**Prevention of Coronary Heart Disease**

The increasing morbidity and mortality from coronary artery disease, particularly in young and middle-aged men in Britain, the U.S.A., and Australia, are causing growing concern. Indeed, some authorities have concluded that we are facing a modern epidemic comparable to the large-scale outbreaks of the contagious diseases in the nineteenth century. Certainly it is important to look at those factors which are probably associated with coronary artery disease to see whether any measures can be recommended to try to halt the rise in its incidence.

Several recent epidemiological studies have clearly indicated that people with certain characteristics form a high-risk group, in which the chances of death from myocardial infarction are several times greater than in the general population. Coronary artery disease affects mainly men between 40 and 60 years of age, and its incidence rises sharply with each decade. In women the condition is much less common than in men until about 10 years after the menopause. Heredity is another important aetiological factor. The man whose father or mother died suddenly in middle age is probably about twice as likely to have a cardiac infarction as one with a negative family history, and the risk may be fivefold if both parents have had premature coronary artery disease.

Fortunately the other characteristics of the high-risk group offer more scope for preventive measures. They have recently been listed by M. F. Oliver and C. H. Stuart-Harris as hyperlipidaemic states, hypertension, cigarette-smoking, physical inactivity, and premature cessation of ovarian activity. There is good evidence that apparently healthy people living in a Western society who have one of these characteristics or habits have an increased likelihood of developing coronary heart disease. The effects of the individual factors are independent and additive. The incidence of clinical coronary heart disease in men aged 40–59 rises from 9 per 1,000 when one of these factors is present to 77 per 1,000 when any three of them are noted at the initial examination. Other possible influences on the development of coronary artery disease are obesity—especially a rapid gain in weight—hyperglycaemia, psychogenic stress and the individual's reaction to it, hyperuricaemia, and a thrombotic tendency.

Most of these factors can be influenced by present-day treatment. Thus hyperlipidaemia can be controlled by a diet which is low in unsaturated fat content or by the use of drugs, of which the most successful so far is clofibrate. Studies carried out on survivors from myocardial infarction have failed to show that lowering the serum lipids thereafter improves the prognosis. Nevertheless, this does not mean that similar measures employed prophylactically in subjects known to be at risk would not be effective, and the results of prospective trials both with diet and with clofibrate which are in progress at present are eagerly awaited. Some information is already available. The experience of "The Anti-Coronary
Neuroblastoma

Neoplastic disease in children is now one of the main causes of death once the neonatal period is past. Leukaemia and associated disorders of the haemopoietic tissues account for about one-third of these deaths, and a further third result from tumours of the nervous system, including neuroblas- tomas. Neuroblastosomas and ganglioneuromas are the third commonest tumours in children and adolescents. Neuroblastosomas are seen most frequently in infants and young children, and in some instances the tumours are undoubtedly congenital in origin. In addition to the quite large tumours which are obvious at necropsy and which may have metastasized widely at birth or shortly afterwards, small foci of neuroblasto-oma may be discovered in the suprarenal glands and elsewhere during routine histological examination of tissues obtained at necropsy during the neonatal period. This is sometimes referred to as neuroblasto-oma in situ.

Neuroblastosomas, especially those arising in the suprarenal glands, seem commoner in the male, and the male–female ratio is of the order of 2:1. By contrast the ganglion- neuroma, which is regarded as a benign tumour and incapable of metastasis, occurs in older children and may even first be detected in adult life. Unlike neuroblastosomas, ganglio- neuromas are commoner in females, and the sex ratio may be of the order of 1:3. It has been suggested that in a few instances a neuroblasto-oma may gradually mature into a ganglioneuroma, and it is an interesting hypothesis that this process may be commoner in the female.1 3

In spite of the frequency with which neuroblastosomas are seen in young children it is a rare event for more than one...