

To the Editor: The letter by Pattison, Nelson and Klein is reminiscent of the note by Egerton Yorick David (William Osler's pseudonym) on "vaginismus", which appeared in the *Philadelphia Medical Journal and Record* about 1880. It's good to know that editors of American as well as those of English scientific journals allow a little impishness to appear in their publications! However, as a stockholder, I should resent the implication that spread of disease is now added to the "Bell" system's alleged crimes.

Medford, MA

RALPH E. WHEELER, M.D.
Tufts University

SNEAKERS AND SUPPORTERS TO FIGHT CHD

To the Editor: There is a third world that Blackburn does not acknowledge in the binary system of thought that he uses to describe the problem of coronary heart disease (N Engl J Med 292:105-107, 1975). Those with what he calls the "academic view" comprise the lipoprotein-phenotyping contingent, who in effect say, "Give us more time and money and in the meantime phenotype everyone, even babies, and send off to Washington for the appropriate diet manual." This looks to me like busy work — not problem solving. In the second world — where Blackburn lives in a large, circular, stone edifice — are those who like to call themselves pragmatists in these health matters. They violate the first premise of good medicine because they treat symptoms, not disease. Their facilities hum with patients being measured and treated for one or another risk factor (a glossy new term for an attribute associated with coronary disease) even while they studiously ignore the stark fact that no one has been able to show that treating one or all of these risk factors does any good, although some of the treatments do some harm.

In the third world, small and less well known, where I live, we believe that the most important conclusion to be drawn from epidemiologic studies of coronary heart disease is that fit and active people are spared its clinical disasters, even though many of them have atherosclerosis. The preventive of coronary heart disease appears to be exercise. Paradoxically, this is a dirty word under the Minnesota Stadium. In this clear-eyed third world the most probable cause of the rise of coronary heart disease appears to be the leisurely life — not diet, not obesity, not hypertension, not cigarettes, not temperament, not emotional strain and probably not even genetics.

A common feature of each of these three worlds is industrial muscle. Segments of the food and pharmaceutical industry find diet, hypertension and hypercholesterolemia very profitable disorders. Unfortunately, the sneaker-and-supporter crowds have been slow to organize. It is a commentary on our system of science that, until they do, the necessary clinical trial to examine the role of exercise in protecting health will not be done. In the meantime, anyone with even a scrap of evidence that the phenotyping of lipoproteins or the consumption of an oily, low-fat diet helps protect health should send it at once to Dr. Blackburn — even a little clay suitable for chinking his wall would help. It will be a long winter in Minnesota.

Nashville, TN

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The above letter was referred to Dr. Blackburn, who offers the following reply:

To the Editor: Dr. Mann may be right.

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For years it was labeled PVC, later re-labeled VPB, and now assumes yet a third name, VEA (N Engl J Med 292:262, 1975).

May I suggest one final name, that of FLB (funny looking beats)?

Massapequa, NY

ROBERT M. SMITH, D.O.

BENEFITS OF TAY-SACHS SCREENING

To the Editor: The Birth Defects Group at our institute has been engaged in research studies of the cerebral sphingolipidoses for the past 20 years, and in community mass-screening programs for carriers of Tay-Sachs disease for the past five years. Being in almost daily contact with both children with the disease and their parents over this time span, we were appalled by Dr. Kuhr's letter and its accompanying heading, "Doubtful Benefits of Tay-Sachs Screening." The parents of a child with the disorder and their relatives would find ludicrous the statistical conclusion of the Dayton, Ohio, physicians advisory committee "that the psychic burden on these 72 heterozygotes was too high a price to pay for the prevention of a single case."

We agree with the letter of Beck et al.² that information about genetic defects may be disturbing to a person, and that the main question is whether such information can be used productively. Our experience has shown that it is possible to dispel unreasonable fears on the part of potential heterozygotes by careful planning and education of the community before the testing program is inaugurated. Talks by a mother of a child with Tay-Sachs disease about the domestic trauma created by the birth of a doomed child and by a medical scientist or genetic counselor that, with discovery of the defective enzyme, even carrier couples can be assured of having only nonaffected children, provide such needed assurance to almost all interested individuals.

In contemporary society, in which medical costs are a family responsibility, the presumed psychic burden carried by heterozygotes may be further lightened if they are informed that it costs in excess of \$50,000 per year to hospitalize a child with Tay-Sachs disease for periods of three or more years. At this institute, in conjunction with the Obstetrics and Gynecology Department of Downstate Medical Center, we have monitored more than 40 pregnancies of high-risk couples and have prevented the birth of 12 infants with Tay-Sachs disease. There is therefore no need for any well informed couple of Ashkenazic Jewish extraction to have a child with the disorder. There is, however, a need for better designed and executed testing programs and adequate and competent genetic counseling when one informs a person that he is a carrier of a genetic disorder.

