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MEMORANDUM

DATE: February 1, 1982

PC Sent 2/8/82 LB

TO: H. Blackburn

FROM: R. Prineas

RE: Preventive Researches for NHLBI Preventive Cardiology Branch
(In addition to those put forward in your handout)

Thanks - Ron

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1. It is about time a review of preventive cardiology programs from all U.S. State health departments was made. This is a large resource group that is largely ignored by academic and research groups. Many such departments have started hypertension programs but there is certainly no coordinated effort to target in a useful way against chronic disease.

Not an NIH function?

2. A workshop on family intervention for nutrition would be useful at this time.

Yes added

3. There has never been a test of comparing total population strategies of intervention to intervening on all at risk families (including children and adolescents). The argument has been that by the time adults have increased risk factors, it is only touching the "tip of the iceberg". This could be changed by including the young who are likely to be at future risk.

Don't understand what different from our MNH&D Family Program?

4. RFP for family studies of blood pressure, sodium handling, sodium sensitivity, potassium sensitivity and sodium/potassium rbc membrane reflux studies are needed to unravel those "at risk" for essential hypertension.

Yes added.

5. A working group should be convened now to discuss standardization (yes, once again) of blood lipoprotein measurements. With newer enzyme methods being introduced there is also a need for the design of studies of stored blood sample deterioration testing. This should include people from CDC, community program studies, and the LRC.

Strong recommendation bring CDC lab to NIH.

6. RFA for measurement of physical activity in childhood.

Yes, added.

7. RFP for long term support of a nutrition coding center beyond MRFIT and LRC for developing a system to include fat, protein, calories, minerals, sodium, potassium, etc. from new commercial products. It should include continuing programs of current food analysis. USDA and Cancer Institute might provide joint support.

8. There were more than 140,000 operations for reestablishing peripheral vascular circulation in the U.S. last year. This rivals the number of coronary bypass operations. Descriptive studies are needed to delineate the difference (from stroke and CHD) of atherosclerosis effect in this circulatory bed.

9. Long term (more than five years) studies are needed to monitor protein and salt as well as fat and cholesterol in intervention studies that measure the outcome of CHD, stroke, peripheral vascular disease, and cancer. This is because of the low cholesterol/cancer controversy and low protein/stroke dilemma.

10. In relation to the above different programs, nutritionists have "prudent" diets for CHD, for hypertension, for diabetes mellitus, for obesity, and for cancer. The academic array is nearly as great as "pop" diets available to the public. A workshop might be useful now to unify these usually overlapping, often conflicting messages.

11. Given the Bogalusa studies of drugs in young children of the top 5% of BP distributions, it is urgent for an RFA/RFP hygienic intervention randomized study (using multi-factorial approach) among children (must include black and white) in the top 5% of the BP distribution. Also, as the idea that "mild" hypertension (from HDFP) is bad for adults and can be treated by drugs filters down to general awareness, the question arises: "Is mild hypertension even worse in children and therefore should drug treatment be started immediately?"

12. Basic studies in the causes of impotence in diabetes, hypertension, and secondary to anti-hypertensive drugs should be encouraged. Descriptive as well as therapeutic studies are needed. Although we are pushing primary prevention, more and more of the 60 million estimated hypertensives in the country will be taking drugs. This is one area that is still frequently cited in clinical meetings for therapeutic nihilism for young (and not so young) male "mild" hypertensives.

13. I don't know how this should be done. However, most physical education programs in U.S. schools emphasize coordination and static exercise. The President's Physical Fitness Award patches are more likely to be given to cardiovascular unfit children than the reverse. Proper long term habits for cardiovascular fitness need to be taught by Physical Education teachers. Maybe a review could be made of the content of curriculum training of such people in U.S. colleges as a start.

monitor economic changes.

14. Changes in the health behavior of families when heads of households become unemployed and vice versa is important to know in such times. I know of no such studies.

yes medical epidemiologists.

15. Start a training program for cardiovascular disease health interventionists to work with industry, HMO, and state health departments. They could be trained in nutrition, smoking cessation and physical activity encouragement methods. This could be under the umbrella of Preventive Cardiology awards.

RJP:lle