Public Health Guidance

Prevention of Cardiovascular Disease (PH25)- Consultation on the review proposal
Stakeholder Comments Table

17 January – 31 January 2014

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Cardiovascular Society	General		The British Cardiovascular Society welcomes the update of NICE guidance on "Prevention of Cardiovascular Disease" from a public health perspective. The proposed emphasis of this update on diet, given new scientific evidence, is appropriate and diet should be linked to the epidemic of obesity in the UK driven by the twin engines of diet and sedentary behaviour. We would welcome specific recommendations for national legislation on public health issues arising from this review which can then be benchmarked in subsequent updates. Legislation for tobacco control has been particularly successful, and there is new proposed legislation on banning smoking in cars transporting children, but comparable legislation on the production and marketing of foods rich in saturated fats, trans fatty acids, salt, simple carbohydrates and so on is lacking. The same is true in relation to the built environment and the need for legislation to facilitate walking, cycling and other activities in everyday living. We would welcome a specific focus on children and young people given the alarming prevalence of overweight and obesity and the associated development of type 2 diabetes. The pernicious role of some parts of the food industry marketing unhealthy foods to children requires legislation to protect these young hearts. Legislation is also required for the school environment regarding school meals, recreational spaces and facilities, sports in the curriculum and so on. Prevention of cardiovascular disease at a population level can be approached in many different ways but legislation is a powerful tool and specific recommendations for areas requiring legislation, and what form this could take, will make this guidance much more powerful.	Thank you.

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British Heart Foundation	General		As the nation's leading heart charity we are working to achieve our vision of a world in which people do not die prematurely or suffer from cardiovascular disease. In the fight for every heartbeat we fund ground breaking medical research, provide support and care to people living with cardiovascular disease and advocate for change. The British Heart Foundation welcomes the proposed review of Prevention of Cardiovascular Disease (PH25). The BHF is supportive of the expert group's recommendation to update this to take account of the new policy and structural landscape affecting the guidance and to reflect new evidence on fats, salt and sugar that has emerged since the guidance was produced. We would like to bring to your attention that updated Joint British Societies Guidelines on Prevention of Cardiovascular Disease (JBS3) will be published in April 2014, which will be a valuable source of information to incorporate into a future review should NICE decide to conduct one. If you require any more information regarding this response please contact Amy Smullen, Policy Researcher at smullena@bhf.org.uk	
Cochrane Heart Group	General (salt reduction)		The search for new evidence and the selection of papers for consideration seems to have included non-contributory articles (Bibbins-Domingo K, Chertow GM, Coxson PG et al. (2010) Projected effect of dietary salt reductions on future cardiovascular disease. New England Journal of Medicine 362:590–9) and missed articles which	Thank you for identifying this evidence. It is our intention to update the guidance to take into

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			would be highly relevant in the salt area (Millett C, Laverty AA, Stylianou N, Bibbins-Domingo K, Pape UJ. Impacts of a National Strategy to Reduce Population Salt Intake in England: Serial Cross Sectional Study.. PLoS ONE 2012;7:e29836; IOM (Institute of Medicine). Sodium intake in populations: Assessment of evidence. Washington DC.: The National Academies Press, 2013; O'Donnell MJ, Yusuf S, Mente A et al. Urinary sodium and potassium excretion and risk of cardiovascular events.. JAMA 2011;306:2229-2238.) The review appears to have missed an entire area of research published since 2011 indicating that the relationship between salt intake and cardiovascular events may not be linear, and consequently that efforts to reduce salt intake to 3g/day (as suggested in NICE targets) may not be beneficial. The US Institute of Medicine report was convened to consider this new evidence and concluded: However, the evidence on health outcomes is not consistent with efforts that encourage lowerng of dietary sodium in the general population to 1,500 mg/day. Further research may shed more light on the association between lower—1,500 to 2,300 mg—levels of sodium and health outcomes.	account development in relation to the dietary components listed. This includes salt and at that time a thorough review of the relevant literature will be carried out when the guidance is reviewed.
Consensus Action on Salt and Health (CASH)	General		Yes we should be updated – it is vital – particularly as the Responsibility Deal has caused chaos to nutrition and prevention of NCDs. We are still awaiting the setting of further targets for salt reduction would should have been set in 2010. As a result the whole salt reduction programme has lost impetus and we calculate that more than 6,000 lives per year could have been saved have been lost, and	Thank you.

