feasible approach, though it would obviously be more
difficult for pediatricians. While not addressed by Bell
or Garcia, it would seem to me important for them to
have examined how many children with high cholesterols
in fact had parents with normal cholesterols. These are
the children who would truly be missed given effective
screening of parents' cholesterol and subsequent screen-
ing of "high-risk" children. This is likely to be a much
smaller fraction of hypercholesterolemic children than
the 36 to 48 percent found in the Bell and Garcia studies.

Until this type of data is available, it may still make
sense for pediatricians to screen all children, given their
more limited access to unscreened parents. For family
physicians, however, who are likely to have the parents
under their care, it may be more desirable to screen par-
ents first, and children of hypercholesterolemic parents
second.

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References
1. Bell MM, Joseph SJ. Screening 1140 fifth graders for
hypercholesterolemia: family history inadequate to predict
2. Garcia RE, Moodie DS. Routine cholesterol surveillance
3. Schucker B, Bailey K, Heimbach JT, et al: Change in pub-
lic perspective on cholesterol and heart disease. Results
from two national surveys. JAMA 1987; 258:3527-31.

The above letter was referred to the author of the article
in question who offers the following reply.

To the Editor: Dr. Kelly makes an important point
that family physicians need to be diligent in screening
adult patients for hypercholesterolemia. As he points
out, however, up to one-half of all adults have never had
their cholesterol levels checked. Healthy young adults
often fail to seek preventive health care and may
see family physicians only episodically for acute illnesses.
On the other hand, most children do routinely see
physicians until age 5 to complete primary im-
munizations. The preschool visit could be a good op-
portunity for cholesterol screening, discussion of diet,
and a reminder that the parents should also have cho-
lesterol levels tested.

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