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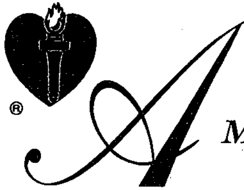

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January 25, 1973

file AHA Board
PC to F. Grande, L. Mjonnes & N. Foster

Henry Blackburn, M.D.
Chairman, Council on Epidemiology
Laboratory of Physiological Hygiene
University of Minnesota
Stadium Gate 27
Minneapolis, Minnesota 55455

Dear Henry:

A revision of the diet statement including most, but not all, of the suggestions made by you is enclosed. I am also sending it to John Mueller and Bob Shank of the Nutrition Committee, and Gardner McMillan of the Council on Arteriosclerosis. May I have your reaction?

and Jerry!

Although it still somewhat resembles a giraffe, it has considerably more validity than the original version and does a reasonable job of stating the recommendations of the AHA at this time.

I regret that I've not been able to make it a more positive statement as you requested. This may be possible with the next revision in 197?.

I know that you have seen the program for the Council on Epidemiology meeting coming up and I hope you approve. It looks like a very exciting couple of days and I look forward to it.

Best personal regards.

Very truly yours,

Cam

Campbell Moses, M.D.
Medical Director

CM/lh/W7
Enclosure
cc: Mrs. Mary Winston

Comments of Henry Blackburn on December, 1972 draft of
AHA Statement on Diet and Coronary Heart Disease

I wonder if there is new information explicitly summarized here compared to the prior AHA statement? The most significant current reference from Finland on the experimental effect of diet associated with CHD mortality has not been added to this draft and should be (Lancet II:835-838,1972). It is also important that the work of Stamler's group be quoted (now in press but to be published before release of this statement) on the effect of the AHA prudent diet on all types of hyperlipidemia, showing it effective in all but a few persons.

The introductory paragraph is a bit diverting. The second paragraph might start it off and could be more forthright. It should summarize the evidence briefly before jumping into "warranted action."

No note is made in the third paragraph of the agonizing decisions of the NHLI Task Force on Arteriosclerosis (1971) not to do a diet trial in the general and no explanation is given here of these reasons. It is important that the physician understand the reasons why AHA recommendations and NHLI policy are different, and why a single factor primary prevention trial of diet and CHD in the free-living population probably won't happen in our time or ever. It would be useful for them to know about the NHLI Multiple Risk Factor Intervention Trial as well as the existing diet trials in closed populations (Frantz' Minnesota Hospitals Study).

The language and style throughout is negative, and might easily be turned around more appropriately to simple positive declarations. Fact is often not separated from supposition and opinion. Opinion is appropriate but should not be declared as fact: e.g. "Avoidance of obesity in children. . . substantially

reduces the risk of CHD" ; "The fat-controlled diet is less effective in adults free of all risk factors . . . "; etc.

A positive statement is needed that the broad, garden variety problem of blood lipids and of coronary disease does not necessarily require complex typing and does not require 5 different diets, and that the eating pattern recommended by AHA is effective in lowering all serum lipids in most people, rather than emphasis as here on short-term triglyceride raising effects of low fat diet.

Eating habits and food choices may be more appropriate terms for the pattern recommended than "diet" with its connotations of rigidity, measurement and sacrifices. The tone might more emphasize the pleasures, palatability, safety, relative ease, and variety possible with the AHA diet. Have we given up the fairly widely used term "AHA Prudent Diet"?

The implication in paragraph 3 is that no dietary efforts should be made if cholesterol is "approximately 200." This is probably unwise for many reasons. We are talking of a way of life for all Americans who are on such a high curve of serum cholesterol values and CHD risk (200 is very high in Japan and Greece). Little is said about the wife's and family role and that this way of eating is good for all ages and sexes irrespective of individual relative risk of CHD in our culture. Much more use could be made of the Intersociety Report which presents the problem in a broader view and with more specific recommendations.