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			the longer the delay goes on, the more the number of deaths that could have prevented won't be.	
Consensus Action on Salt and Health (CASH)	General		We also feel that there should be much greater action in that that whole field of obesity and prevention of type 2 diabetes, particularly in reducing the huge and unnecessary amounts of sugar in food, and also tackling saturated fat and reducing this as well as substitution for polyunsaturated fat, which would cause a further fall in cholesterol with big reductions in vascular disease, and even bigger reductions in coronary disease.	Thank you.
Consensus Action on Salt and Health (CASH)	General		There is also a tremendous need for action on smoking and alcohol reduction which the government has refused, so far, to take.	Thank you. NICE has published several pieces of guidance on these topics and it is not our intention to update these in this piece of work.
Department of Health	General		The Department of Health believes that NICE public health guidance which focuses on advising local services is of most value to the public health system. Issues of national public policy and legislation are not suitable topics to address routinely in NICE guidance. We agree that these aspects of the prevention of cardiovascular disease public health guidance do not need updating at this time and should be excluded from the scope of the updated guidance.	Thank you.
Diabetes UK	General		We welcome the expert review panel recommendations to review this guidance. We would urge NICE to take into account the forthcoming Joint British Societies Guidelines on Prevention of Cardiovascular	Thank you. We look forward to the publication of the

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			Disease (JBS3).	Guidelines.
European Atherosclerosis Society	general		For your awareness, see publication ESC-EAS Joint Guidelines on management of dyslipidaemias Atherosclerosis. Volume 217, Supplement 1, Pages 1-44, doi:10.1016/j.atherosclerosis.2011.06.012	Thank you for drawing our attention to this evidence.
European Atherosclerosis Society	general		For your awareness, see publication Joint European Guidelines on Cardiovascular Disease Prevention in Clinical Practice Atherosclerosis. Volume 223, Issue 1 , Pages 1-68, July 2012 doi:10.1016/j.atherosclerosis.2012.05.007	Thank you for drawing our attention to this evidence.
European Atherosclerosis Society	general		For your awareness, see publication Plant sterols and plant stanols in the management of dyslipidaemia and prevention of cardiovascular disease Atherosclerosis - February 2014 (Vol. 232, Issue 2, Pages 346-360, DOI: 10.1016/j.atherosclerosis.2013.11.043)	Thank you for drawing our attention to this evidence.
European Atherosclerosis Society	general		For your awareness, see publication Familial Hypercholesterolaemia is Underdiagnosed and Undertreated in the General Population: Guidance for Clinicians to Prevent Coronary Heart Disease Eur. Heart J, doi:10.1093/eurheartj/eht273	Thank you for drawing our attention to this evidence.
European Atherosclerosis Society	general		For your awareness, see publication Triglyceride-rich lipoproteins and high-density lipoprotein cholesterol in patients at high risk of cardiovascular disease: evidence and guidance for management Eur. Heart J. (2011) 32 (11): 1345-1361. doi: 10.1093/eurheartj/ehr112.	Thank you for drawing our attention to this evidence.

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European Atherosclerosis Society	general		For your awareness, see publication Lipoprotein(a) as a cardiovascular risk factor: current status Eur. Heart J. (2010) 31 (23): 2844-2853. doi: 10.1093/eurheartj/ehq386.	Thank you for drawing our attention to this evidence.
European Atherosclerosis Society	general		For your awareness, see publication The polygenic nature of hypertriglyceridaemia: implications for definition, diagnosis, and management Lancet Diabetes Endocrinol Early Online Publication, 23 December 2013. doi:10.1016/S2213-8587(13)70191-8 *Free to download from 31 January – 28 February 2014 at* http://www.thelancet.com/journals/landia/article/PIIS2213-8587(13)70191-8/fulltext	Thank you for drawing our attention to this evidence.

Global Organization for EPA and DHA Omega-3s (GOED)	3		With respect to fish, which contains the n-3 LCPUFAs, EPA and DHA, new evidence (citations follow) supports and strengthens the following statement made in the June 2010 guidance, "A 'healthier' diet based on fruit, legumes, pulses, other vegetables, wholegrain foods, fish and poultry is consistently associated with lower levels of CVD risk factors (Fung et al. 2001; Lopez-Garcia et al. 2004) and lower CVD mortality (Heidemann et al. 2008; Osler et al. 2001)."
			• Lancet. 2012; 380:2224-2260
			  ○ http://www.ncbi.nlm.nih.gov/pubmed/23245609
			• Circulation 2014; 129:e28-e292
			  ○ http://www.ncbi.nlm.nih.gov/pubmed/24352519
			• Ann Intern Med 2013; 158:515-525
			  ○ http://www.ncbi.nlm.nih.gov/pubmed/23546563
				Thank you for drawing our attention to this evidence. It is our intention to update the guidance to take into account development in relation to the dietary components listed in the update proposal. This includes fats and at that time a thorough review of the relevant literature will be

