UNIVERSITY OF *Minnesota*

SCHOOL OF PUBLIC HEALTH · LABORATORY OF PHYSIOLOGICAL HYGIENE
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June 19, 1968

Dr. Alessandro Menotti
Via Latina 49
Rome, Italy

Dear Alessandro:

Thank you for your response to the material sent on the question of publication of 5-year follow up findings. There are many questions to be considered in the final decision as to what should be included, how defined, etc., in the publication. The material I sent to all of the collaborators was tentative and a basis for mutual consideration. Below I shall take up the questions you raise in the order given in your letter dated June 14, 1968.

It seems reasonable to hope for inclusion of myocardial infarction in the ms. under preparation and we propose to try.

I propose several cohorts for analysis in several ways. Exclusion of diabetes, tuberculosis, rheumatic heart disease, etc. in a primary cohort seems desirable to prevent disparities in prevalence of those conditions becoming sources of confusion in analyzing total (all-causes) death rates. Actually, we may analyze 4 or more cohorts, differently defined for different purposes.

You may be sure that the disease categories "coronary" and "other heart," etc. will be carefully defined; work on those points is an early requirement, of course. We propose to list each of the defined manifestations and to provide analyses on these separately and also pooled in various ways. In regard to M.I., we do propose to distinguish between "definite" and "possible" (or "probable"). Proposed definitions and methods of classifying all of these relevant clinical conditions should be in good preliminary shape, at least, in a few weeks.

For the analysis we have not provided separately for conditions that will be too uncommon in our material to have any significance.

We propose to consider only definite angina pectoris and even that will be treated with some hesitation in comparisons.

In regard to the proposal to group centiles, in many respects the extremes are of greatest interest. Our material will be too small for analysis

by 10 deciles and probably by quintiles. The 20-30-30-20 scheme automatically provides a median cut which is useful and not available in tertile or quintile analysis.

We propose that CHD will include No. 412 (in the new revised classification) and we do propose to distinguish between definite and possible M.I. for prognosis, but would exclude possible angina pectoris from all of the analyses of total data. Local groups may, of course, wish to make internal comparisons, etc. for their own areas separately. But I, at least, am opposed to doing anything about comparing areas in regard to reported possible angina.

We shall keep you informed.

Regards.

Sincerely,

Ancel Keys, Director

AK:mh
cc: Dr. Blackburn