

THE ABC DIGEST OF **URBAN**  
**CARDIOLOGY**

A PUBLICATION OF THE ASSOCIATION OF BLACK CARDIOLOGISTS, INC.



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the 53rd Annual  
Scientific Session of  
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MARCH/APRIL 2004

# THE ABC DIGEST OF URBAN CARDIOLOGY

A PUBLICATION OF THE ASSOCIATION  
OF BLACK CARDIOLOGISTS, INC.

6849 B-2 Peachtree Dunwoody Road  
Atlanta, GA 30328

**Urban Cardiology** is a bimonthly publication of the Association of Black Cardiologists, Inc., a non-profit organization of medical professionals dedicated to the reduction of cardiovascular and related diseases in minority and underserved populations. The ideas and opinions expressed in this publication do not necessarily reflect those of the Association, editors, or publisher.

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### OUR EDITORIAL MISSION

The *ABC Digest of Urban Cardiology*, published bimonthly, is an official publication of the Association of Black Cardiologists, Inc. (ABC). The ABC is a non-profit organization of health professionals dedicated to the reduction of cardiovascular and related diseases, especially in minority populations, wherein lies a burden of excessive morbidity and mortality. This publication is provided as an educational service to all health professionals who share this dedication.

*The mission of this publication* is to assist such clinicians to deliver the best of care to patients with cardiovascular and related diseases and to do so in a culturally competent and demographically appropriate manner. We do so by providing—in a compact, easily comprehensive journalistic style—up-to-date information of immediate applicability to the unique clinical setting of urban medicine. This information consists of:

- Original, evidence-based, clinical and research main articles (including CME self-assessment).
- "Tidbits"—a regular column of useful clinical knowledge gleaned from recent clinical research trials and other information drawn from the medical literature.
- "Developments"—a regular column covering newsworthy recent events such as new drug and device market introductions, new controversies in medicine, new trends in health care, new scientific insights, and new demographic, economic, and governmental activity affecting the practice of medicine.
- Commentary from the president of ABC, the publication's editor in chief, and the publisher.

We strive continually to improve upon the execution of our editorial mission and therefore encourage and welcome your suggestions on how we can serve you, our reader, better.

In this issue you will observe product advertisements from Pfizer Pharmaceuticals, GlaxoSmithKline, Schwarz Pharma, McNeil-PPC and AstraZeneca. These pharmaceutical firms are providing educational grant support to the Association of Black Cardiologists, Inc. to enable us, among other things, to provide you with this publication without a subscription charge to you.

We encourage you—as you deem appropriate—to acknowledge and show appreciation for this support, as well as for these supporters' recognition of the special health challenges faced by minority and underserved populations and by the clinicians who treat them.

## EDUCATION IS THE FIRST STEP

We at Hilton Publishing are excited about this issue of *Urban Cardiology*. From the thoughtful and inspiring health message of Dr. Ofili, to the Highlights of the 53rd session of the American College of Cardiology this digest is loaded with extremely important health information needed to help combat obesity and the silent killer—high blood pressure. Education, at all levels, is the key to eliminating health disparity in the United States and abroad. And educating doctors, nurses, residents, health care professionals and laymen is the cornerstone of effectively fighting unequal treatment and its consequent increased mortality and morbidity especially with regards to cardiovascular disease—but only if that knowledge is utilized, acted upon and most importantly shared.

We at Hilton Publishing Co and the ABC ask that you share *Urban Cardiology* with your colleagues and hospital or clinical staff. It should be on every medical library shelf for all to read. In doing so you will be able to spread accurate, reliable and culturally responsible and sensitive cardiovascular health knowledge to other health care providers who also treat minority patients and in doing so, you will have far-reaching effects on the lives of others who need our help and will benefit from your knowledge.

We challenge you here to make a difference and continue to share your knowledge as well as that gained from *Urban Cardiology*. As in most things in life, the man or woman who is most educated and prepared usually is the most successful.

We hope you enjoy this issue. We are proud to publish it.

