

man (News & Comment, 4 Sept., p. 1101), I know what "self-interest," "mutual interest," "common interest," and even "common self-interest" mean, but what is "mutual self-interest"?

ROBERT A. STAIRS

*Department of Chemistry, Trent University,
Peterborough, Ontario, Canada K9J 7B8*

California's Proposition 65: A Reply

The recent editorial of Philip H. Abelson (25 Sept., p. 1553) concerning California's Proposition 65, the Safe Drinking Water and Toxic Enforcement Act of 1986, painted an unrealistically woeful picture. The implementation is being carried out in a manner that will not encumber industry with unnecessary burdens, yet it will protect the state's sources of drinking water and provide information to Californians about chemicals to which they are exposed.

The California Health and Welfare Agency is the agency responsible for the implementation of the Act. A Scientific Advisory Panel, consisting of 12 members from academia and industry, recommends to the agency those chemicals that are to be listed as chemicals known to the state to cause cancer or reproductive toxicity. Contrary to Abelson's views, it is unlikely that common table salt will be listed as a reproductive toxicant.

The 15,000 items on supermarket shelves will not require warnings. The public's first statewide introduction to warnings will be with regard to the reproductive toxicity of ethanol in alcoholic beverages. In this case, warnings will be required by 1 October 1988. Similar warnings for alcoholic beverages are already in place in Los Angeles and San Diego, the result of local actions. Labels are not required by the Proposition, nor by the agency's proposed regulations.

The Health and Welfare Agency has issued proposed regulations that address naturally occurring substances. The presence of such chemicals in food will not constitute an exposure under the Proposition. The agency intends to recognize regulatory levels for carcinogens and reproductive toxicants that are regulated by state and federal agencies, to the extent that they provide the same level of human health protection required by the Proposition.

California is implementing Proposition 65 in a manner that is fair, predictable, and based on a firm scientific foundation. When fully implemented, it will serve to complement existing laws concerned with environmental and public health protection. Those who comply with existing laws and regula-

tions will, in most cases, be in compliance with Proposition 65. Those, however, who fail to comply with existing laws designed to protect the public health will also be out of compliance with Proposition 65. Such activities, if not addressed by government enforcement agencies, would be the most likely targets for the "bounty hunter" provisions of the Proposition.

STEVEN A. BOOK*

*California Health and Welfare Agency,
Sacramento, CA 95814*

*Science Adviser to the Secretary, Health and Welfare Agency, State of California.

Cholesterol Guidelines

The report (1) of an expert panel of the National Cholesterol Education Program of the National Heart, Lung, and Blood Institute (NHLBI) announced on 5 October and discussed by Leslie Roberts (Research News, 23 Oct., p. 482) exaggerates the risks of coronary heart disease (CHD) from total serum cholesterol values and magnifies the predicted benefits of following the guidelines proposed. Although there is some evidence that a "desirable level" of serum cholesterol is less than 200 milligrams per deciliter (mg/dl), there is no convincing evidence that 199 mg/dl is less risky for CHD than 210 mg/dl (2). The range of 200 to 239 mg/dl is a gray area of mild risk reaching twice the baseline risk at 240 mg/dl.

The range of 200 to 239 mg/dl under no imaginable circumstance could be considered to be "borderline high." This is analogous to saying that a systolic blood pressure of 121 to 139 millimeters (mm) of mercury and a diastolic blood pressure of 81 to 89 mm are "borderline high." Borderline values in clinical medicine are single values that demarcate negligible risk from measurable risk. The usually accepted borderline value for blood pressure is 140/90 mm of mercury; for fasting blood sugar, 100 mg/dl; and for serum cholesterol, greater than 240 mg/dl. Most physician-scientists believe that values of serum cholesterol of 240 to 280 mg/dl constitute moderate risk and greater than 280 mg/dl, high risk.

Recommending that more than 25% of the adult population of this country go on fat-modified diets for cholesterol values in the gray zone is, in my opinion, a gross exaggeration of the hazards. If other risk factors are present, it might be important to do so. Furthermore, both low-density lipoprotein cholesterol and high-density lipoprotein (HDL) cholesterol should be measured because of the protective action of

HDL cholesterol above 40 mg/dl. Most are agreed that intervention should begin at 240 mg/dl, first with diet and then with drugs, if necessary. It is also important to realize that in the moderate range of serum cholesterol, reduction of smoking and hypertension are more important than reduction of cholesterol levels (3).

With regard to the benefits of reduction of serum cholesterol, NHLBI director Claude Lenfant is quoted as saying that "If adopted, these recommendations could result in 300,000 fewer heart attacks each year." Since there are about 800,000 initial heart attacks per year in the United States (and about 550,000 deaths from coronary heart disease per year), this number represents a 40% reduction in initial heart attacks. None of the intervention studies, which have involved 36,000 persons worldwide with diet, or drugs, or both, has achieved a 40% decrease in heart attacks. Furthermore, these studies show only a slight reduction in mortality from CHD, with no change in all-cause mortality (4). These intervention trials, furthermore, have shown only a 5 to 13% change in serum cholesterol as a result of dietary modification over 6 to 8 years.

All of us are most concerned with developing strategies for the prevention of coronary heart disease. It is unjustifiable, however, to magnify the benefits of reduction of serum cholesterol, particularly for those persons at low risk.

ROBERT E. OLSON

*Department of Medicine,
School of Medicine,
State University of New York,
Stony Brook, NY 11794-8160*

REFERENCES

1. National Cholesterol Education Program, *Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults* (National Heart, Lung, and Blood Institute, Bethesda, MD, 1987).
2. R. E. Olson, *J. Am. Med. Assoc.* **255**, 2204 (1986).
3. W. C. Taylor, T. M. Pass, D. S. Shepard, A. L. Komaroff, *Ann. Int. Med.* **106**, 605 (1987).
4. *Lowering Blood Cholesterol to Prevent Heart Disease: Proceedings of an NIH Consensus Development Conference* (National Institutes of Health, Bethesda, MD, 1984).

Liability Insurance and Litigation

The article by Peter Huber on "Injury litigation and liability insurance dynamics" (2 Oct., p. 31) asserts that the reason for the current crisis in liability insurance is an increase in liability law, inducing "mushrooming litigation" and an "avalanche of suits," leading to "unexpectedly large" payouts by insurance companies, thus caus-