Correspondence

Comment on 'Routine health check-ups'

We read with interest the paper by Honnikeri *et al*. entitled 'Routine health check-ups: A boon or a burden?' published in the *Journal*.[1] The authors need to be complimented for putting forth recommendations for routine health screening in asymptomatic adults in India. They have rightly pointed out that though various guidelines are available for screening and management of dyslipidaemia in the USA and Europe, following western guidelines is not an ideal practice. Indian patients have diverse socioeconomic, cultural, lifestyle and genetic differences that influence the prevalence of dyslipidaemia among them and none of the western guidelines would take these aspects into consideration.

The authors advise routine screening for dyslipidaemia in men >45 and women >55 years of age. They further state that in the presence of risk factors for atherosclerosis, screening for dyslipidaemia is advisable for men 35–45 years and women 45–55 years of age. Atherosclerotic cardiovascular disease (CVD) occurs at a younger age among Indians and surveys have shown that the prevalence of coronary artery disease in urban Indians older than 35 years is about 10%.[2] Moreover, rapid escalation of CV risk factors (such as smoking, hypertension, dyslipidaemia, diabetes and metabolic syndrome) has been noted in urban Asian Indians by 30–39 years of age.[3] Due to an earlier onset of CVD in Indians, prediction of CV risk is challenging and many of the conventional risk assessment tools underestimate the CV risk in Indians.

Hence, we suggest that for Indian patients an even lower age threshold of screening for dyslipidaemia may be justified, i.e. all men >35 years and all women >45 years of age. This should include only a complete lipid profile (total cholesterol, triglycerides, low-density lipoprotein-cholesterol [LDL-C] and high-density lipoprotein-cholesterol [HDL-C]). Routine estimation of Apo B and Apo A-1 levels should not be part of general health screening for dyslipidaemia. Estimation of non-HDL-C may provide a more accurate estimate of CV risk than LDL-C alone, since it provides a fairly accurate estimate of various atherogenic lipid molecules, viz. very low-density lipoprotein (VLDL), intermediate-density lipoprotein (IDL), chylomicrons, chylomicron remnants and lipoprotein (a) (Lp[a]).

The consensus statement on management of dyslipidaemia in the Indian population has also recommended performing lipid estimations as a routine in all adults above 30 years of age.[4] It further suggested that in patients younger than 30 years, a lipid estimation needs to be individualized, based on the presence or absence of concomitant risk factors and/or pre-existing CVD.

REFERENCES

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