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				carried out when the guidance is reviewed.
Global Organization for EPA and DHA Omega-3s (GOED)	3		In 2009, for primary prevention of coronary heart disease, the European Food Safety Authority (EFSA) established a dietary reference value (DRV) for the n-3 LCPUFAs, EPA & DHA, the dominant fatty acids found in fish. • EFSA Panel on Dietetic Products, Nutrition, and Allergies (NDA); Scientific Opinion on Dietary Reference Values for fats, including saturated fatty acids, polyunsaturated fatty acids, monounsaturated fatty acids, trans fatty acids, and cholesterol. EFSA Journal 2010; 8(3):1461. o http://www.efsa.europa.eu/en/efsajournal/pub/1461.htm	Thank you for drawing our attention to this evidence.
Global Organization for EPA and DHA Omega-3s (GOED)	7		GOED agrees with the expert group that the guidance should be updated.	Thank you.
Hrtlepool Borough Council	4		Regarding the challenges for implementation	
Hrtlepool Borough Council			The regional implementation and monitoring could be taken over by PHE who will work with the PCT/LA commissioning teams within its geographical area to look at Regional CVD prevention initiatives - look at local take up of NHS Health Check particularly numbers for those in low deprivation areas - Look at those who have had a NHS Health check and been referred onto lifestyle services then look at the outcomes of	Thank you.

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			this referral ie : Weight loss Smoking cessation Increased physical activity Alcohol reduction Funding to be based on the delivery of the check but also on successful measurable outcomes.	
HEART UK – The Cholesterol Charity	3.74		The current guidance notes that "Daily consumption of plant sterols and stanols may reduce blood cholesterol by about 10% - and so may reduce CVD mortality substantially." Plant stanols and sterols are then mentioned further in the recommendations for research questions. For regional CVD prevention programmes, the Expert Panel might consider recommendation of possible use of plant sterols and stanols for people with high cholesterol, where appropriate. A recent European Atherosclerosis Consensus Panel Paper concludes that consuming foods with added plant sterols and stanols can lead to significant reduction in blood levels of low density lipoprotein (LDL)-cholesterol. However, the article does acknowledge that there is no randomised, controlled clinical trial data with hard end-points to establish clinical benefit from the use of plant sterols or plant stanols. A randomised, controlled trial could prove valuable. (See Gylling et al (2014) Plant sterols and plant stanols in the management of dyslipidaemia and the prevention of cardiovascular disease, *Atherosclerosis*, 232: 346 – 360).	Thank you for drawing our attention to this evidence. A thorough review of the relevant literature will be carried out when the guidance is reviewed.
Johnson & Johnson Limited	General		Recent European Atherosclerosis Society Consensus on	Thank you for drawing

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			phytosterols/stanols should be considered (Gylling et al., Atherosclerosis 2014, 232, 2, 346-360) in relation to recommendations. Foods with plant sterols/stanols, as a component of lifestyle intervention, may have potential value in those with high LDL-cholesterol levels at intermediate or low global CVD risk who do not qualify for pharmacotherapy, in line with the joint ESC/EAS Guidelines for Management of Dyslipidaemia (Gylling et al., Atherosclerosis 2014, 232, 2, 346-360) Similarly, foods with added plant sterols/stanols may be considered in the context of lifestyle intervention in individuals at high or very high CVD risk.	our attention to this evidence. A thorough review of the relevant literature will be carried out when the guidance is reviewed.
Johnson & Johnson Limited	Recommendation 2 saturated fats		Suggest that conditions should be created whereby consumption of products, such as those with added phytosterol/stanols that have been independently evaluated by EFSA and demonstrated to reduce a major risk factor of CVD are encouraged. Consider legislative and fiscal levers that support further formulation/category development that includes these cholesterol-lowering ingredients. The Predi-Med study (Bes-Rastrollo 2013) suggests that economic difficulties may have had a detrimental effect on adoption of favourable dietary behaviours, including reduced adherence to the Mediterranean diet, therefore efforts should be made to facilitate access to foods with proven CVD benefits, such as foods	Thank you.

