Letter by Kuller and Neaton Regarding Article, “Association of Race With Mortality and Cardiovascular Events in a Large Cohort of US Veterans”

To the Editor:

Kovesdy et al conclude that among veterans receiving health care through the US Veterans Health Administration, event rates among blacks compared with whites are lower or similar for all-cause mortality, coronary heart disease incidence, and stroke. Their Table 2 shows a slightly higher age-adjusted all-cause rate for black compared with white men, a higher incidence of coronary heart disease among white compared with black men, a much higher rate of stroke in black compared with white men, and similar rates of acute myocardial infarction.

We previously reported that for the 300,647 white and 20,223 black men screened for the Multiple Risk Factor Intervention Trial (MRFIT), there were 2518 deaths among blacks and 30,772 deaths among whites resulting from cardiovascular disease over 25 years. The black/white hazard ratios (HRs) adjusted for age, risk factors, and income were 1.05 (95% confidence interval [CI], 1.01–1.10) for cardiovascular disease mortality, 0.86 (95% CI, 0.81–0.91) for coronary heart disease mortality, and 1.37 (95% CI, 1.20–1.57) for stroke mortality. HRs for cardiovascular disease varied significantly by age (P<0.0001) and declined from 1.23 (95% CI, 1.06–1.43) for those 35 to 39 years of age to 0.98 (95% CI, 0.92–0.98) for those 55 to 57 years of age at the time of screening.

In an earlier article, we showed that the age-adjusted HR of death in 16 years for blacks versus whites in MRFIT was 1.47 (95% CI, 1.42–1.53) but dropped to 1.19 (95% CI, 1.14–1.25) after adjustment for income and risk factors. For men 35 to 44 years of age, this adjusted HR was greater (1.36; 95% CI, 1.25–1.49) than the HR for those 45 to 57 years of age (1.14; 95% CI, 1.08–1.20). These are similar to the data in Table 2 of the Kovesdy et al article. HRs vary by cause of death. The HR (black versus white) for cardiovascular disease mortality adjusted for age, income, and risk factors did not differ significantly from 1.0; the HR for coronary heart disease mortality was significantly less than 1.0; and the HRs for stroke, especially cerebral hemorrhage, homicide, prostate cancer, lung cancer, and pneumonia were significantly greater than 1.0. With the exception of the 12,866 men who were randomized and followed up closely for 7 years, the MRFIT screening included no additional medical care or any specific follow-up for risk factors.

The black–white differences reported in MRFIT and other studies are greater for younger age groups. To fully understand the results of Kovesdy et al, the authors need to show age-specific outcome differences among blacks compared with whites.

Considering the results from MRFIT, in addition to variation by age, the results of this Veterans Affairs study may be attributable to selection for military service and subsequent use of Veterans Affairs services among blacks and whites. This limits the generalizability of the findings, and the results should be interpreted with caution.

Disclosures

None.

References

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