Risk of mortality from cardiovascular disease in relation to plasma cholesterol concentration in 5616 males by age observed over five years

Plasma cholesterol (mmol/l)	No in category	Average age (years)	No of deaths ICD 390-458	Mortality per 1000	Individual risk			Community risk
					Relative risk	P*	Attributable risk	Attributed No of deaths
Age <50 years								
<6.7	2667	43.0	21	7.9	1.00	—	—	—
6.8-7.5	377	43.6	6	15.9	2.02	0.07	8.0	3.0
>7.5	165	44.0	1	6.1	0.77	0.60	-1.8	-0.3
Total	3209		28					2.7
Age ≥50 years								
6.7	1954	54.9	42	21.5	1.00	—	—	—
6.8-7.5	299	54.6	9	30.1	1.40	0.19	8.6	2.6
>7.5	154	54.8	8	52.0	2.42	0.01	30.5	4.7
Total	2407		59					7.3

*Significance levels of relative risk.

Conversion: SI to traditional units—Cholesterol 1 mmol/l ≈ 38.6 mg/100 ml.

The kind of definitive studies demanded by many who are not actively involved in epidemiological or indeed any other form of research are so large and expensive as to require national or international resources like the current trial of treatment for mild to moderate hypertension.¹ If it was feasible, this is what we would all like to resolve the lipid problem. The alternative is to review the consistency of a large number of studies which fall short of the absolute criteria needed for a definitive trial; and, as in cigarette smoking, to reach a balance of probabilities that forms a basis for preventive action. A decline in smoking-associated disease is now manifest both in Britain and North America.

As evidence supporting the balance of probabilities in favour of a change in dietary lipid intake grows epidemiologists are sustained or not sustained in their own hypotheses by the evidence of their own data. In the West of Scotland the Mass Health Examination Unit of the Glasgow Mass Radiography Service is conducting cohort studies of census-identified samples of the general population into the natural history and prevention of the cardiorespiratory diseases.² The accompanying table describes the risk of mortality from cardiovascular disease in 5616 males observed over five years. The values of distributions of fasting serum cholesterol, measured by a laboratory using techniques standardised and tested with an international reference centre, below and above 50 years were made by taking the 80th and 95th percentiles as cut-points for the combined ages and relating the number of deaths from cardiovascular disease according to the *International Classification of Diseases* (8th revision) rubrics 390 to 458. Although numbers are small, particularly in the younger group, the individual relative risk ratios and attributable (excess) risk rates and also the community attributed number of deaths, show a small trend in the older age group which independently tends to support, albeit at a preliminary stage, the contribution made to the multifactorial aetiology of coronary heart disease (CHD) by cholesterol. Moreover, of the 10 (16%) deaths which might have been prevented in the community more than half (9%) of the excess might have been prevented by some form of action among the large numbers in the middle range of plasma cholesterol concentration, 6.8-7.5 mmol/l (261-290 mg/100 ml). Taken with experience in studies elsewhere these findings support the view taken by the Joint Working Party of the Royal College of Physicians and the British Cardiac Society³ that in the current epidemiological situation in CHD the cost of inactivity was

greater than that of giving advice on preventive measures to the public now, particularly where one or more risk factors coexist.

Sir John McMichael and his distinguished colleagues must accept the fact that health education, to be effective in an informed and articulate society, must have a public forum. Ex-cathedra statements based on undocumented debate in private sessions are no substitute for research data, epidemiological or otherwise, and must not be allowed to inhibit perfectly legitimate, sincere, and well-founded initiatives aimed at altering the lipid component of the diet in the United Kingdom until definitive evidence supporting a contrary policy emerges.

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¹ Medical Research Council Working Party on Mild to Moderate Hypertension, *British Medical Journal*, 1977, **1**, 1437.

² Hawthorne, V M, Greaves, D A, and Beevers, D G, *Community Studies of Hypertension in Glasgow: Epidemiology and Control of Hypertension*, ed O Paul, p 537. London, Stratton International, 1974.

³ Joint Working Party, *Journal of the Royal College of Physicians of London*, 1976, **10**, 213.

Lactulose in baby milks

SIR,—From inquiries received since the publication of our brief paper on "Lactulose in baby milks causing diarrhoea simulating lactose intolerance" (7 May, p 1194) it would appear that there is some confusion as to which products contain lactulose. To the best of our knowledge all the currently available prepacked liquid baby milks contain lactulose, while all the available powdered milks are free of this product.

"Baby Milk Plus" and "Premium" were singled out for mention in our paper because these are the products in routine use in this hospital. The paper could well have been based on any other liquid prepacked milk on the market.

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Cataract management today

SIR,—I feel that I must challenge the view expressed in your leading article on this subject (25 June, p 1616). No doubt enzymatic zonulolysis, the cryoprobe, and the microscope

have made the operation for cataract safer, though none of these can properly be described as "new concepts." Intracapsular extraction of cataract was described in 1866, so that is not exactly new either.

I do not think that I can be alone in believing that the only indication for an intraocular operation on both eyes at one sitting is bilateral acute glaucoma and that it is foolhardy to remove both cataracts at the same time. I have no experience of phakoemulsification, but its originator's description does not impress me. It would seem that its effect is the same as that of extracapsular extraction, which in a mature cataract is a perfectly satisfactory operation. The admittedly considerable advantage of the very small incision must be balanced by the doubtful effect in immature cataract, by the further doubt as to whether a hard nucleus can be emulsified, and by the possible dangers of high-energy ultrasound to the eye, or indeed to the operator—I believe that Raynaud's disease has been noted in those who handle such apparatus.

So far as optical correction is concerned, I regard the intraocular prosthetic lens as too dangerous for routine use, while the correction of unilateral aphakia by a contact lens is by no means always successful even in the younger patient. Thus the indication for operation in the average case turns out to be failing sight in the better eye, as it has been for many years.

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SIR,—I was most interested to read your leading article on this subject (25 June, p 1616). Some surgeons would think that you give an altogether too optimistic view of the role of intraocular implants. Although they undoubtedly have a place, they should still be regarded as being on trial and I would strongly advise your readers to note the editorial in the May number of your sister journal, the *British Journal of Ophthalmology*,¹ which takes a more restrained view of the present position of intraocular implants and the use of contact lenses in aphakic eyes.

A C L HOULTON

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¹ *British Journal of Ophthalmology*, 1977, **61**, 307.

SIR,—As you say in your leading article (25 June, p 1616) patients are better informed and more articulate than formerly and I am writing this both as an aphakic patient and as a district community physician.