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			with added plant sterols/stanols. Actively promote heart healthy ingredients that have been authorised by EC to bear CVD risk reduction health claims. The European Atherosclerosis Society EAS has recently prepared a Consensus Statement on plant stanols and plant sterols in the management of dyslipidemia and the prevention of cardiovascular diseases. Bes-Rastrollo 2013 Europrevent, 610	
Johnson & Johnson Limited	Recommendation 13 Regional CVD programmes-good practice principles		Ensure foods proven to reduce cholesterol such as those with added phytosterols/stanols are included in interventions.	Thank you.
Johnson & Johnson Limited	Recommendation 15 Regional CVD prevention programmes-programme development		Suggest that information on foods that have been independently evaluated by EFSA and are demonstrated to reduce cholesterol and authorised by EC to bear disease risk reduction claims, such as phytosterol/stanol containing foods should be included in promotion policies.	Thank you.
Johnson & Johnson Limited	Recommendation 20 Public sector food provision		Promote foods and ingredients to the public sector that have been independently evaluated by EFSA and are demonstrated to reduce cholesterol and authorised by EC to bear disease risk reduction claims, such as phytosterol/stanol containing foods and other ingredients.	Thank you.
Lactation Consultants of Great	PH25 - General		Review of the evidence in the document: UNICEF UK “Preventing	Thank you.

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Britain			disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK" (2012) may be helpful in identifying evidence of the health benefits of increasing breastfeeding rates and the impact on prevention of cardiovascular disease for both mothers and infants.	
Lactation Consultants of Great Britain	PH25 - General		Consideration should be given to the way in which breastmilk reduces obesity in babies, e.g. the role of Leptin, and that evidence suggests that the effects of this can last well beyond the time when breastfeeding ceases	Thank you.
Lactation Consultants of Great Britain	PH25 - General		A discussion about the ingredients of formula milk, including the amount of sugars and the different types of fats in formula milk and the effects these may have on levels of obesity in babies and children, may also be beneficial.	Thank you.
Lactation Consultants of Great Britain	PH25 - General		Information describing the role of breastfeeding in aiding mothers to lose the weight stored during pregnancy, or the fact that breastfeeding helps to reduce the risk or delay the onset of Type 2 diabetes in mothers, should be included in discussions.	Thank you.
National LGB&T Partnership	Section 6 Equality & Diversity Considerations		Section 6 states: "There has been no evidence to indicate that the guidance does not comply with anti-discrimination and equalities legislation." However, there is nothing in the proposal outlining on what evidence this decision was made. The current Guidance does not mention equality considerations or advise on meeting the needs of those with protected characteristics, such as lesbian, gay, bisexual and trans (LGB&T) people. All public bodies are required by the Equality Act 2010 to pay due regard to the needs of those with protected characteristics and NICE guidance should endeavour to	Thank you. We agree that addressing equality and diversity is important and this is considered in all our guidance. The evidence gathered for the Evidence Update and the feedback from

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			support this where appropriate.	stakeholders and other groups on the original guidance did not suggest that the guidance failed to comply with anti-discrimination and equalities legislation. The planned update will include an assessment of these important issues and we would welcome comment from groups such as NLGB&T as stakeholders during the development process.
Public Health England	General		***Recommendation:*** PHE agrees with the expert group that guidance should be updated in light of new evidence and changes to the sub-national structures of delivery. We would recommend that the panel include **consideration of the**	Thank you. Please note that referral of air pollution as a separate topic is under consideration. We ensure that guidance links to other topics.

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			effects of air pollutants on cardiovascular morbidity and mortality when updating its guidance on prevention of cardiovascular disease. There is scope to incorporate recommendations regarding the need for measures to reduce emissions of pollutants and to reduce exposure of the population, including vulnerable groups, to air pollution. These would complement current recommendations regarding physically active travel and health impact assessment of plans and policies. Evidence from studies of the effects of air pollution on biomarkers of cardiovascular disease development and non-fatal events is increasingly being added to the existing evidence from studies in the US, Europe and elsewhere on mortality from cardiovascular causes.	
Public Health England			***Sources of information*** that might be useful to the panel when considering the cardiovascular effects of air pollution include reports by the Chief Medical Officer's expert advisory **Committee on the Medical Effects of Air Pollutants (COMEAP)** which has published a number of reports in this area: 1. *Cardiovascular Disease and Air Pollution* (COMEAP, 2006)[1] which concluded that clear associations, many of which are likely to be causal, have been reported between both daily and long-term average concentrations of air pollutants and effects on the cardiovascular	Thank you.

