and the *BMJ* researchers followed them up and recorded the outcomes.

For about two thirds of submissions seen during the study, editors were able to make decisions based on reading only abstracts. They went on to make similar decisions when they read the corresponding whole submissions. For all papers that editors thought should be rejected after reading the abstract, the final decision after full processing was still rejection. The *BMJ* researchers concluded that it would be valid for editors to reject a submission after reading only the abstract if they were confident about that decision, and that when they felt they needed to read a full submission to make a decision, they should do so.¹

BMJ editors now begin screening original research papers by reading only the abstract. Our estimate is that an initial decision is made on the abstract alone in 15-25% of papers. In a further 30-40% of papers editors look at the full paper for one or two specific points, which usually concern the paper's originality or methods. The remaining papers are read more fully before an initial decision is made. This is not as radical as it might sound: it is routine, for example, for conference panels to screen submissions by assessing abstracts. The 30-40% of papers that we send to exter-

nal peer reviewers are read more fully by editors, and by reviewers and—if they survive external peer review—in painstaking detail by several people at our editorial advisory (or hanging) committees.

If you intend to submit an original research paper to the *BMJ* please ensure that its structured abstract is as complete, accurate, and clear as possible—but not unnecessarily long—and has been approved by all authors (see our full advice on writing structured abstracts at <http://bmj.bmjournals.com/advice/sections.shtml>). All too often abstracts are poorly written, incomplete, misleading, and plain wrong.^{2,3} And, anecdotally, we know that the abstract is often the last piece written and is left to the least experienced author to produce.

Trish Groves *coordinating editor BMJ*

(tgroves@bmj.com)

Kamran Abbasi *acting editor BMJ*

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Is good cholesterol always good?

Genetic and pharmacological increases of HDL cholesterol need further evaluation

Cholesterol has an essential physiological role in humans, but an excess is pathogenic. Its metabolism is regulated by various enzymes, receptors, and transfer proteins present in the small intestine, liver, peripheral cells, and plasma. Cholesterol is secreted from the liver into plasma as very low density lipoprotein (VLDL), which gets converted to low density lipoprotein (LDL). LDL cholesterol is a risk factor for coronary heart disease, hence its synonym—bad cholesterol. High density lipoprotein (HDL) helps to carry cholesterol mobilised from peripheral cells and destined for disposal by the liver, a process termed reverse cholesterol transport. This role and epidemiological evidence that the concentration of HDL cholesterol in plasma correlates inversely with risk of coronary heart disease have earned it the reputation of being “good” cholesterol.¹ The recent report of a drug that markedly raises HDL cholesterol by interfering with reverse cholesterol transport poses the question whether this method of increasing HDL will prevent or promote coronary heart disease.²

The new drug, torcetrapib, raises HDL cholesterol by inhibiting cholesterol ester transfer protein (CETP), which mediates reverse cholesterol transport (figure). A recent study shows that almost 40% of the variation in HDL cholesterol between individuals is genetically determined, one quarter of which is attributable to

polymorphisms of the CETP gene.³ Lower concentrations of CETP mean increased concentrations of HDL cholesterol. Lifestyle factors that raise HDL cholesterol include alcohol consumption, which decreases CETP activity and accounts for half the environmental variation in men.^{4,5}

Evidence that an increase in HDL cholesterol is associated with longevity and inversely correlated with incidence of coronary heart disease implies that genetically determined increases in HDL cholesterol should be protective. Several CETP gene mutations decrease CETP activity and raise HDL but the evidence as to whether they are beneficial is conflicting. For example, a case-control study of Ashkenazi Jews with exceptional longevity showed a highly significant increase in the frequency of a mutation associated with reduced CETP activity compared with two groups of controls.⁶ In contrast, an earlier observational study showed that the frequency of a CETP mutation associated with markedly raised concentrations of HDL cholesterol, common in the north of Japan, was reduced in subjects over the age of 80, but at only a borderline level of significance.⁷ An increased prevalence of coronary heart disease was seen in men of Japanese ancestry with a different CETP mutation and moderately (but not markedly) raised HDL cholesterol in the Honolulu heart programme's cohort,⁸ and a large case-control

The adverse effects of CETP deficiency have been attributed to impairment of reverse cholesterol transport and loss of the anti-atherogenic properties of HDL resulting from its increased cholesterol content and particle size.^{8,9} This explanation is challenged by three studies. One showed that increased HDL size was associated with longevity in Ashkenazi Jews.⁶ The population based Framingham offspring study found that another common CETP polymorphism conferred a reduced risk of coronary heart disease in a sample of men (but not women).¹⁰ CETP polymorphism also reduced the risk in men participating in the Veterans' Affairs HDL cholesterol intervention trial (VA-HIT), a randomised controlled trial of gemfibrozil.¹¹

In the meantime, how should clinicians react? Firstly, they should continue to measure HDL cholesterol, since a low value (< 1 mmol/l in men, < 1.2 mmol/l in women) remains a strong and independent risk factor for coronary heart disease. If the concentration is low, efforts should be made to increase HDL by encouraging exercise and discouraging smoking. Fibrates raise HDL cholesterol moderately and may decrease the risk of coronary heart disease. Alternatively, statins lower LDL cholesterol and the ratio of total cholesterol to HDL cholesterol.

Gilbert R Thompson *professor*

472

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