Dr. Caceres and others names and references should be given, as well as references to automated screening devices, using technician coding for screening, and the availability and approximate cost of each such service.

I don't see the relevance of the detailed AAGP Continuation Study requirements, codes, and officers.

For fasting blood specimens, fasting should be defined with the method given for "determining" fasting state. There should be a preamble to indicate the feasibility of first level screening with non-fasting sugar and triglyceride methods, and a promise to update this as more information becomes available. There is no mention of the Tecumseh, one hour non-fasting glucose tolerance test, except in the Appendix.

These laboratory sections might contain more cookbook enumerated procedures and less gab.

The section on Triglycerides might be eliminated or vastly reduced. What does "control groups" mean in paragraph 5 and who really cares what clinical chemists think about screening procedures?

The BP section does not mention the importance of any postural change in the five minutes before the reading. It gives insufficient detail on the number of readings, the manner of reading, cuff size, etc. It makes no mention of tested automated, or other bias-free devices. It only pays lip service to auditoryacuity. Training and testing for random and systematic observer variation is inadequately described.

Dr. Fienlieb's committee is suggesting that the Framingham risk index be used in a way in which the basic four factors, age, blood pressure, cholesterol and smoking can be employed, with added risk probabilities given for ECG findings and blood sugar when available.

Cordially,

Henry Blackburn, M.D.
Chairman, Council on Epidemiology

HB/rs

c.c. L. Cook
N. Borhani
M. Feinlieb
W. Kannel
J. Stamler
G. Barrow
C. Moses