Dr. Kuhr and his advisory committee are also advocates. They advocate genetic nontesting and a paternalistic attitude that newer genetic knowledge imparted to the general public may be more harmful than useful. In this sense they are doing a medical disservice to the Ashkenazic Jewish community of Dayton, Ohio. Fortunately, this matter may be taken out of their hands, since a father of a child with Tay-Sachs disease, who is a lawyer, has instituted a malpractice suit against his wife's obstetrician because he failed to inform them that a carrier test for Tay-Sachs disease was available. It is more unfortunate that some members of the medical community need prodding of this kind to practice rational medicine.

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1. Kuhr MD: Doubtful benefits of Tay-Sachs screening. N Engl J Med 292:371, 1975

propranolol and 100 mg. atenolol and placebo (double-blind design) on the 2,000 m. running time was measured in a group of healthy volunteers, and related these results to muscle fiber composition. As expected, individuals with a high percentage of slow twitch fibers ran faster both times than those with a high percentage of fast twitch fibers. However, when on propranolol, the performance was relatively more impaired in individuals with a high percentage of slow twitch fibers than in those with a high percentage of fast twitch fibers. Individuals with a high percentage of slow twitch fibers took 20% to 30% longer to complete their 2,000 m. running. On atenolol 100 mg. the same individuals needed less than 10% longer to complete the 2,000 m. running. Thus, cardioselectivity (β , selectivity) seems to be of importance to joggers.

Hypertensive individuals, previously accustomed to physical activity, can expect a certain degree of deterioration of their performance capacity when treated with beta-blockers. It seems important that adequate information about these side effects of beta-blockers is included in the over-all information to hypertensive patients.

However, it also seems important to warn against unguided withdrawal of antihypertensive drug therapy.

Lennart Kaijser

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Reply

To the Editor:

It is interesting to have the data of Dr. Kaijser and his colleagues to support my anecdotal experience with beta-blockers and exercise. The 20% to 30% slowing they noted in the 2,000 m. time of individuals with a high percentage of slow twitch fibers (presumably those best equipped for running long distances), correlates well with this. I am, of course, intrigued to think that cardioselective blockade might impede my training less, but then the value of such "loaded" training would then be reduced.

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Lo—the poor Eskimol

To the Editor:

Dr. Oster's Editorial "Duplicity in a Committee Report on Diet and Coronary Heart Disease" (AMERICAN HEART JOUR-

nal, in press), where the effects of 80 mg. propranolol and 100 mg. atenolol and placebo (double-blind design) on the 2,000 m. running time was measured in a group of healthy volunteers, and related these results to muscle fiber composition. As expected, individuals with a high percentage of slow twitch fibers ran faster both times than those with a high percentage of fast twitch fibers. However, when on propranolol, the performance was relatively more impaired in individuals with a high percentage of slow twitch fibers than in those with a high percentage of fast twitch fibers. Individuals with a high percentage of slow twitch fibers took 20% to 30% longer to complete their 2,000 m. running. On atenolol 100 mg. the same individuals needed less than 10% longer to complete the 2,000 m. running. Thus, cardioselectivity (β , selectivity) seems to be of importance to joggers.

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However, it also seems important to warn against unguided withdrawal of antihypertensive drug therapy.

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important factor for a high incidence of coronary heart disease. Dr. Oster argues that "to establish a causal relationship it must be shown that all population groups with a high saturated fat and cholesterol intake also exhibit a high incidence of atherosclerosis. This is decidedly not the case with the French, the Eskimos, and the Masai, all populations consuming diets high in saturated fats."

The Eskimos are probably the most frequently quoted, or rather—as factual research in contrast to popular assumption has shown—misquoted example used ad nauseam in this controversy. Most researchers found that Eskimo groups living a relatively traditional life-style consumed, despite their predominantly carnivore diet, not more but substantially less fat than other North Americans.¹⁻³ Furthermore, the fats they consumed, although derived from animals, were not highly saturated, as presumed by Oster and others. In fact, a much higher content of long-chain polyunsaturated fatty acids than prevailing in North American diets was found in diets of Greenland,⁴ Alaskan,⁵ and Canadian Eskimos.⁶ Platelet lipid analysis in Greenland Eskimos reflected their high consumption of omega-3 polyunsaturated fatty acids; and this results in a significantly longer bleeding time due to a reduction in platelet aggregation.⁷

These recent biochemical and physiological findings may explain earlier epidemiological observations that Eskimos were relatively free of thrombotic cardiovascular diseases but suffered from increased bleeding tendencies with undue frequency of severe postpartum hemorrhage and Sheehan's syndrome.^{3, 4, 9, 10} The degree of deviation from modern North American "norms" of the inversely related thrombotic and bleeding tendencies in various Eskimo population groups shows clear trends in geographical distribution and changes with time best explained by changes in their diet.

