The May 16, 2001 issue of JAMA carries the Executive Summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel (Adult Treatment Panel III [ATP III]). The Executive Summary is an excellent condensation of the comprehensive ATP III document, which is based on a rigorous evidence-based framework constituting more than 200 pages and 800 references.

The original guidelines, published in 1988, emphasize primary prevention for individuals with high low-density-lipoprotein cholesterol (LDL-C) levels. In 1993, a second set of recommendations shifted the direction toward more aggressive therapy for those who already had cardiovascular disease. Since 1993, there has been an abundance of information on lipoproteins, resulting in the most recent set of guidelines with a multitude of new recommendations. The new features of ATP III are summarized into three categories: abdomen obesity, hypertension, hyperglycemia, elevated triglyceride levels, and decreased high-density-lipoprotein cholesterol (HDL-C) levels.

ATP III recognizes the metabolic syndrome as a secondary target of risk reduction after the LDL-C goal has been attained. Specific recommendations for treatment of the metabolic syndrome include intensified therapeutic lifestyle changes and, if elevated, triglyceride level (defined as >200 mg/dL) into the treatment strategy. If the triglyceride level is elevated, a second lipid goal for non-HDL cholesterol (total cholesterol-HDL-C), which targets triglyceride-enriched atherogenic lipoproteins, can be set at 30 mg/dL higher than that for LDL-C.

The second general category consists of modifications of lipid classifications. In this category, LDL-C levels less than 100 mg/dL are deemed optimal. A low HDL-C level remains a risk factor; however, the level at which the risk is conferred is now raised from less than 35 mg/dL to less than 40 mg/dL. A third change in lipid classification is lower triglyceride cutpoints to give more attention to moderate triglyceride elevations.

The third general category where changes are noted are areas in support for implementation. In this category, a complete lipid profile as the preferred initial test rather than screening for only total cholesterol and HDL-C levels is recommended. The use of a Therapeutic Lifestyle Change (TLC) diet is the recommended diet of choice. This diet includes: reducing saturated fat to less than 7% of total calories, reducing dietary cholesterol to less than 200 mg/d, and supplementing the diet with plant stanols/sterols and viscous (soluble) fiber.

Also in this category are recommendations for strategies promoting adherence to therapeutic lifestyle changes and drug therapy to support the use of these guidelines into routine clinical practice. Recent data suggest that even under the previous guidelines, individuals at risk are not currently being treated to their LDL-C targets. The new guidelines have now raised the anti-cholesterol targets considerably, estimating 36 million Americans would benefit from drug therapy, up from 13 million under the previous guidelines. Diet should now be recommended for 65 million Americans, up from 52 million.

The osteopathic medical profession is one that embraces... (continued on page 363)
the tenets of primary care, health promotion, and disease prevention. It is time that we as a profession step up to the plate and take the lead by implementing these guidelines in our daily practices. In doing so, our actions will help lead the way in having a positive impact on the number one killer—cardiovascular disease—in the United States.

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References


Correction
An error appears in the article titled “Clinical review of home uterine activity monitoring (HUAM),” by Mark A. Kalchbrenner, DO (JAOA 2001;101(2 Suppl):S18-S24). On page S21, the first sentence of the last paragraph in the first column should read, “In a recent randomized prospective trial that led to FDA approval of an HUAM device, Mou and associates addressed the effectiveness of the HUAM device alone compared with self-palpation of uterine activity for early detection of preterm labor in a study of 377 women at risk for preterm labor.” The study by Mou and associates was incorrectly referred to as a “randomized, retrospective trial.”