



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

May 7, 1976

NATIONAL INSTITUTES OF HEALTH
NATIONAL HEART INSTITUTE
HEART DISEASE EPIDEMIOLOGY STUDY
123 LINCOLN STREET
FRAMINGHAM, MASSACHUSETTS 01701

Dr. Jeremiah Stamler
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Department of Community Health and Preventive Medicine
303 East Chicago Avenue, Ward 9-105
Chicago, Illinois 60611

Dear Jerry:

I think the reply to Lars Wérko for the American Heart Journal is timely and appropriate. It is especially important because we need credibility on this issue in view of the fact that we plan to use pooling project data once again.

I would, however, suggest adding on a paragraph as follows:

"No doubt, Dr. Wérko has taken the trouble to write his critique out of fear that the medical profession is being grossly misinformed about the epidemiology of coronary heart disease. Comparing the pooling project and Framingham data with that of the best information available - obviously Dr. Wérko's own Gothenberg Study - reveals no evident distortions with regard to conclusions about cholesterol, triglyceride, cigarettes, or any other major consideration. Thus, Dr. Wérko can put his mind to rest."

I do think we owe him one little jab, and this is not non-sequiter.

Cordially,

Bill

W.B. Kannel

William B. Kannel, M. D.
Medical Director

k/k

CC: Dr. Joseph Doyle
Dr. Henry Blackburn
Professor Felix E. Moore
Dr. Fredrick H. Epstein
Dr. Oglesby Paul

D R A F T

George E. Burch, M.D.
Editor
The American Heart Journal
The CV Mosby Company
11830 Westline Industrial Drive
St. Louis, Missouri 63141

Sir:

In his recent article in the American Heart Journal (91, 87, 1976), Dr. Lars Werkö noted certain inconsistencies in the data from the national cooperative Pooling Project, published in the Report on the Primary Prevention of the Atherosclerotic Diseases of the Inter-Society Commission for Heart Disease Resources (Circulation, 42, A55, 1970) and elsewhere. It is indeed a fact that there are inconsistencies, overlooked by us heretofore, and we are grateful to Dr. Werkö for detecting them. Specifically, of the several sets of data (Table 4, Figures 3, 9, 10, 12), there are errors in Table 4 and for one of the four end points in Figure 10, and one of the eight end points in Figure 12 of the original ICHD Report, as verified by a computer re-run of the total set of data.

Tables 1-3 below set forth the originally reported findings containing the errors, and the correct data, based on the computer re-run just completed. This re-run used the final edited tape of the Pooling Project data, prepared by its statistical center at the University of Michigan School of Public Health under the direction of Professor Felix Moore. It is a tape prepared many months after the original tape used in 1970 for the preparation of the data for the Pooling Project tabulations in the ICHD Report. The subsequent editings of this earlier tape produced small numerical differences in the numbers of men in the denominators, and in the numbers of men with events as indicated in the numerators. All such differences are small and inconsequential, and are unrelated to the inconsistencies noted by Dr. Werkö.

In the accompanying tables, the data sets on the right give the corrections for Table 4 and Figures 10 and 12 of the ICHD Report, containing errors. For reasons not readily ascertainable, these three sets of data in the 1970 ICHD Report contained a low count of the numbers of men experiencing coronary events.

All the remaining data from the Pooling Project in the 1970 ICHD Report are correct.

The corrections in Table 1 result in even higher percentages than before for the proportion of first major coronary events that terminated fatally, suddenly or otherwise. Therefore the point made in the 1970 Report is reinforced, i.e., a high percentage of first major coronary events manifest themselves as sudden death (death within three hours of onset of symptoms) or terminate fatally during the course of this first acute event.

The corrections in Tables 2 and 3 make no change in the originally reported findings of the strong relationship between various combinations of risk factors and incidence of first major coronary events.

This letter makes no attempt to deal with other aspects of Dr. Werkö's paper, although many of the judgments and critiques set forth there certainly merit further discussion.

Very sincerely yours,

JS/nd

H. Blackburn
J. Chapman
T. R. Dawber
J. Doyle
F. H. Epstein
W. B. Kannel
A. Keys
F. Moore
O. Paul
J. Stamler
H. L. Taylor

Sudden Death and Acute Mortality with
 First Major Coronary Episodes
 7,594 Men Age 30-59 at Entry, Pooling Project.
 Ten Year Experience

Event	ICHD Rept. (Table 4)		New Data	
	No. of Events	Prop. per 1,000	No. of Events	Prop. per 1,000
All 1st major coronary episodes, nonfatal and fatal	501	1,000.0	585	1,000.0
Sudden death	123	245.5	159	271.8
All acute deaths with 1st episodes	165	329.3	257	439.3
No. of Men	7,594		7,534	

↑
errors

FIRST MAJOR CORONARY EVENT

	ICHD Report (Fig. 12)			New Data		
	N	Events	Rate	N	Events	Rate
None of 3	1,249	28	20	1,223	30	22
1 of 3	3,320	171	48	3,287	201	55
2 of 3	2,178	198	90	2,193	234	101
All 3	595	82	171	615	96	185
All with C,H, & S Data	7,342	479		7,318	561	72
Missing Data				216	24	101
ALL				7,534	585	73

↑
*errors
here*

FIRST MAJOR CORONARY EVENT

	ICHD Report (Fig. 10 lower)			New Data		
	N	Events	Rate	N	Events	Rate
None of 3	1,249	28	20	1,223	30	22
S Only	2,018	97	45	1,989	117	54
C or H Only	1,302	74	52	1,298	84	56
(S+C) or (S+H)	1,794	167	92	1,797	197	105
(C+H)	384	31	85	396	37	91
(C+H+S)	595	82	171	615	96	185
All with C,H,&S Data	7,342	479		7,318	561	72
Missing Data				216	24	101
All				7,534	585	73

↑
errors
here