Eskimos do therefore provide a good example for and not against the validity of the fourth report of the American Heart Association Committee on Nutrition and similar recommendations issued in recent years in various countries.

I hope that drawing attention to these facts will help to relieve the Eskimos from being used as false witnesses for the fat lobby, a practice entrenched by repetition of popular myths never supported by factual research. Indeed, their example provides valid ammunition for the side advocating dietary intervention. I suspect that the other two population groups used in your editorial argument against the recommendations of the Nutrition Committee—namely the Masai and the French—are also not very suitable examples. The Masai are subjected to frequent periods of famine and regularly have to walk long distances as nomadic cattle herders.^{11, 12} Most French men drink fair amounts of wine. Famine, physical exertion, and wine drinking all tend to elevate high density lipoproteins which may counteract the effect of low and very low density lipids and cholesterol. There may be other complicating factors,¹³ evident to observers more familiar with local conditions in France and East Africa than I am.

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Reply

To the Editor:

It would indeed be presumptuous of me to enter into an argument with Dr. Schaefer about the diet of the Eskimos; I accept his expertise on this subject. However, in its imbalance, the Eskimo diet does not approximate the American Heart Association Committee on Nutrition's suggested dietary proportions nor do the Eskimos have high serum cholesterol values. Eskimo summer food was found to consist of 32% protein, 21% fats, and 46% carbohydrates.¹ With this high protein consumption, it is understandable how the name, "Eskimo" or "eater of flesh," was derived. Eskimos prefer to be called "Inuit" (man).

The low heart attack rate of the Eskimos is ascribed to their intake of eicosapentaenoic acid (EPA) which might be partially substituted for arachidonic acid, thereby reducing thrombogenesis.² However, the diet which causes bleeding tendencies in the flesh-eating Inuit seems to have no influence on heart

common trap of alibiing commonly-known findings in order to prop up the faltering diet-heart-cholesterol hypothesis. I have studied the nutrition of the Masai and published my findings.³ Their diet includes 60% saturated fats from curdled milk. It is ludicrous to equate their lack of coronary heart disease with the walking of long distances and frequent periods of famine. The lumber workers of East Finland, an agrarian population, expend much more of their caloric energy in pursuing their livelihood than do nomadic cattle herders. They live in a lower stress situation than an urban population and still have the highest coronary heart disease rate in the world. I hope that Dr. Schaefer is not serious when he accepts the wine-drinking habits of French men as the reason for their experiencing less coronary heart disease than similar American men with the identical risk factor constellation, despite the documented high saturated fat intake of the French. This naivete of wishing away findings contrary to one's favorite idea is shared by Stamler, who blames the differences in coronary heart disease incidence between European and American men on the European food deprivation of World War II, another alibi.⁴ Even the mentors of the Framingham Study have changed their opinion about serum cholesterol. "The previous position that virtually all of the lipid information pertaining to coronary heart disease resided in the serum total cholesterol must be (accordingly) modified."⁵

Self-styled and chest-thumping "experts" transpose a paucity of nutritional knowledge into an abundance of diverse and questionable advice on altering nutrition and the food supply system of the nation.⁶ A brouhaha was created in May, 1980, by the recommendation on fats and cholesterol in the diet by the Food and Nutrition Board of the National Academy of Sciences, National Research Council. The Board's action was consistent with its recommendations of 1972. However, slanted nutrition research in the political arena has fostered dissension and varied and unsubstantiated recommendations. Examples are: (1) U. S. Senate Select Committee on Nutrition and Human Needs, *"Dietary Goals for the United States"*; (2) U. S. Department of Agriculture and the U. S. Department of Health, Education, and Welfare, *"Nutrition and Your Health, Dietary Guidelines for Americans"*; and (3) the Surgeon General's report on health promotion and disease prevention, *"Healthy People."* Each differs in its stance on cholesterol and fats, and all are out on a limb. Proponents of dietary changes have not come to a meeting of the minds and stray in different directions, thereby confusing the American consumer. The dissonance of recommendations in the ranks of the AHA's Committee on Nutrition, which was the theme of my Editorial, has spread and is now to be found in most nutrition scenarios of politically inspired organizations.

*Cuius pecunia, eius diaeta.*⁷ (Whose money, his diet)

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