

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

One Family of Generalists

To the Editor: As a reader of the *Journal* since its inception, I value the effort put forth by this high-quality publication. It is in this light that I believe a response is needed to Dr. Benson's reply¹ to Dr. Greenberg in the Correspondence Section of the October-December 1990 issue regarding the comparison between family medicine and internal medicine.

Dr. Benson has received a number of replies to his essay and should be assured that he is not alone in his misunderstanding of family medicine. I have no disagreement with him about the importance of primary care. As President of the American Board of Internal Medicine, he takes a courageous stance in advocating primary care. It may be of value, however, to recognize that there are significant philosophical differences between the specialties of family medicine and internal medicine.

The specialty of family medicine has remained committed to its goal of training physicians who are able to provide continuous, comprehensive care to their patients regardless of age, sex, or type of problem. This cohesive approach to patient care is taught to the residents by family physicians. The graduates of family practice residencies almost never subspecialize, whereas internal medicine traditionally has been a breeding ground for subspecialists. Now, internal medicine is developing an interest in primary care and recognizes the current trend of subspecialization as a problem. The specialty wishes to increase the number of general internists and is adding various office rotations to its curriculum. This is a good start, but it does not result in similarly trained physicians. The philosophy and skills taught in these specialties are very different. Family medicine is more than hospital training with the addition of a few outpatient rotations.

While it might be true that family practice residents spend a great deal of time on internal medicine rotations, it is misleading to claim that they receive more training from internal medicine than from any other specialty. In fact, little of their education is from general internists, who typically are not identified as role models for young family physicians. More training is received from subspecialists during these rotations and from subspecialists

who serve as consultants. Family physicians provide the most vital aspect of the resident's education, and this process continues in the ambulatory setting during rotations.

To assume that family physicians are not "trained for or interested in the care of the very sick newborn" contradicts the fundamental philosophy of family practice. Pediatric care, including sick newborns, is undeniably an integral aspect of family practice. Also, the practice of obstetrics, which is not addressed by Dr. Benson, is at the very heart of family practice; the delivery of the newborn marks the beginning of the family life cycle. Family practice residents are trained in obstetrics, and their pediatric education includes newborn intensive care rotations providing skills essential for continuity of care, especially in rural areas.

In closing, I would encourage Dr. Benson to continue his exploration of family medicine and its unique philosophy of primary care. Family medicine may not have all the answers, but it may well have ideas beneficial to the training of general internists.

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Blood Cholesterol Lowering

To the Editor: In a recent *JABFP* guest editorial, Dr. Froom¹ advanced three arguments against the use of medications to lower elderly patients' elevated cholesterol levels. Two of his three arguments articulate sound reasons for caution in considering medical treatment for such patients. Many clinicians consider the lack of controlled trials documenting benefit of medical treatment in this population to be sufficient grounds for withholding lipid-altering medications from most, if not all, elderly patients. The only controlled trial that showed preventive benefit from lowering cholesterol in an elderly population was the Los Angeles Domiciliary Trial.² This dietary intervention study ran for 8.5 years with 846 men in a Veterans Administration Hospital. At the beginning of the study, most of the men were in their 60s; mean age was 65.6 years.

The potential for adverse drug effects also can be a dissuading factor, despite the fact that physicians treat other chronic health problems in the elderly with long-term medications having far more frequent and serious side effects than the currently used lipid medications. The high cost of lipid-altering prescription medications would seem to be a more serious problem for the majority of patients.

Froom's first argument, however, is not valid. He asserted that the relation between total blood cholesterol

and either mortality from coronary heart disease or total mortality in persons aged 60 years or more is uncertain. He cited the Honolulu Heart Program³ data reported in 1990 supporting cholesterol as a major risk factor in elderly men. He then contrasted this with Framingham⁴ data reported in 1987 that did not show a relation. He neglected, however, to consider more recent Framingham⁵ data, reported in 1989 for larger numbers of elderly, showing total cholesterol to be a primary risk factor in persons aged 60 to 70 years, even with multivariate analysis controlling for other risk factors. Because of the greatly increased incidence of coronary artery disease and myocardial infarction with advancing age, the latter Framingham article noted that the relative impact of cholesterol was somewhat stronger at younger ages, and the absolute impact was worse with advancing age.

Froom also ignored previously published Framingham data showing elevated low-density lipoprotein (LDL) cholesterol and low high-density lipoprotein (HDL) cholesterol to be powerful predictors of heart disease in elderly as well as younger persons.⁶ For the healthy elderly with a good quality of life, and for those with known coronary artery disease, the potential for at least postponing myocardial infarction would seem to be substantial.

This would include many of those with total cholesterol levels above 6.2 mmol/L (240 mg/dL), along with LDL cholesterol above 4.2 mmol/L (160 mg/dL) or HDL cholesterol below 1.1 mmol/L (40 mg/dL). Longevity would probably not be significantly extended in most cases. If, however, the existing functional status could be preserved for an additional several years, the benefit of such treatment would justify some degree of expense and an acceptable level of risk for adverse effects.

Moore's article,⁷ described by Dr. Froom as "excellent," raised salient issues in a provocative manner. It also, however, distorted some information, focused on carefully selected data, isolated facts from their overall scientific context, and omitted a vast body of well-established knowledge contradictory to the author's opinions. It was far from a balanced objective review of the evidence regarding lipids and heart disease. Dr. Froom's earlier article,⁸ on the other hand, raised problematic practical issues that should be addressed.

Research is needed to clarify the safety, acceptance, and efficacy of lipid-altering medications in the elderly, as well as to investigate their preventive effects. A National Heart, Lung, and Blood Institute initiative for a multicenter trial of HMG-CoA reductase inhibitors for hypercholesterolemia in the elderly may eventually produce data that will resolve this controversy. Meanwhile clinicians still have to respond to elderly patients' questions and concerns about cholesterol. We must decide whether to extrapolate to our elderly patients what we do know about the natural history of patients with high blood cholesterol levels and the treatment response of middle-aged men. Several analyses of this issue have recently been published.⁹⁻¹⁴

Allman¹⁵ concluded a recent article in the newsletter of the Society of General Internal Medicine saying,

Recognition of the misconceptions that might prompt one to ignore hypercholesterolemia in older persons will permit physicians to make management decisions on a case-by-case basis for active and independent older persons who are likely to benefit from lowering serum cholesterol levels.

Kafonek and Kwiterovich¹² concluded,

The decision to treat older persons with lipid-lowering medication should be made cautiously and based on the assessment that the benefits will outweigh the risks. In either case, the elderly patient should understand the rationale for using or not using cholesterol-lowering medication and agree with the proposed plan.

At this point, an individualized approach seems to be more appropriate than blanket discouragement of concerned elderly patients wishing medical treatment for high blood cholesterol levels.

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