September 20, 1977

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Dear Lew:

Thank you for your letter of August 19 and your thoughtful suggestions for the MRFIT scientific conference. In general, I support them as interesting, provocative issues. I assume that in question A under blood pressure, you mean effectiveness, more than efficiency. I think B is a good issue and I wonder if we could ask for some analyses befhrehand or suggest to the data monitoring committee that they provide some analyses on potential dangers of low potassium. Trial directors hate such subgroup analyses, which may lead to the identification of spuriously high risk subgroups. But I have some concern about the combination of low potassium, VPB and ST segment depression. We recently had a sudden death in an individual a day before we received the low potassium alarm value from the Central Laboratory in a man who had ST depression and a ventricular tack on ECG. That case might actually make a good introduction to a discussion of the complications of hypertension treatment, at least the low potassium complications. I think your operational questions about blood pressure are very reasonable ones and very interesting.

With regard to cigarette smoking, the direct evidence that cigarette smoking cessation decreases the risk of heart attack is limited to only one small experiment as far as I know and lots of observational data. I guess I don't see a very strong reason for reviewing this evidence because we all know its weaknesses and yet we are committed to a continued vigorous anti-smoking strategy. I guess I feel that if your idea is to question the potential short term benefit of stopping cigarette smoking in very high risk men with multiple combined risk, that we should pose this as a problem to an ad hoc working group in the Design and Analysis Committee to see if our design structure is threatened. I suppose I am just not terribly enthusiastic about Section A.

With regard to Section B and changes in pulmonary function, I guess we run straight against the severe criticisms of the existing MRFIT data. I think weoought to request preliminary analyses on this in the centers that seem to have adequate quality control of these data. With respect to reasons for failure to stop smoking, I haven't the faintest idea how we would approach that, but I would agree to a thorough-going analysis of available data on characteristics as collected at baseline and subsequently.

With respect to nutrition, I suppose a short presentation on triglycerides and VLDL as risk indicators would be worthwhile, and HDL, are always interesting topics. Again, I liked the review of the intervention "failures" based on direct analysis of information available to MRFIT. I also responded positively to your section on endpoints without much enthusiasm for the exercise test in prediction.

I think you have made a very good start. I guess I would like to see that data on MRFIT baseline associations between psycho-social and other variables, but that can onme at any time and doesn't have to be in the first scientific meeting.

Cordially,

Henry Blackburn, M.D.
Professor and Director

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