Second paragraph: A possible addition for the second sentence: "In well-documented population studies using standard methods of diet and coronary disease assessment, no populations habitually subsisting on low saturated fat diets have an appreciable burden of coronary disease. The evidence suggests that a high saturated fat diet is a <u>necessary</u> factor for an important population incidence of CHD and that other risk factors are important contributory causes when present. For example, in the U.S., where the diet is generally high in saturated fats, hypertension and cigarette smoking are most powerful risk influe

This sort of information, as well as that from early controlled trials, provides sufficient evidence to warrant prudent action at this time, in the population at large."

Possibly a quotation from the ISCR, would be useful if the above doesn't appeal to you.

Third paragraph, line 9: evidence instead of consensus. Suggest omit: "containing cholesterol and certain triglycerides." The next sentence would be accurate if "average" were eliminated and "many" substituted for "most." Line 17: "These" is unnecessary and refers to no object before or after. Same paragraph, last line: Suggest omit; the declaration "is less effective" is vague and unfounded in fact if it refers to reduction in CHD risk.

Paragraph 4: Suggest eliminating statement "who have had clinical manifestations" because there is no reason why they would require "more stringent control of diet" than those at high risk without heart disease and, of course, in fact, they may be less likely to benefit from a diet.

Page 2, paragraph 1: The last sentence is supposition, suggest: "May reduce risk of CHD in later life, perhaps through reducing the frequency of hypertension and glucose intolerance"?

Paragraph 2: I agree with the opinion and recommendation about no single massive high fat meal but don't know of the evidence for it and don't see why this is "inherent" in the recommendation of 10:10:10 fatty acids.

Paragraph 3: Is is a necessary qualifier to insist that "care must be taken to assure adequate protein intake . . . etc" or to down-grade vegetable proteins, in this prudent AHA diet which will certainly include adequate animal protein.

Paragraph 4, last line: suggest eliminate "unduly" which is parhaps misleading.

Page 3, paragraph 1: Suggest change to "There is evidence in short term feeding experiments that change from the usual high fat American diet to one

containing 80% CHO calories . . . etc." However, that sentence would be better off eliminated. This is just another negative scare-off for the clinician and is *not* relevant to the broad situation and diet we are recommending. Add possibly: "There is also evidence that natural populations subsisting habitually on 50-70% carbohydrate diets have low fasting serum triglycerides and that the AHA prudent diet with appropriate weight loss, controls hyperlipidemia effectively, including hypertriglyceridemia, in all but a few special cases." (Suggest you get reference for this paper now in press from Stamler).

Paragraph 2: Suggest eliminate salt supplementation sentence as well as the questionable term "stroke situations."

Paragraph 3 (6): I believe that a definitive statement is *essential* here about the lack of evidence that vitamin E plays a role in the prevention and treatment of coronary heart disease. It would be a serious mistake to avoid this issue in such a broad and definitive policy statement on Diet and CHD at this time. We would perhaps not be so insistent on this if a separate statement on Vitamin E were in preparation.

Conclusion: Paragraph 2, line 3, suggest 2 sentences: "Present evidence clearly *indicates* that populations maintaining low serum lipid levels have a low incidence of . . . etc," then, "Present evidence *suggests* that reduction and maintenance of low serum lipid levels *will* reduce the population incidence . . . etc." Suggest add: Diets similar in composition to the AHA prudent diet are the usual diets of many natural populations having low CHD incidence. American diets similar to . . . etc (as is)."

Paragraph 3: Make the approach more positive and avoid the "going on a diet" concept.

There should be a strong statement, as in the ISCR, concerning making "better" food products available and labelling the fat composition so that the consumer can make informed choices. This *must* be AHA policy.

The general tone of the statemant may be rather too clinical and "diet" oriented. The AHA prudent diet and approach should be attractive and should emphasize a habitual way of choosing and eating foods. It should point to palatable and varied alternatives, including eating meals resembling Italian, Chinese, Greek, Japanese, Polynesian menus and all the many interesting products now available.

The statement sorely needs a general guide that the physician can use with no further delving including food groups to emphasize, and those to downplay or avoid. This is actually the only type of information most physicians will ever need or use directly, and has, I believe, been a useful part of earlier AHA statements as well as the Intersociety Report.