[One of the authors responds:]

Françoise Bouchard and associates suggest that in our study[1] we should have compared total suicide rates within custody to total suicide rates in the community, rather than comparing strangulation-specific suicide rates. We submit that such a change in comparison groups would not change the message of our paper. By using the strangulation-specific rates, it is likely that we underestimated the suicide rate in prisons, since deaths from poisoning or toxic effects probably included some suicides.

Our observations do not support a decline in rates over the period of observation. We identified several people who committed suicide very soon after the end of a "suicide watch" and others who clearly had a history of suicide attempts for whom no intervention was attempted. The simple fact remains that death by suicide and death by overdose within the incarcerated population is a major health concern. We look forward to observing the impact on prisoners' safety of the recent changes in CSC's suicide-prevention policy, and we would support the adoption of additional policies to address the burden of death by overdose.

Marc Daigle raises some interesting points. It may be difficult to directly compare suicide rates between Ontario and other provinces, because (as we pointed out[1]) the Ontario coroner's system may be using a somewhat more restrictive definition of suicide than is used elsewhere. The apparently greater rate of violent death among "non-incarcerated delinquents" than in the general population is interesting, if not entirely surprising. We also endorse Daigle's statement that correctional facilities are not the right place to treat mental illness and would support a wider application of diversion programs for both mentally ill and addicted people.

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1. Wobeser WL, Datema J, Bechard B, Ford P. Causes of death among people in custody in Ontario, 1990–1999. *CMAJ* 2002;167(10):1109-13.

Managing hypertriglyceridemia

On reading the article about hypertriglyceridemia by Michelle Fung and Jiri Frohlich,[1] I wondered about the recommendation for a diet containing less than 10% of calories from fat. The report of an expert panel[2] cited by Fung and Frohlich on this point recommends that 25% to 35% of caloric intake be derived from fat. Clarification of the recommendation for a 10% diet would be appreciated.

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References

1. Fung MA, Frohlich JJ. Common problems in the management of hypertriglyceridemia [published erratum appears in *CMAJ* 2003;168(1):16]. *CMAJ* 2002;167(11):1261-6.
2. Executive summary of the third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). *JAMA* 2001;285:2486-97.

The ratio of high-density lipoprotein cholesterol to triglycerides has been documented as one of the most important cardiovascular risk factors.[1] However, Michelle Fung and Jiri Frohlich[2] perpetuate the myth that a low-fat diet will be helpful in the management of this problem.

Lichtenstein and Van Horn[3] extensively reviewed this approach a few years ago. Examination of their evidence suggests that a low-fat dietary regimen will produce a result opposite to the desired effect: triglyceride levels will actually increase.

This outcome is not surprising if one considers that insulin resistance

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1/4 page, 4 clr.

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