negative antibody screen's strong predictive value for subsequent compatibility. In circumstances where the antibody screen is positive, however, additional testing becomes necessary. The antibody expressed in the recipient's serum must be characterized and the donor red blood cells tested for the presence of the corresponding antigen.

The process of characterizing donor red blood cells as to their expression of a particular antigen or antigens is no less time-consuming than the crossmatch and requires expensive typing serum samples. Simultaneous crossmatching of an appropriate number of type-specific units at the same time is more cost-effective. The procedures are thus complementary and not at all substitutable in certain situations. The crossmatch has been considerably abbreviated at many institutions over the years, but has yet to become outmoded. The relationship is thus not so obviously old/new, outmoded/state-of-the-art for these two procedures, as is the case with the other four paired studies, which may in part explain this pair's relatively weak statistical performance in the authors' analysis.

Carl L. Parrott, Jr, MD
The Deaconess Hospital
Cincinnati, Ohio


Results for Patients With Total Cholesterol Levels (in Millimoles per Liter) in the Desirable Range*

<table>
<thead>
<tr>
<th>Gemfibrozil, 1.2 g/d</th>
<th>Lovastatin, 40 mg/d</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Placebo Period</strong></td>
<td><strong>Drug Period</strong></td>
</tr>
<tr>
<td>TC</td>
<td></td>
</tr>
<tr>
<td>4.65 ± 0.20</td>
<td>4.58 ± 0.19</td>
</tr>
<tr>
<td>TG</td>
<td></td>
</tr>
<tr>
<td>1.82 ± 0.15</td>
<td>1.17 ± 0.06†</td>
</tr>
<tr>
<td>VLDL + IDL-C</td>
<td></td>
</tr>
<tr>
<td>0.85 ± 1.00</td>
<td>0.82 ± 0.05†</td>
</tr>
<tr>
<td>LDL-C</td>
<td></td>
</tr>
<tr>
<td>3.05 ± 0.13</td>
<td>3.13 ± 0.16</td>
</tr>
<tr>
<td>HDL-C</td>
<td></td>
</tr>
<tr>
<td>0.74 ± 0.02</td>
<td>0.85 ± 0.03†</td>
</tr>
<tr>
<td>TC/HDL-C</td>
<td></td>
</tr>
<tr>
<td>6.28</td>
<td>5.39</td>
</tr>
</tbody>
</table>

*TC indicates total cholesterol; TG, triglycerides; VLDL + IDL-C, very-low-density plus intermediate-density lipoprotein cholesterol; IDL-C, low-density lipoprotein cholesterol; and HDL-C, high-density lipoprotein cholesterol. †Level is significantly different than corresponding placebo period by paired t test (P < .05).

Therapy for Low High-Density Lipoprotein Cholesterol in the Face of ‘Desirable’ Levels of Total Cholesterol

To the Editor.—The National Cholesterol Education Program defines hypercholesterolemia as a total cholesterol level of 6.2 mmol/L or greater and borderline hypercholesterolemia as a serum total cholesterol level between 5.2 and 6.2 mmol/L. Desirable cholesterol levels are below 5.2 mmol/L. In the study by Drs Vega and Grundy, “normolipidemic” patients (most of whom had coronary disease) with reduced high-density lipoprotein cholesterol were given pharmacologic agents to determine if elevations in high-density lipoprotein cholesterol levels could be achieved.

This is an important issue, since low levels of high-density lipoprotein cholesterol are prevalent among patients with coronary artery disease even when cholesterol levels are below 5.2 mmol/L. However, it is not clear from the study how “normolipidemia” was defined. Exclusion criteria included plasma total cholesterol levels greater than 6.47 mmol/L; based on this criterion, patients with borderline to high cholesterol levels qualified. Indeed, the concentration of plasma cholesterol in the placebo group of the gemfibrozil treatment phase was 5.12 ± 0.75 mmol/L, which encompasses the range of desirable to borderline-high cholesterol level. Thus, although the study and results were interesting, perhaps it would also be of interest to perform such a study when only desirable cholesterol levels are included.

Patients who were receiving β-blockers made up nearly one third (7/22) of the cohort. Because β-blockers (especially the nonselective agents) often reduce levels of high-density lipoprotein cholesterol, it may have been useful to document if hypoalphalipoproteinemia existed prior to β-blocker administration. Lack of this information makes it difficult to assess how many of these subjects had secondarily low high-density lipoprotein levels, otherwise excluding them from participating in the study.

Further studies that address the treatment of subjects whose sole abnormality is primary hypoalphalipoproteinemia are therefore warranted.

Michael Miller, MD
The Johns Hopkins Hospital
Baltimore, MD


In Reply.—Dr Miller points out that our definition of normolipidemia included total cholesterol levels below 6.47 mmol/L and was not restricted to levels below 5.2 mmol/L, which have been called “desirable” cholesterol levels by the National Cholesterol Education Program. He suggests that our findings for the latter category would be of interest. In response, our patient group included 13 patients in whom total cholesterol levels were in the desirable range (<5.2 mmol/L) at the time of entry into the study. The results for these patients are summarized in the Table.

The direction and magnitudes of changes were similar for those with cholesterol levels below 5.20 mmol/L and for the whole group with levels below 6.47 mmol/L. Therefore, it appears that the conclusions drawn for the whole group can be extended to patients with low-high density lipoprotein cholesterol levels in whom total cholesterol levels are in the desirable range, ie, lovastatin therapy produces a more favorable lipoprotein pattern than gemfibrozil.

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Scott M. Grundy, MD, PhD
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Dallas

Excision of Congenital Nevi: Immediate, Complete, and in the Office

To the Editor.—The question “Congenital Nevi: Should These Be Excised?”[1] is well put and thoughtfully answered. However, important part was not addressed.

The surgery should be carried out in an office, not a hospital, with local anesthesia. The excision should be complete, but conservative, with almost no margin of normal skin. Done quickly and with little fuss at an early age, there is minimal stress; also, the scar will be smaller than if one waits for the congenital nevus to grow.

Robert Auerbach, MD
New York, NY

1. Rhodes AR. Congenital nevi: should these be excised? JAMA 1989;262:1086.

CORRECTION

Incorrect Value in Table.—An error occurred in the Brief Report entitled “Consumption of Olive Oil, Butter, and Vegetable Oils and Coronary Heart Disease Risk Factors,” published in the February 2 issue of THE JOURNAL (1990;263:688-692). In Table 4 on page 690, the glucose level for the high category of consumption among men should have been “4.6 mmol/L” (not “4.9 mmol/L”).

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