Hilton M. Hudson II, M.D., F.A.C.S., F.C.C.P  
Chief of Cardiothoracic Surgery, Reid Health System,  
Richmond, IN  
President and CEO, Hilton Publishing Company, Inc.  
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## THE ABC DIGEST OF URBAN CARDIOLOGY

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Cover: Inset Illustration by Joel Gresham

The paintings used on the cover of the Digest of *Urban Cardiology* depict teachable moments between children and their grandparents. The dialogue here is:

**Granny:** Give me a big ol hug and a kiss. I haven't seen my Sweetie all week long.

Would you like to help Granny in the garden?

**Sweetie:** You know I do Granny; I love working in the garden with you. Can we pick those roses over there? I want to surprise Momma when she comes to pick me up.

**Granny:** That's sure is a nice thing to do for your Mother, Sweetie.

**Sweetie:** Like you always taught me, "Do unto others, as you shall have others do unto you."

**Granny:** I'm glad to see that I'm rubbing off on you.

To "Talk Back" write to:  
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## LET'S PUT AN END TO HEALTH CARE DISPARITIES ONCE AND FOR ALL

If the number one threat to longevity was our number one priority, under the rules of the “Homeland Security Act”, cardiovascular disease would keep us in the red zone. Perhaps we should start profiling all citizens who eat too much of the wrong foods and don't exercise. But for reasons that are not entirely clear, cardiovascular disease is not being recognized for the devastation it causes.

In his inaugural speech, Dr. Augustus Grant, President of the American Heart Association, said: *“During the six week war in Iraq, 165 soldiers perished, but there were 115,000 casualties from heart disease and stroke.”* And then, Dr. Levi Watkins, in one of his erudite speeches, reported that *“Unwanted obstacles exist for African Americans to receive appropriate health care even when they have the same education, same insurance, same economic status. African Americans are 10% less likely to be diagnosed with an emergency medical condition, 30% less likely to be tested for artery blockage, 40% less likely to be treated with angioplasty and 50% less likely to undergo cardiac surgery—conditions for which African Americans have a higher prevalence”*.

A well-meaning gentleman whom I was encouraging to exercise retorted that if the amount of time regular exercise adds to one's longevity is equal to the amount of time spent exercising, if you don't like to exercise, why bother? I have also been asked often enough why everything one feels passionate about is bad for us. What is this penchant for “bad behavior?” We live in a society that encourages unhealthy living. The smell of Krispy Kreme doughnuts, the taste of Big Macs, Coke, ice



cream, and chocolate, the lure of the couch, large screen TV and computers is driving us to distraction and contrary to our best interest. What has evolved is that what we do and what we know contributes to our health and longevity is not well aligned.

These are the best of times and the worst of times. We may not be reducing heart disease but due primarily to better diagnostic and treatment options, deaths from heart disease and stroke have declined by 50% over the past fifty years and the life expectancy for African Americans has doubled over the last century. But further progress is threatened by the obesity-diabetes epidemic and the low rate of hypertension control in our community. If we can send spaceships into the air and take a virtual walk on Mars, why can't we do a better job of controlling excess mortality here on earth? It is troubling that we give so little attention to the millions of American lives that are lost to

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*continued on page 10*



# UNEQUAL TREATMENT CAN WE “PUBLISH” OUR WAY OUT OF THE PROBLEM?

Dear Colleagues:

The Digest is uniquely positioned to bring to the forefront, clinical issues relevant to cardiology practice in the context of healthcare disparities.

The Digest continues to advance its editorial mission, through the publication of evidence-based clinically-relevant articles to advance the cardiovascular health of African-Americans and other underserved populations.

The Digest’s “easy read” style is appreciated by clinicians everywhere. Retrieving previous publications of the Digest is sometimes a challenge, because it is not on Medline or other indexed search tools.

The Editorial Board has been charged with working to get the Digest “on line” through Medline and other search tools. This is no small task, but we take it on with passion and with enthusiasm.

As we continue to struggle with the implications of the IOM reports *Unequal Treatment* and the *Quality Chasm*, issues such as evidence-based guidelines, and culturally-competent healthcare delivery, rise to the top. Our charge is indeed timely. If we are to make a



lasting impact in the area of disparities in cardiovascular care for African-Americans and other underserved populations.

Our challenge, of course, is to continue to maintain the interest of our readership. This is why I come to you, in this first editorial message, with a strong plea to share your clinical and research experiences with our readership through timely articles. We will maintain the practical format of the Digest through the transition. We will introduce some new concepts, including more focus on case-based CME discussions, as well as provide highlights of recent scientific sessions.

