Pharmacogenomics of lipid-lowering therapy is further complicated in that the appropriate response phenotype is unclear. For example, pharmacogenetic studies investigating apolipoprotein E (APOE) polymorphisms suggest a gene-dose effect, with ε2 carriers showing greater reductions in LDL cholesterol in response to statins, while ε4 carriers are least responsive. In contrast, when adverse cardiovascular outcomes were examined in a substudy of the Scandinavian Simvastatin Survival Study, ε4 carriers had the greatest reduction in death rates in response to simvastatin compared with non-ε4 carriers. Therefore, while ε2 carriers may have a better response to statins using a surrogate outcome, ε4 carriers have a better response using mortality as the outcome. Of note, these differences in risk reduction based on APOE genotype do not appear to be related to variable LDL cholesterol treatment responses.

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This letter was shown to Dr Chasman, who declined to reply on behalf of the authors.—Eo.

Individuals and Global Health Improvement

To the Editor: Many JAMA readers practicing in developed nations may have searched in vain for a personal role in global health, the theme of the June 2, 2004, issue of JAMA.

Yet I believe there is a call for clinicians in the Commentary by Lee and colleagues. As funding from groups such as the Global Fund and Gates Foundation facilitates basic research and evidence-oriented field trials, the limiting factor becomes “whether poor countries have the capacity to put additional resources to effective use. . . .” The overarching systemic challenge—scientifically, ethically, and politically—continues to be “going to scale” with what the world already knows. The sine qua non of scaling up is the practicing and teaching of quality clinical and public health care at district/regional hospitals worldwide. In dramatic contrast to Chad, which has 1 physician per 40000 citizens, or even Bangladesh (1:4000), the United States (1:350) has had an abundance of physicians.

Why not forge a new public/private partnership to educationally prepare and logistically support clinical and public health practitioners, both early and mid-career, to work alongside dedicated but overextended health professionals of developing nations? Putting prepared professionals in the places where the dying goes on daily will finally apply outcomes-based research at the outposts where it ultimately matters. And, much more than money or technology, such collaboration may replace mutual mistrust with insight into our shared humanity.

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In Reply: Dr Pust asks how clinicians in high-income countries can contribute to the attainment of the United Nations Millennium Development Goals and the improvement of health more broadly in low-income countries.

He is correct to draw attention to the dramatic contrast between the physician-citizen ratio in a country like the United States and in sub-Saharan Africa. However, it is important to acknowledge that the United States and other high-income countries contribute to the problem by employing and depending on medical and nursing graduates from many low-income countries. For example, between a third and a half of South African medical graduates emigrate. The situation may be even worse in poorer countries such as Zambia where, some years ago, it was found that only 50 of the 600 physicians trained by the medical school in Lusaka worked in the public sector health service. The situation is similar for nurses. In Malawi, two thirds of jobs in the public health system remain vacant, with more nurses emigrating in the past 4 years than the 336 who remain to serve a population of 11.6 million. Clinicians in countries such as the United States can play an important role by drawing public attention to the problems caused by migration of health professionals and pressing for the development of effective policy responses. These could include encouraging investment in domestic policies to improve the retention of health workers within low-income countries and reduce requirements for overseas recruitment by high-income countries, together with the development, implementation, and enforcement of ethical guidelines on international migration of health professionals.

Collaboration between training and research institutions in low- and high-income countries has produced benefits for decades. Schools of international public health are staffed with dedicated people, many of whom have worked alongside...
Compensation for Energy Intake From Fast Food Among Overweight and Lean Adolescents

To the Editor: While 2 recent articles addressed the close relationship between fast food consumption and obesity in both children and adults in the United States,1,2 the same phenomenon appears likely to be occurring in China.

Childhood obesity shows an alarming increase in prevalence in recent years. In urban China, it increased from 1.5% in 1989 to 12.6% in 1997, and the prevalence of overweight increased from 14.6% to 28.9% in the same period.3 In a more recent report on urban Chinese children, the prevalence of overweight for children was 27.7% in boys and 14.1% in girls.4 At the same time, Chinese children are consuming western fast food more quickly than ever.5

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