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MEMO

TO: LPH Academic Staff

FROM: Henry Blackburn

CHD death endpoint and sudden death should be principal references in the new VPB analyses of Europe. I think we should recheck all these deaths in the original data and also try to separate out instantaneous deaths.

We must together figure how best to adjust for the principal VPB associations:

Age
SBP
Body Mass Index (exercise EGC VPB)
Smoking class
Activity Class
Other ECG codes

Conceptually (and above the numbers problem) I have the biggest problem with the apparent excess mortality in VPB cases in the upper quintiles of risk score (therefore suggesting independence?), with the possibly not improved discrimination in the more stringent stepwise add-on tests, if such is confirmed with adequate numbers later.

I also have a problem with interpreting (in the CDP data) the meaning of the relative steepness of slopes of sudden death and all deaths against VPB and need your help. Dave Jacobs says both could be true, a real and interesting relationship to sudden death (causal or non-specific) and a non-specific relationship to total death (which means something in CDP having 90+ % C.V. deaths). My feeling is that if there were really a specific mechanism as an important phenomenon of the late recovery period after infarction (VPB → repetitive response → disorganized thythm → sudden death), the slope of sudden death might be expected to be higher than that to deaths, any cause. Maybe this isn't necessary. At any rate, I think we have done as well as possible in adjusting for the influence of confounding variables and need your suggestions (pair-matching?), if you think we can do better.

I want us to complete all the 5-year VPB analyses by May 1 for the National Conference (Baltimore) on VPB on May 9-10. I hope that several of us can go to that.

HB:jp