
This slim volume contains 15 concise presentations and 14 pages of edited discussion by many of Britain’s experts on coronary prevention. The emphasis is on strategies based on contact with individuals.

Three problems are highlighted: the low specificity and sensitivity of known risk factors, the logistics and costs of screening, and the disappointing results of risk factor intervention trials. Haemostatic factors are given prominence as a potential new risk factor, but Epstein pours water on the idea that these problems might be solved by identification of new risk factors. The key question now is how these uncertain scientific data can be applied in practice.

Although not a consensus conference, the contributors did agree on several issues, the most practical of which is that the existence of a case-finding approach for the detection of high blood pressure in general practice pre-empts the setting up of any separate screening service for coronary disease.

Although the workshop also reached a consensus against population-screening for high cholesterol, the arguments in favour of this conclusion ranged from Mitchell’s view that the risks of raised cholesterol have not been shown to be reversible, and that prevention should concentrate on stopping smoking and improving coronary care in the community, to Shaper’s arguments that there is no point in screening for high risk individuals when the whole population is at high risk, and that knowledge of individual cholesterol levels adds little to the value of risk scores which are based on more easily collected data.

This issue is given greater scrutiny than the proposal for selective screening of relatives of patients with premature CHD (“which will require co-ordination between general practices throughout the country”). This appears in the editors’ conclusions, although Shaper twice points out that the contribution of family history to coronary risk is marginal.

The range of possible preventive activities in clinical practice is not, of course, restricted to “screening” in the narrow sense. Thus, while “screening is not necessary to identify smokers . . . ”, there is a case for screening smokers (or, more accurately, for recording smoking status in the case-notes) with the aim of generating a challenge to do something, rather than of providing new information.

Williams suggests that this type of approach to smoking is a better buy (per QALY) than screening for either hypercholesterolaemia or hypertension. His assessment of hypertension screening is limited, however, by the exclusion of the effects on stroke and naive assumptions concerning the effect of