Editorials

Guest Editorial: Blood Cholesterol Lowering in Elderly Patients

My elderly patients want blood cholesterol tests. Moreover, in contrast to results of other tests when a report of "normal" will suffice, they want to know their precise number. For example, S.N. is 75 years old, active, thin, and without significant disease except for borderline blood pressure elevations, but she is worried that her blood cholesterol level is 318 mg/dL. Because she is not obese, exercises, and always has eaten a relatively low-fat diet, my only remaining treatment alternative is medication. We are both reluctant to take this next step. I would like to allay her anxiety, but the arguments I use with colleagues are hard for her to believe or to understand. They are as follows:

1. The relation between total cholesterol blood levels and either mortality from coronary heart disease or total mortality in persons aged 60 years or more is uncertain. In the Framingham Study, 1959 men and 2415 women, aged 31–65 years, who were free from cardiovascular disease and cancer, were monitored for a 30-year period. There was no correlation between cholesterol levels and cardiovascular or total deaths in persons more than age 60.[1] In contrast, the Honolulu Heart Program, which monitored 1480 men aged 65 years and older for an average of 12 years, reported a relative risk of 1.64 (95 percent confidence interval, 1.14–2.36) for the upper quartile of cholesterol levels when compared with those in the lowest quartile.[2] Women were not included in this study.
2. There have been no large-scale controlled trials of cholesterol-lowering drugs in either the elderly or in women. Benefit from drug or dietary treatment in these groups, therefore, is uncertain.
3. Cholesterol-lowering drugs have adverse consequences. Cholestyramine is a cocarcinogen in animals[3] and was associated with more gastrointestinal malignancies in a treated group of middle-aged men than in those given a placebo (not statistically significant).[4] In the Helsinki Heart Trial, men treated with gemfibrozil had more gastrointestinal operations than those who received the placebo ($P = 0.02$).[5] Effects of the long-term use of lovastatin are unknown.

S.N. is not convinced that she shouldn't worry. It is hard to overcome the steady stream of cholesterol-lowering advice that emanates daily from the media with endorsements from the National Heart, Lung and Blood Institute; the American Heart Association; and other professional medical organizations. The attractive elderly man who is jogging in the Mazola™, television commercial feels much better now that his cholesterol level is under 200. "I can live with that," he states proudly.

My colleagues also are not convinced. From 1983 to 1988, their prescriptions for cholesterol-lowering drugs in the United States increased from 2.6 million to nearly 13 million, and from 1978 through 1988, 54 percent of persons using these drugs were 60 years of age or older.[6]

C.R. is a 66-year-old distinguished professor who has authored a multitude of articles and several books. He was very complimentary about my paper "Consequences of the National Cholesterol Education Program"[7] in which the costs, physician work load, legal risks, and adverse patient consequences from universal adult cholesterol testing and treatment are detailed. He also enjoyed reading the excellent article by Thomas J. Moore published in the *Atlantic Monthly* (September 1989), which covers many of these same issues.[8] He is healthy, vigorous, and without demonstrable disease. At his last checkup, he sheepishly asked whether a cholesterol test was included in the blood work I ordered. He said, "I am not concerned, but you know my wife. . . ."

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New Horizons For *JABFP*

This issue of *JABFP* marks the start of its fourth year of publishing and its first issue as a bimonthly publication. The American Board of Family Practice has made the commitment to increase the *Journal*'s frequency to bimonthly at this time and to monthly as the need develops. This issue also marks the start of my role as Editor of *JABFP*. In my own transition from previous editorial activity to my present role, I have been very much impressed with the extent of support and understanding by the leadership of the American Board of Family Practice for this kind of journal as a forum for publication of original work in the field.

Journals in many fields are complex organisms, subject to many pressures for their viability and survival in competing markets. It is not uncommon for there to be some tension between the goals and interests of the publisher-owner of a journal and its editorial philosophy and policies. In this instance, it is a privilege to become involved with this *Journal* under circumstances of strong organizational backing and complete congruency of editorial goals and purpose between the editorial staff, sponsoring organization, and publisher. High standards of quality and commitment to the literature of record have already been established between the American Board of Family Practice and the Publishing Division of the Massachusetts Medical Society under the leadership of the founding editor, Dr. Paul Young. My task will be to build on this solid foundation as *JABFP* expands into its next phase of development.

The increasing frequency of *JABFP* will make it more accessible to the readership and provide new opportunities for publication of original work in the field. The original editorial goals and directions, as charted through the vision of Drs. Pisacano, Young, Stephens, Brucker, and others, will be continued. Undoubtedly, new editorial features will be added as the need arises, but the overall goal will be to continue to publish a broad spectrum of papers relevant to family practice, both as a clinical specialty and as the foundation of primary care in the nation's evolving health care system.

In a generalist specialty like family practice, it is difficult to categorize neatly all of the kinds of papers that will be useful to the field and of interest to the readership. Research advances relevant to the field, for example, may involve studies at various levels, ranging from the individual patient to the family, to the community, and to the health care system. Research studies may be oriented to clinical outcomes, health services, clinical epidemiology, clinical decision making, biopsychosocial factors, and other perspectives. The *Journal* will provide an active forum for publication of a broad range of scholarly work. High priority will be given to reports of clinical studies and experiences in family practice settings and to papers that advance family medicine as an academic discipline. The *Journal* will welcome a spectrum of contributions, including original articles, clinical reviews, case reports, editorial commentaries, correspondence, book reviews, and related scholarly articles relevant to family medicine and the family physician. As the field develops and its literature base matures, we can anticipate that reported studies