[1] COMEAP (2006) *Cardiovascular Disease and Air Pollution* Committee on the Medical Effects of Air Pollutants. http://www.comeap.org.uk/documents/reports

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			system, including risk of death and of hospital admissions. The Committee's view was that it was likely that pollution by fine particles plays an important part in these effects. It recommended that, "because of the implications for public health, a precautionary approach should be adopted in future planning." 2. *The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom* (COMEAP, 2010)[2] which includes an estimate of the mortality burden of anthropogenic particulate air pollution in the UK in 2008 to be an effect equivalent to nearly 29,000 deaths. The Committee noted that "much of the impact of air pollution on mortality is linked with cardiovascular deaths". Also: 3. A scientific statement from the **American Heart Association** published in 2010[3] which deemed fine particulate air pollution ($PM_{2.5}$) to be "a modifiable factor that contributes to cardiovascular morbidity and mortality". COMEAP (for which PHE provides the Secretariat) is currently starting a follow-up piece of work on cardiovascular morbidity, with a view to	

[2] (COMEAP, 2010) *The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom* Committee on the Medical Effects of Air Pollutants http://www.comeap.org.uk/documents/reports

[3] Brook, R D et al. (2010) Particulate matter air pollution and cardiovascular disease: an update to the scientific statement from the American Heart Association. *Circulation* **121**: 2331-1378

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			making recommendations for quantification of morbidity attributable to air pollution. PHE would be happy to assist NICE further (e.g. signposting authoritative sources of data and information on this topic) if that would be helpful.	
Royal College of Paediatrics and Child Health	General		Thank you for inviting the Royal College of Paediatrics and Child Health to put forward a nomination for the forthcoming **Prevention of cardiovascular disease review proposal**. We have not received any responses for this consultation.	Thank you.
Royal College of Nursing	General		This is to inform you that there are no comments to submit on behalf of the Royal College of Nursing to inform on the Prevention of Cardiovascular Disease (PH25) review proposal. Thank you for the opportunity to review this document.	Thank you.
Royal College of Psychiatrists	General		Comments on behalf of the Child and Adolescent Faculty: Prevention of cardiovascular disease has its roots in childhood development (Williams 2002, attached). Adoption of healthy lifestyle choices early in the lifespan will have significant impact on prevention of later life health problems and health resource use. This has been explored to some degree in NICE **Managing overweight and obesity among children and young people (PH47).** Child and Adolescent mental health difficulties can impact significantly on the adoption of healthy lifestyle choices and obesity (attached McElroy 2004). The 2009 Danese cohort study (attached) highlights the link between childhood adversity and age-related disease. Due to	Thank you.

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			the complex nature of the interaction between mental health difficulties, treatment and physical health outcomes, there is not yet a robust evidence base that links mental health interventions with prevention of health problems such as cardiovascular disease. We hope that there will be support for further research into this area. Cardiovascular Health in Childhood: A Statement for Health Professionals From the Committee on Atherosclerosis, Hypertension and Obesity in the Young (AHOY) of the Council on Cardiovascular Disease in the Young, American Heart Association, 2002 Adverse Childhood Experiences and Adult Risk Factors for Age-Related Disease *Depression, Inflammation, and Clustering of Metabolic Risk Markers, 2009* Are Mood Disorders and Obesity Related? A Review for the Mental Health Professional, 2004	
Royal Pharmaceutical Society	General		The Royal Pharmaceutical Society welcomes an update to the NICE Public Health guidance on prevention of cardiovascular disease. As the structure of the NHS, particularly at a local level, has undergone significant changes it would seem sensible to review and update references to old systems.	Thank you.

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			Pharmacists have a significant role in public health raising awareness of cardiovascular disease (CVD) and its risk factors, supplying medicines for the prevention and management of CVD, advising on the prevention and management of CVD, and providing support for healthy lifestyles. The RPS are currently drafting professional standards for public health to help lead, support and develop pharmacists and pharmacy teams across Great Britain, to enable delivery of high quality public health services.	
Royal Pharmaceutical Society	Recommendation 22		As pharmacists have a key role in delivering public health services, pharmacists and pharmacy teams should be considered in any recommendations regarding training for health assessments to prevent CVD.	Thank you.
South Asian Health Foundation			This is badly needed. As lead of prevention and rehabilitation for the East of England, a current trustee and former chair of the cardiovascular group of the South Asian Health Foundation and consultant cardiologist and cardiovascular epidemiologist, here are some worrying issues: 1. We still are not changing patient lifestyles after heart attack. The results of latest EUROASPIRE survey demonstrates a high prevalence of unhealthy lifestyles, modifiable risk factors and inadequate use of drug therapies to achieve blood pressure and lipid goals in patients with established CHD and in people at high risk of developing cardiovascular disease.	Thank you.

