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Dear Colleagues:

I appreciate your inclusion of my 1980 "Public Health View of Diet" among the "Classics in Quote" of your first decade in publication. It is rare to have the chance that you gave me at that time to synthesize, conclude and recommend.

In looking over the 1980 presentation, I think I shall not rewrite it. It is clear that much new knowledge has developed but the basic synthesis of causal relationships of habitual diet to mass elevation of blood cholesterol and atherogenic lipoproteins in coronary risk has not changed. Subsequent events have largely confirmed these relationships, improved our understanding of mechanisms, and demonstrated by the rapid decline in age specific death rates that coronary disease is preventable.

This new information also supports the importance of reducing population intake of saturated fatty acids as the major public health strategy as well as the salubrious effects of fishes, and a balanced ratio of poly- and mono-unsaturated fatty acid intake.

The dramatic downward shift in cardiovascular deaths bolsters the idea that we are "doing something right."

At the other extreme of cardiovascular risk, in the Orient, there is important evidence that departure from their traditional diets, very low in fat and protein and high in salt, may be associated with lower rates of hemorrhagic stroke without an excess risk, so far, of brain or myocardial infarction. Apparently a threshold of exposure to elevated blood cholesterol levels is necessary for the mass disease phenomena of atherosclerosis to develop.

The principle that humankind is widely susceptible to high blood pressure and blood cholesterol levels is borne out by increasing evidence. The rate of exhibition of these

phenomena is largely dependent on cultural exposures, lifestyle and habitual diet.

As for the recommendations I summarized in 1980, many are now realized. Agribusiness is actively seeking lower fat and lower salt in processed foods, meats and dairy products and is voluntarily labelling and promoting the health message at the point-of-purchase. The cholesterol-raising forces of which I warned are weaker and the cholesterol-lowering forces are stronger. Qualitative U.S. dietary guidelines were effectively reiterated in 1980-85 and again in the Surgeon General's Report in 1988. Quantitative recommendations of the American Heart Association were enhanced by the authoritative Diet Health Report of the National Academy of Sciences, National Research Council in 1989. The blood cholesterol goals for populations and individuals given for 1980 are incorporated in the National Cholesterol Education Program. The rationale for a population-wide strategy, which includes both public health and high risk preventive measures, was formally proposed in a WHO Expert Committee Report in 1982.

All the new basic knowledge has enhanced our ability to deal with individual risk. New health promotion strategies now tested in several communities improve our capability to help whole communities modify their risk.

For the future we need greater focus on the risk and health behaviors of youth, women, and underserved populations not participating fully in these healthier trends. Finally, there continue to occur major blasts against preventive practice and a public policy of health promotion. In every case, they appear to be motivated either by academics who are very good at saving lives but who fail to recognize the cultural causes of most modern diseases, or by vested interest of the food and chemical industry. If the informed public continues to lead, our leaders will eventually follow.

Cordially,

Henry Blackburn (nf)

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Professor and Director

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