather than with individual patients. It goes on to speak of the special knowledge of the principles of epidemiology and of the techniques of health education and rehabilitation.