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			2. Dietary advice and latest evidence is about to question long-held beliefs in what constitutes a good diet for heart health. Evidence relating to salt is starting to suggest that too little salt can be bad for you as well as too much salt. Differences exist between saturated fats, with dairy sources being arguably better. Equally, not all trans fats are bad - it is the industrially-produced ones that we should care about. And oily fish is not as good for you as we thought. 3. Cardiac rehabilitation remains messy. For a start, there are huge variations in uptake regionally, with up to 60% of patients in some areas not attending after a heart attack. There is no consensus in which bits of rehabilitation actually work, and one could question the utility of exercise training and psychological support considering one-third of heart attack patients do not stop smoking. Finally, the delivery of the service is uncoordinated. Some primary care providers do the basic minimum for patients after a heart attack as stipulated by QOF targets, others even have 'healthy heart advisors' who have debatable qualifications and certainly do not interact with hospital-led services. Some models (myaction based at Imperial) show that a joint service between primary and secondary care is the way forwards, but funding flows are so messy that most areas could not hope to replicate such a model, and money is wasted through duplication of services. 4. The food industry continue to fight against the flow of prevention 5. There remains little emphasis on communities and families in prevention - the children of a heart attack patient are at risk themselves not because of genetics but because they eat the same food and also smoke. Their communities are unhealthy, as fast food	

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			restaurants abound. Without an appreciation of the wider social determinants of poor health, one will never prevent premature heart disease.	
The Lesbian & Gay Foundation	Section 6 Equality & Diversity Considerations		Section 6 states: "There has been no evidence to indicate that the guidance does not comply with anti-discrimination and equalities legislation." However, there is nothing in the proposal outlining on what evidence this decision was made. The current Guidance does not mention equality considerations or advise on meeting the needs of those with protected characteristics, such as lesbian, gay, bisexual and trans (LGB&T) people. All public bodies are required by the Equality Act 2010 to pay due regard to the needs of those with protected characteristics and NICE guidance should endeavour to support this where appropriate.	Thank you. We agree that addressing equality and diversity is important and this is considered in all our guidance. The evidence gathered for the Evidence Update and the feedback from stakeholders and other groups on the original guidance did not suggest that the guidance failed to comply with anti-discrimination and equalities legislation. The planned update will include an assessment of these important issues and we would welcome

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				comment from groups such as NLGB&T as stakeholders during the development process.
Unilever	General		Unilever welcomes the review of the public health guidance on the prevention of Cardiovascular Disease in line with the latest scientific evidence.	Thank you.
Unilever	Recommendation 2: Saturated Fats		We would suggest considering, as an adjunct to this guidance, the findings of the recent EAS Consensus Panel Paper on *"Plant sterols and plant stanols in the management of dyslipidaemia and the prevention of cardiovascular disease",* published in Atherosclerosis 2014. (Gylling *et al* Atherosclerosis 2014: 232; 346-360 doi:10.1016/j.atherosclerosis.2013.11.043). This paper recommends that foods with added plant sterols and plant stanols in an amount up to 2 g/d are equally effective in lowering plasma atherogenic LDL cholesterol levels by up to 10%. Thus, plant sterols/stanols may be considered as an adjunct to diet and lifestyle approaches in subjects at all levels of CVD risk. On the basis of their critical assessment the Consensus Panel of 21 international experts concluded that foods with added plant sterols/stanols may be considered in the following populations: • Individuals with high blood cholesterol levels but with	Thank you for drawing our attention to this evidence. A thorough review of the relevant literature will be carried out when the guidance is reviewed.

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			intermediate or low global CVD risk who therefore do not (yet) qualify for drug treatment. • Subjects receiving lipid-lowering therapy such as statin treatment who fail to achieve LDL-cholesterol targets, or in those who are statin-intolerant, in conjunction with other lifestyle interventions. • Adults and children (>6 years) with familial hypercholesterolemia especially in light of the increasing importance of early preventive strategies in hypercholesterolemia.	