account may improve the utility of IMA in predicting serious cardiac outcomes.

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We thank Giuseppe Lippi and colleagues for their comments. The average serum level of IMA that they reported in their study (94 μ/mL, 97.5% confidence interval 84-104 μ/mL) is higher than the 2 cutoffs we employed: 85 μ/mL (suggested by the manufacturer) and 80 μ/mL. In our paper we indicated that we explored multiple IMA thresholds (including 100 μ/mL) but this did not alter our findings.[1] Therefore, in patients presenting with chest pain who have not yet experienced a serious cardiac outcome, IMA appears to be a poor predictor of serious cardiac outcomes.

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Questioning the benefits of statins

The assessment by Douglas Manuel and associates[1] of the 2003 Canadian dyslipidemia guidelines[2] is welcome, but they overlooked the all-cause mortality issue, where statins have essentially failed to deliver.[1] There are no statin trials with even the slightest hint of a mortality benefit in women,[3-5] and women should be told so. Likewise, evidence in patients over 70 years old shows no mortality benefit of statin therapy: in the PROSPER trial there were 28 fewer deaths from coronary artery disease in patients who received pravastatin versus placebo, offset by 24 more cancer deaths.[6]

The failure of statins to decrease all-cause mortality is possibly best illustrated by atorvastatin: while both the ASCOT[7] and TNT[8] trials found that atorvastatin therapy decreased the risk of cardiovascular events, in the ASCOT trial (placebo v. 10 mg atorvastatin daily) the all-cause mortality curves effectively touched at mean study end (3.3 years) and in the TNT trial (10 v. 80 mg of atorvastatin daily) there were 26 fewer deaths from coronary artery disease in patients taking the higher dose offset by 31 more noncardiovascular deaths at median study end (4.9 years). Incidentally, the ASCOT trial failed to find a cardiac benefit of statin therapy in women and patients with diabetes.

The Web site of the ALLHAT study says it best:[9] "trials [primarily in middle-aged men] demonstrating a reduction in [coronary artery disease] from cholesterol lowering have not demonstrated a net reduction in all-cause mortality." What is the point of decreasing the number of "events" without decreasing overall mortality, when the harm caused by the side effects of statin therapy is factored in?

The failure of statins to reduce all-cause mortality clearly supports the call for more effective approaches. Guidelines should reflect this finding, certainly in their recommendations for women and probably in those for most men too.

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The recently published controversy on the 2003 Canadian dyslipidemia guidelines[1-3] should be cause for some reflection on the utility of guidelines. The back-and-forth dialogue was reminis-