The paradox of implementing cutting edge technologies in our practice, even as we struggle with the most fundamental disparities in cardiovascular preventive care was appropriately captured at the recently concluded 17th Annual Scientific Sessions of the Association of Black Cardiologists. Titled *Cardiovascular*

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*The Digest continues to advance its editorial mission, through the publication of evidence-based clinically-relevant articles to advance the cardiovascular health of African-Americans and other underserved populations.*

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*Diseases, The Cutting Edge: 2004 and Beyond*, the session co-chairs, Drs. Keith Ferdinand and Ivor Benjamin put together an outstanding program! Leading the way with the Daniel D. Savage Memorial Lecture, Dr. Carl J. Pepine, ACC President, discussed the manpower issue "The Future of Cardiovascular Specialty Care: Will There Be An Adequate Supply of Providers?"

Other sessions and topics included "New Frontiers in Preventive Cardiology," "Acute Coronary Syndromes," "3 Dimensional Echocardiography," "Multislice CT" and "Electronic Medical Records." A special keynote lecture by J. Craig Venter, PhD, reviewed how genomics may affect the future of cardiovascular medicine.

If you missed the sessions, register early for 2005, and be sure to check out the ACC Highlights summary in the Digest!

In this issue, we have a feature article by Dr. Anekwe Onwuanyi, Associate Chief of Cardiology, Morehouse School of Medicine, on the role of hypertension as a leading cause of death. These data from the vital statistics records of New York City provide important insights as we continue to refine our clinical preventive strategies.

The health message on hypertension by Dr. Cristina Beato, Acting Assistant Secretary for Health is definitely timely. Dr. Beato affirms the importance of hypertension in cardiovascular morbidity and mortality. She also acknowledges the key role that physicians and other providers, such as yourself, must play in advocating effective prevention and treatment strategies.

Finally, the lay article by ABC, CEO Dr. B. Wayne Kong, "A Gentleman is Never Obese" is a sure winner with the ladies! Gentlemen, we will be watching!!

The old staples including tidbits as well as highlights from the recently concluded ACC meeting in New Orleans make interesting reading and timely tips for your practice.

Happy reading and I look forward to hearing about your ideas!

Best Regards,

Elizabeth Ofili, MD, MPH  
Associate Dean of Clinical Research  
Director, Clinical Research Center  
Professor of Medicine  
Chief of Cardiology  
Morehouse School of Medicine

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***Message from the President***  
*continued from page 8*

heart disease per year. As I write this, I am reminded of Wilt Chamberlain, and Florence Griffith Joyner, who succumbed to a preventable disease.

I do not mean to suggest that implementing preventive health is simple or inexpensive. Changing human behavior is complex and not well understood. On the one hand, we have enough knowledge and resources, but I suspect we lack the will as a nation to do what we can

to prevent the next CVD epidemic that will add incalculable cost to our health care system and rob our children of ever knowing their grandparents. The CDC reports that in 2003 the cost of cardiovascular disease was \$351 billion dollars. Let's develop the will to conquer heart disease! Let's declare an attack on reckless lifestyles and other CVD risks. This should carry the sense of urgency it deserves.

Paul Underwood, M.D.  
President

# SOME HIGHLIGHTS FROM THE 53RD ANNUAL SCIENTIFIC SESSION OF THE AMERICAN COLLEGE OF CARDIOLOGY

Anekwe Onwuanyi, MD

April 5, 2004

The 53rd Annual Scientific Session of the American College of Cardiology was held in New Orleans, Louisiana, March 7-10, 2004. One major focus of the meeting was ischemic heart disease in women. Dr. Carl Pepine, President of the American College of Cardiology discussed this issue in his presidential address titled "Ischemic Heart Disease in Women: Facts and Wishful Thinking." The First Lady, Laura Bush, who was the special guest at this occasion, also spoke on heart disease in women in the United States and highlighted some of the initiatives that are ongoing to bring awareness to this important health issue, such as "The Heart Truth" with the National Heart Blood and Lung Institute of the NIH and "Go Red for Women" with the American Heart Association.

