

December 26, 1972

Letter to the Editor  
Nutrition Reviews  
665 Huntington Avenue  
Boston, Massachusetts 02115

Dear Sir:

It is a time to rejoice when two of the more conservative and respected scientific bodies of the land take a firm stand on an issue of the public health. Nutrition councils of the National Academy of Sciences and of the American Medical Association have prepared a forthright statement about diet and coronary heart disease (CHD) and made some important general recommendations (Nutrition Reviews 30: 223, 1972).

Indeed, most evidence suggests strongly that reduction of serum cholesterol levels would be useful in reducing coronary risk, both for the individual and overall in this country. For effectiveness and safety, it is important that experiments of nature be considered. In countries having a low general burden of coronary disease, the common denominator is a low saturated fat intake, not a high polyunsaturated fat intake. A relatively high polyunsaturated fat intake may indeed be effective, but is clearly not essential to a low population experience of coronary disease (A. Keys, *Circulation* 41, Supplement I: 1-211, 1970). Therefore, little divergence of opinion exists on the desirability of lowering serum lipids, but some remains on the best way to go about it. We might do well to avoid replacing one very deviate way of eating (The American Way), with another (greater than 10% calories as polyunsaturated fats).

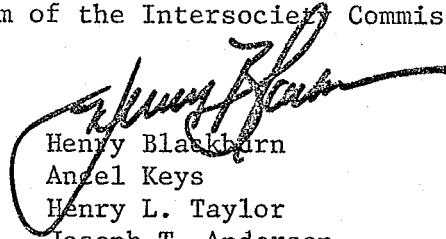
This is a strong and much needed Council Statement and emphasizes the essentiality of primary prevention to reduce the CHD burden. The approach recommended to primary prevention, screening for identification of especially high risk, is an important approach now being exploited effectively in the NHLI Multifactor Risk Factor Intervention Trial. It should be kept in mind that in a disease of epidemic proportions and largely of social origins, when virtually the entire population is at high coronary risk (compared to numerous other countries), selective therapy in the higher risk cases among the U.S. will simply not do the whole job of effective prevention. It will not stop the continual development of high risk "habits" among the young, and that cycle will perpetuate itself. Hopefully, the demonstration by current prevention trials that the burden of CHD can indeed be reduced among those at high risk will initiate the larger chain of social-economic events required for an effective national approach of primary prevention (Intersociety Commission Report on Atherosclerosis, Atherosclerosis Study Group, *Circulation* 42, A55, 1970).



Finally, the Councils' report seems to embrace the confusion caused by an extension of the special diet requirement for lipid metabolic types according to Fredericksen, Levy and Lees (New Eng. J. Med. 276: 33-44, 94-103, 148-156, 215-225, 273-281, 1967) to the mass CHD problem. Fredericksen recognizes that the garden variety case of the mass disease requires no fancy phenotyping (Fredericksen, D.S.: A Physician's Guide to Hyperlipidemia, Mod. Concepts C.V. Dis. 41, 1972). It should also be recognized that the garden variety of hyperlipidemia responds well to the American Heart Association "Prudent Diet" which reduces total fat intake and replaces only a part of the saturated fat with unsaturated; the rest is replaced with carbohydrates. This way of eating is not tailored to fit specific types, it works in all but a few high risk cases, achieves reduction of both serum cholesterol and triglycerides (Stamler, J., Hall, Y., Cohen, D.B., Mojonier, L., Epstein, M.B., Whipple, I.T., and Catchings, S.: The effectiveness of a low saturated-fat, low-cholesterol, weight reducing diet for the control of hypertriglyceridemia, Atherosclerosis, in press).

Natural populations subsisting longterm on relatively higher carbohydrate and lower fat diets than in the U.S. have not only lower serum cholesterol and less CHD but also lower serum triglycerides. The dissemination of "five diets for five lipid types" is valuable for certain specific types, but is not essential or even relevant to the larger problem of CHD risk in this country (Fredericksen, D.S. et al.: Dietary management of hyperlipoproteinemia, A handbook for physicians, National Heart and Lung Institute, Bethesda, January, 1971). This issue has managed to complicate and confuse the clinician's approach to mass CHD. The Councils' report may help perpetuate this confusion.

All told, the Councils' statement is a step in the right direction and complements the social viewpoint on the CHD problem of the Intersociety Commission for Heart Disease Resources.



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