May 14, 1968

Dr. Alessandro Menotti
Via Latina 49
Rome, ITALY

Dear Alessandro:

Thank you for your May 8 letter. In general I find the area deaths in very good shape, but I sent for the Minnesota Forms 10 just to have all information at hand as we finalize them.

I think when you redo your coding form for the 10 year deaths you should re-align precisely the boxes, where now decisions on the check marks are ambiguous I would also appreciate your reinserting the line on my form which you removed; under Other Cardiac Event with Death insert Cardiac Causes (specify and code) so there can be a visual comparison between English language and numerical codes.

Only a few comments on your codes:

I wonder if we should pursue your policy of changing the cause of death code for acute myocardial infarction to the code for chronic ischemic heart disease (410.9 to 412.9) on the basis of past history of heart disease. Would it not be better to leave the cause of death 410.9 as assigned by the hospital, physician or our collaborator, and record 412.9 as the first major contributory cause?

I concur with your change in assignment of an out-of-hospital death from 410.9 to 427.0 or 429.9, when the story of infarct is poor. I also concur with your change from a death certificate code of 410.9 to 795 when the death is sudden and unexpected, and out-of-hospital. However, I question the several changes you have made from 410.9 to 427.1 when the death was in-hospital. I believe we must accept that witnessed cause of death. We may eventually compare frequencies of medically witnessed deaths in the different areas.

I don't quite see how we can change an in-hospital death diagnosis of pneumonia and bronchitis to cancer as you have done for 1746 in W. Finland and I have changed it bakk to 491.

Without Forms 10 I am unable to ascertain why you changed Ushibuka 556 from paeumonia 486 to CVA 436. I also do not find this case on my Ushibuka death list, so I presume you have better information than I and have left this code.

Your point on class 01.03 as a new morbidity event is a good one. I have not tested these criteria most of which are still "armchair."

Let's make together a more detailed study of each criterion to see how sensitive and specific each ECG item is, using as independent reference the clinical history of definite, possible or no infarction. In other words, let's find the sensitivity and specificity of each ECG code suggested (01.01, 01.02, 01.03, 02.01) using as reference those cases meeting clinical code 02.02 (possible) and, separately, those meeting 01.05 (definite).

Regards,

Henry Blackburn, M.D.

HB/rk

c.c. Dr. Keys