Dr. Pepine stated that cardiovascular disease (CVD) is the leading cause of death in women, more so than cancers, and that the mortality from CVD is increasing for women while decreasing for men, largely because of deaths from ischemic heart disease and stroke. Ischemic heart disease manifests clinically in women about 10 years later compared to men; women are more likely to have more symptoms and non-invasive testing positive for ischemia but less luminal obstructive disease compared to men, thus the therapeutic decision-making is more difficult for women. Dr. Pepine indicated that our current research tools are biased towards men. He gave examples, such as the

Seattle Angina Questionnaire, which evaluated 4,484 patients and only 79 of them were women. The findings, though valid, may not be applicable to women. He also outlined the differences in mortality between men and women for acute myocardial infarction (AMI). The AMI mortality rate for all women less than 65 years is two times higher than in men and 1 year mortality is 1.5 times higher for women.

The data from the Crusade registry also supports the position of a bias in care for CVD towards men. The Crusade registry includes data from 500 hospitals dedicated to guideline-based care in non ST elevation myocardial infarction patients. Dr. Bloomkins and his colleagues reviewed the data with the objective of understanding the gender issues related to treatment modalities and strategy of care. There were significant differences in treatment between men and women. With the exception of beta blockers, men were more likely to receive aspirin, plavix, IV heparin, and glycoprotein IIb/IIIa, irrespective of troponin status.

## Heart Failure

There were two important heart failure trials in the Late Breaking Clinical Trial session. First the results of the Sudden Cardiac Death-Heart Failure Trial (SCD-HeFT) were greatly

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anticipated. This study was presented by Dr. Gust Brady and was performed to determine by intention to treat analysis whether amiodarone or ICD programmed to shock only will reduce all cause mortality compared to placebo in both ischemic and non ischemic patients with NYHA Class II and III heart failure and EF less than or equal to 35%. The patients were on good background therapy for heart failure and 25% of them had non sustained ventricular tachycardia on holter. 2521 patients were enrolled and followed for 5 years. There was a 23% reduction in all cause mortality in the ICD arm. Amiodarone use did not result in improvement in survival. Mortality in placebo controlled patients was 7.2% over 5 years. The second is the DINAMIT study: This study evaluated prophylactic ICD use early after an acute MI, specifically 4-40 days post index MI in patients with EF less than 35% and evidence of impaired cardiac autonomic modulation. 674 patients were randomized, 332 with ICD and ICD implanted median of 7 days post MI. 65% of patients were reperfused and 90% had optimal medical therapy with beta blockers, ACE inhibitors and antiplatelet agents.

Primary end point was all cause mortality. Follow up for 4 years, with mean of 30 months. There was no difference in primary end point between optimal medical treatment versus optimal medical treatment plus ICD. The incidence of arrhythmic deaths was lower in the ICD group but with an increased incidence of non arrhythmic deaths. Other heart failure trials include the role of Candesartan in prevention of type diabetes in heart failure patients. Data was presented by Dr. Salim Yusuf for the CHARM investigators. 7601 patients were randomized to Candesartan 32mgs vs placebo, 5436 had no diabetes at entry. The incidence of new diabetes was significantly lower with Candesatan (6% vs 7.4%).

Data presented from the COMET trial showed that adverse events, such as sudden death, MI, unstable angina, stroke dyspnea,

peripheral edema, were less common with Carvediol compared to metoprolol. Hypotension dizziness and syncope were more common with Carvediol while there were fewer new diabetes and hypokalemia. This lower occurrence of adverse events reflects the beneficial effect on mortality. There were several studies on the subject of anemia in heart failure. In summary, they showed that anemia is associated with diastolic heart failure, elevation in the brain natriuretic peptide level, worse outcome and more severe LV systolic dysfunction. Anemia is an independent risk factor for adverse outcome in heart failure and it results partly from the blunting of erythropoietin production and defective iron supply. A meta-analysis of large placebo controlled trials in heart failure involving more than 500 patients was presented by Dr. Krum from Australia. It showed a greater prognostic benefit for beta blocker use than with ACE inhibitor, thus supporting the position of early introduction of the beta blocker in heart failure patients.

