jury pattern (after resuscitation from a ventricular fibrillation arrest) has a much higher risk of mortality than a patient with an average inferior myocardial infarction of the type reported in the Fibrinolytic Therapy Trialists’ overview, i.e., at least 17.4% on the basis of a simple risk index calculation derived from the InTIME II substudy.\(^1\) Thus, the benefits in this case clearly outweigh the risks.

**Paul W. Armstrong**
Professor of Medicine
University of Alberta
Edmonton, Alta.

**References**

**Risk factors for cardiovascular disease**

Most patients do not show any of the conventional risk factors for cardiovascular disease.\(^2\) In a recent *CMAJ* article, Jean-Pierre Després and colleagues emphasized the need to look beyond traditional risk factors, such as plasma level of low-density lipoprotein cholesterol, as they might not provide enough predictive power for accurate risk stratification.\(^2\) The authors focused on a cluster of factors characterizing the “metabolic syndrome” and especially on the novel measurement of the ratio of total cholesterol to high-density lipoprotein cholesterol.

In a recent study in which we evaluated the cardiovascular risk profile of elderly male patients, we confirmed the limited significance of traditional risk factors, such as total cholesterol or low-density lipoprotein cholesterol levels, and we observed a striking relationship between cardiovascular disease and the ratio of total cholesterol to high-density lipoprotein cholesterol.\(^1\) However, we also noted that the high levels of lipoprotein(a) and homocysteine in these patients may have contributed to the development of cardiovascular complications in our clinical setting. These 2 factors, along with an elevated ratio of total cholesterol to high-density lipoprotein cholesterol, were highly predictive for cardiovascular disease. Therefore we agree with Després and colleagues on the need to look beyond low-density lipoprotein cholesterol and we further suggest that lipoprotein(a) and homocysteine measurements be included when assessing cardiovascular risk.

**Giuseppe Lippi**
Giancascare Guidi
Istituto di Chimica e Microscopia Clinica
Dipartimento di Scienze Biomediche-Morfologiche
Università degli Studi di Verona
Verona, Italy

**References**

**Waiting times for cancer surgery**

I enjoyed reading the article by Marko Simunovic and colleagues on waiting times for cancer surgery.\(^1\) I was particularly intrigued by the fact that there were no age-related differences in median waiting times from referral to surgery. This is somewhat surprising, given the growing body of literature suggesting that older adults with cancer receive less aggressive diagnostic workups and treatments than younger adults.\(^2\)

The investigators analyzed all tumour types together for patients aged 50 years or less, 51 to 65 years and 66 years or more. Given that they demonstrated differences in waiting times across cancer types, and given that some cancers are more common than others in different age groups, this analysis may mask true age-related differences in waiting times. Did the authors examine age-related waiting times separately for each tumour type?

**Shabbir M.H. Alibhai**
Staff physician
Department of Medicine
University Health Network
Toronto, Ont.

**References**

[One of the authors responds:]