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

Kuller and Neaton contrast the findings of our study1 with those reported in their examinations of the Multiple Risk Factor Intervention Trial (MRFT) cohort.2,3 They note similarities in age-adjusted event rates and risks for mortality and vascular events between MRFT and our Veterans Affairs (VA) cohort, suggesting that age plays a major role in observed race-associated discrepancies in cohort studies, and these may differ for different outcomes. Kuller and Neaton also suggest that we should have performed age-stratified analyses to better characterize the associations of race with various clinical outcomes. We actually did perform such analyses, as shown in the forest plots of our original article. We did not detect any effect modification by age for mortality; coronary heart disease risk was lower in all black veterans in comparison with white veterans <80 years of age, but equal for those ≥80 years of age; and ischemic stroke risk varied by age, with similar risk among blacks versus white veterans <60 years of age, but gradually increased risk for those ≥60 years of age. Although age may modify at least some of the examined associations of race with various outcomes in our study, this trend appears to be opposite of those seen in the studies referenced by Kuller and Neaton.2,3

We do agree with Kuller and Neaton about the importance of age and various other case-mix characteristics in determining differences in outcomes observed in our and other studies. However, we do differ in the interpretation of our findings vis-à-vis those reported by other investigators. The discrepant findings reported by different studies underscore the complex nature of race-associated outcomes and the need to disentangle the effects imparted by biological differences (eg, for health outcomes related to genetic characteristics of individuals of African origin, such as both a higher incidence and lower mortality of chronic kidney disease4) versus socioeconomic disparities (eg, lack of access to health care). We contend that the different outcomes we reported among black versus white veterans in comparison with other studies (including our own National Health and Nutrition Examination Survey analysis5) may in fact help disentangle some of the complexities of racial disparities. Although we noted in our discussion6 the potential for selection bias emphasized by Kuller and Neaton, such selection could be construed as a quasi-experiment leading to new knowledge and should not be regarded primarily as a limitation. In the VA system there are several fundamental differences that could affect the outcomes observed in veterans. These are not limited to black versus white differences for entry into military service or use of VA services, as pointed out by Kuller and Neaton; rather, the VA represents a vastly different approach to healthcare delivery and equitable healthcare access that is not present in the general US healthcare system, and looms large over racial disparities.5 The possibility that unhindered access to health care might have such a large impact on racial disparities in health outcomes is intriguing and, in our opinion, merits serious consideration and further examination.

Disclosures

None.

References


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