tome might suggest). The key symptom headings – the single episode of prolonged vertigo, recurrent vertigo and dizziness, positional vertigo, chronic dizziness, and dizziness and imbalance in the elderly – encompass a surprisingly broad sweep of neurological and general medical practice in succinct and practical form. A brief general section on treatment concludes the book. The authors manage to keep the harassed clinician firmly in view throughout, and successfully resist the temptation to stray into esoterica (no mean feat considering their formidable accumulated erudition and experience). The text is supplemented by useful tables and the illustrations are on the whole clear and occasionally surprising (who could have expected to encounter a medieval exorcism in the middle of a down-to-earth discussion of psychogenic dizziness?). Each chapter concludes with a section, 'What to do if you don't have a clue' which seems set to salvage many an ill-fated outpatient appointment. The enclosed CD is a particular strength of the book; it really does amplify the text and stands alone as a teaching aid in what remains a richly clinical enclave of internal medicine.

Perhaps the single most refreshing thing about this book is the unpretentious and accessible style with which it is written. Bronstein and Lempert make their subject engaging and humane. If not exactly Shakespearean, their book is nonetheless a worthy addition to the canon on this often baffling and too often mysterious symptom. Hippocrates would be proud to own it.

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letters
TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Response to personal viewpoint on revalidation

Editor – Goddard and Cunliffe liken their experience of assessment for certification in colonoscopy to procedures which may be used in revalidation (*Clin Med* June 2007 pp 304–5). They end their letter with the comment that, 'Revalidation will not be good news for everyone, but everyone should be better for it'. Really?

Firstly, nobody yet knows for certain what revalidation will involve – indeed, doubts have already been cast on its legality in respect of doctors now on the specialist register. Secondly, if revalidation is to mean anything, it presumably could mean, potentially, the loss of a doctor's livelihood. I suggest that this risk would be considerably more stressful than failing colonoscopy certification, notwithstanding the blow to the authors' pride, and the delay in establishing their trust's screening programme that would result. Thirdly, how many of us, or our patients, would genuinely benefit from our (effectively) re-sitting our Royal College diploma on a five yearly basis for the rest of our working lives, particularly as we grow older, and more experienced/specialised?

There are many unanswered questions in relation to revalidation, but above all, I should like to see some hard evidence as to its real value. Or is it just another management concept that does not need testing before its wholesale imposition?

I accept that some form of periodical reassessment of medical staff *may* be desirable, but I consider Goddard and Cunliffe's largely uncritical welcome of revalidation both premature and naive.

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The future of coronary heart disease prevention

Editor – Though the recent article by David Wald (*Clin Med* August 2007 pp 392–6) starts well it seems to drift into an advert for the Polypill. The claim that a Polypill will reduce cardiovascular disease by over 80% in both primary and secondary cardiovascular prevention is impressive. This is made in the absence of clinical trial data, or even a product. From a public health perspective, prevention of heart disease is simple. The up-most risk factor is smoking, with a dose linear relationship. The chances of myocardial infarction are about 12-fold greater with 40 cigarettes/day when compared to non-smokers.[1]

Hypertension sets the threshold at which cholesterol becomes important. Hypertension and age-related increases in blood pressure are unknown in societies with a salt intake <3 g/day; the UK average is 10 g/day.[2]

Lipid-lowering agents should only be used as part of the overall management of risk factors for cardiovascular disease and it is important not to over interpret the data.[3,4] Stopping smoking, increasing exercise, and increasing fruit and vegetable intake should be recommended, as these factors are responsible for 80% of heart disease.[1] The restriction of dietary salt to <3 g/day should also be added to this list as a public health measure.

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The future of coronary heart disease prevention

Editor – It is high time that some of the many wildly incorrect and dissembling assertions currently being made about the Joint British Societies' second (JBS2) extremely reasonable recommendations for cardiovascular disease prevention,[1] which are entirely consonant with the National Institute for Health and Clinical Excellence (NICE) assessment of statins,[2] begin to be corrected before they cause real harm.

It was particularly distressing to find in the recent article by Wald a major inaccuracy (*Clin Med* August 2007 pp 392–6). He claims that JBS2 recommends that statins are introduced when serum cholesterol is 6 mmol/l or above. In reality it recommends that statins are introduced on the basis of cardiovascular disease risk. Generally high cardiovascular disease risk is identified by the presence of an atheromatous complication, diabetes, a genetic syndrome such as familial hypercholesterolaemia or a ratio of total serum cholesterol to high density lipoprotein cholesterol of 6 or more. Only some 5% of men and less than 1% of women would be in the latter catergory,[3] most of whom would develop premature cardiovascular disease.

One is also left to wonder why he believes that a Polypill containing three low-dose blood pressure lowering drugs, a statin (presumably low-dose), aspirin and folic acid is safer than atorvastatin 80 mg or rosuvastatin 40 mg when aspirin 75 mg daily alone is about 100 times more likely to cause a serious side effect than a statin even at its maximum licensed dose.[4-7] Atorvastatin or rosuvastatin in these doses will lower low-density lipoprotein cholesterol by 2.6 mmol/l as Wald correctly states. This translates into a 55% decrease in coronary heart disease and stroke risk.[6]

The Polypill concept is an interesting way to focus debate, but is never likely to be a reality except perhaps in secondary prevention. JBS2 on the other hand provides clear, albeit aspirational, guidance which makes use of paradigms in current clinical practice.

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In response to Warren and Durrington

Warren and Durrington seem to have missed three of the main points in my article:

1 That use of the cardiovascular risk factors as screening tests is an inefficient method of estimating a person's risk of a coronary heart disease (CHD) event. Combining different risk factors to calculate a person's risk over a specified time period, adds only a little precision to simply basing the risk estimation on age alone, and is not worth the extra complexity. While Durrington is correct in indicating that it was not total cholesterol concentration alone that was the basis for risk estimation in the guidelines, this observation does not overcome the problem that risk factors make poor screening tests. The cardiovascular risk prediction charts presented in the JBS2 guidelines[1] (and reproduced in the back of the British National Formulary) confirm this – the change in risk with increasing age greatly exceeds that with increasing serum cholesterol: high-density lipoprotein ratio or blood pressure. Current risk factor based screening should be simplified and replaced by using combinations of treatments to simultaneously lower several causal risk factors, in all people above a certain age or with a prior history of vascular disease regardless of the level of the risk factors.
2 The evidence supporting this approach and the efficacy of the individual Polypill components is substantial.[2] The evidence on the combined effect of all the components includes trial evidence that the effects of each are independent of the others,[3,4] a randomised controlled trial of multifactorial intervention[5] and an analysis of multifactorial intervention in general practice.[6] Polypills have been made for both primary and secondary prevention and are being used in trials, for example in India, New Zealand and Iran.
3 Using the Polypill is, of course, not an alternative to healthy dietary and lifestyle practices such as the avoidance of smoking. The two are complementary. The problem is that in practice only relatively modest changes in risk factors are achieved through changes in diet and other lifestyle habits. I agree with Warren that reducing the salt content of our food to less than 3 g/day is important; it requires a reduction in the salt content of manufactured foods by the food industry. This, too, is complementary to the Polypill approach. I also agree with Durrington that statins are safer than aspirin; I never claimed otherwise in my article.

In rejecting the Polypill concept Warren and Durrington are missing a major public