### Lipid Therapy

Perhaps one of the major highlights of the meeting is the presentation of the results of PROVIT-TIMI 22 study by Dr. Christopher P. Cannon. It was a multinational study of 4162 patients with acute coronary syndrome started on a statin, either Pravastatin 40mgs or Atorvastatin 80 mgs less than 10 days following hospitalization for acute coronary syndrome. Follow up was for 2 years and analysis was based on intention to treat. Primary end points were all cause mortality, MI, unstable angina, revascularization and stroke. There were 1001 primary end point events. Atorvastatin decreased LDL to a mean of 62mg/dl and this was associated with a significant 16% reduction in events. Pravastatin reduced LDL to a mean of 95mg/dl. This result challenges the current Adult Treatment Panel guidelines as it relates to LDL cholesterol target of  $\leq 100$ mg/dL. The ALLIANCE trial results presented by Drs.

Koren and Hunninghake also supported the idea of lower LDL targets than current guidelines would require. 2442 hyperlipidemic patients with CHD were started on Atorvastatin to achieve an LDL of 80 mg/dl compared to usual care. Atorvastatin lowered LDL better and significantly decreased events by 17%.

## Ischemic Heart Disease

The SES-SMART study was a randomized study of Sirolimus eluting stent versus uncoated stent in the treatment of patients with small coronary vessel stenosis. The clinical event rate was reduced as well as the restenosis rate in the Sirolimus eluting stent group. The implication is that the use of drug eluting stents could be extended to this patient category.

The DIRECT study looked at outcomes in patients with direct stenting versus standard stenting with pre dilation. The outcomes were similar in the two groups. Dr. Greg Stone presented the study results of primary PTCA for acute ST elevation MI. It examined angioplasty using distal protective device versus usual care. No benefit was observed with the guide wire protective device despite achieving the objective from the mechanistic viewpoint of capturing the emboli in 75% of the patients. It suggests that more attention should be given to events beyond the epicardial coronary arteries.

The SYNERGY trial of 10,000 high risk acute coronary syndrome patients receiving standard therapy, including early invasive treatment, were randomized to IV unfractionated heparin (60 IU/Kg) and low molecular weight heparin (LMWH) (1 ug/Kg Q12 hrs). Primary outcome was a 30 day mortality/MI. No benefit for LMWH was seen.

A study addressing the controversy of Off Pump Coronary Artery Bypass Surgery was presented. This was a meta-analysis of 41 studies of CABG. The early studies showed a 27% increase in risk of 30 day mortality with Off Pump. In later studies there was a significant improvement

in survival at 30 days and 15 months with the Off Pump CABG. This is attributed to the use of cardiac stabilization devices in later studies.

## Valve Surgery

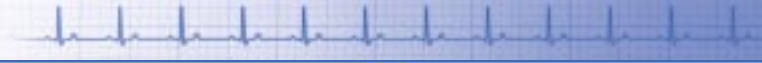
A study was performed in 28 patients with severe mitral regurgitation to evaluate a new surgical technique—edge to edge mitral repair (Alfieri technique). Some of these patients (62.4%) also had annuloplasty. 82% of the patients had no residual regurgitation. No deaths occurred and NYHA class improved. The adverse effects include functional mitral stenosis.

This approach was adapted for a percutaneous approach to repair the mitral valve for severe mitral regurgitation, in the EVEREST 1 study, presented by Dr. Feldman. There is very limited data thus far (10 patients) but what there is shows that it is technically feasible to repair the mitral valve from the percutaneous approach. In this situation a catheter-based system is used to clip the mitral valve leaflets.

## Atrial fibrillation

The PLAATO study: In 103 patients with atrial fibrillation, an expandable closure device was delivered percutaneously to the left atrial appendage to prevent material in the appendage from embolizing out. There was a low incidence of neurologic events. Additional studies are needed.

*Deep Vein Thrombosis (DVT):* An interesting study was performed to compare the effect of two modalities of treatment before a long duration flight in preventing DVT. 458 patients were randomized to no treatment (control), aspirin for 3 days versus fixed dose low molecular weight heparin (LMWH) 2-3 hours prior to flight. There were 5.6% events in the control group, 4.3% in the aspirin group and none in the LMWH group. One fixed dose LMWH is an option for DVT prevention in high-risk patients during long duration flights.



