Madam, we have read with interest the comments on our review and thank the reader for the letter.

The argument that good cholesterol may not be as "good" as previously thought might open new vistas for research within subsets, but to date there are no international recommendations suggesting that it should not be followed as a protective marker for cardiovascular disease and neither are the recent data suggesting that efforts to raise the HDL cholesterol should be considered futile.

Observational epidemiology suggests that an increase of one standard deviation in HDL cholesterol is associated with reduced risk of MI (OR 0.62, 95% CI 0.58-0.66).[1]

In fact the article[2] that has been cited as the reference to this debate has observed the association of genetically raised (due to SNP) HDL cholesterol in patients with ischaemic heart disease not contributing to the expected risk reduction in IHD. However these disorders are complex and multifactorial and one genetic observation that comprised only 2.6% of the studied population doesn't explain away the huge body of observational and clinical epidemiology of HDL and cardiac risk.

We have mentioned in the review that there is a small subset of population where high HDL levels do not appear to protect against cardiovascular disease.

"HDL function rather than its absolute level may predict atherosclerotic disease better in some subsets of patients where the HDL functions as perhaps pro inflammatory. This explains those patients who develop coronary artery disease and stroke despite very high HDL levels."[3]

Thus perhaps not just the SNP,but the downstream effects of the HDL need to be investigated.

Additionally our review also covers the emerging role of HDL and cerebrovascular disease. This is a very heterogeneous population and the data suggest that raising HDL may be useful, although it is emerging.[4]

Although we acknowledge the side effects of statins, this is a risk benefit trade off that at least in the right populations favours statins in spite of their side effects. There have been recommendations to expand statin indications for patients who are not the candidates under present guidelines. The following article has also been published in Lancet online on May 17, 2012.

According to the Cholesterol Treatment Trialists' (CTT) Collaboration, in patients with 5 year risk of major vascular events lower than 10%, each 1 mmol/L reduction in LDL cholesterol produced an absolute risk reduction in major vascular events of about 11 per 1000 over 5 years. This benefit greatly exceeds any known hazards of statin therapy.This subset of population is not currently being offered statin therapy at all.[5]

Lastly, our review does not recommended statin therapy as a sole intervention; it is only one of many interventions. In fact, lifestyle modifications, diet and exercise, then medical therapy like Niacin and fibrates have been advocated as agents helpful in raising HDL cholesterol.The subset of patients where one needs to focus for elevating HDL cholesterol has also been mentioned.

"The Expert Group on HDL, a working group reporting on low HDL-C levels, advised additional treatment with a fibrate or niacin in persons with diabetes, the metabolic syndrome, or HDL levels <40 mg/d."[3]

Whilst the authors point out an exciting observation, what the HDL is doing in these patients needs to be elucidated before clinicians change their practice.

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