## A HEALTH MESSAGE WHEN IT COMES TO HYPERTENSION— WE NEED YOUR HELP

Hypertension affects well over 50 million persons living in the United States,<sup>1</sup> impacting minorities disproportionately. Higher-than-optimal blood pressure (BP) is relatively easy to detect and can also be prevented, or its time of onset significantly delayed. The lifetime risk of developing hypertension is high; being about 90% for normotensive persons 55 years of age. Uncontrolled hypertension generates substantial morbidity due to complications that include stroke, atrial fibrillation and accelerated development of ischemic heart disease, chronic kidney disease and end-stage renal disease,

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*It is estimated that economic costs for care of hypertensive disease will exceed \$53 billion in 2004.*

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peripheral vascular disease and retinopathy. The risk of death due to stroke or ischemic heart disease increases progressively and exponentially as blood pressure rises above 115/75 mm Hg, doubling every 20/10 mm Hg. Uncontrolled and undetected hypertension generate significant healthcare, public health and other costs for society. It is estimated that economic costs for care of hypertensive disease will exceed \$53 billion in 2004. Studies show that uncontrolled hypertension generates more economic cost than controlled hypertension. Put differently, over the long term, it may be less expensive to control hypertension than to leave it uncontrolled. Of course, it is even bet-

ter to primarily prevent hypertension.

How well are we doing nationally with control of hypertension? Better than in past years but, unfortunately, there is plenty of room for improvement. We need your help to achieve higher rates of blood pressure control and hypertension prevention locally and nationally. The most recent national data indicate that about 34% of people with hypertension have their blood pressure controlled to recommended levels of less than 140/90 mm Hg—only one third. Although national BP control rates were as low as 10% in the late 1970s, current national rates continue to be unacceptably low.

President Bush, Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services, VADM Richard Carmona, Surgeon General, U.S. Public Health Services, and I along with the staff and programs of the Department remain committed to primary prevention of chronic health conditions including hypertension and diabetes.<sup>2</sup> We also remain committed to enhancing detection and control such conditions nationally as well as to helping to address demographic and geographic disparities in health.

In order for the nation's health efforts to be effective, we need your help as committed colleagues and collaborators. In order to achieve practical hypertension control goals, we must work collaboratively at multiple levels. All of us as individuals must practice what we preach and, where possible, adopt and maintain healthy behaviors that have been shown to prevent hypertension, delay its onset or contribute to lowering blood pressure levels in people

with hypertension. Obesity and physical activity are the two major risk factors for hypertension. Regular physical activity, weight control, lower sodium consumption, eating at least 5 servings of fruits and vegetables daily, smoking avoidance or cessation and moderate alcohol intake (if that's your preference as an adult), are health behaviors that we all can benefit from.

As a healthcare provider, I know the importance of the role that you play on a regular basis in providing accessible, high quality care to your patients and respect the fact that your own responsible clinical judgment is the central component of any effort to achieve better BP control rates. Accordingly, we ask you to review and incorporate the most recent clinical practice guidelines into your practice<sup>1</sup>, be aware of hypertension-related clinical practice quality measures and standards<sup>3</sup> and continue to work with health systems, health plans and other institutional level partners to achieve and maintain better BP control rates.

Likewise, health systems and health plans are asked to work collaboratively with individual health professionals, medical societies and health-related associations to improve health system- and health plan-specific BP control rates. Health system and health plan commitment to the pursuit of 'best-in-class' hypertension quality control measures and to assisting individual health professionals in achieving their BP control goals is paramount.

Enhancement of community-wide BP control rates and hypertension prevention can only be achieved via true multi-level approaches. Therefore, other members of the community must also be involved, including families, faith-based institutions, schools, businesses, philanthropic organizations, community-based health centers, pharmacies, governmental entities and many other community organizations and individuals with leadership roles.

There are two broad challenges that we ask you to help meet on behalf of this country: 1) effective translation of *that which we know can*

*work*, based on scientific evidence in the form of guidelines, into *that which we know is working*, based on adoption, implementation and evaluation of effective hypertension-reducing activities at multiple levels within the community; and 2) sustainability of positive results or outcomes for BP control and hypertension prevention.

The President and this Department are fully committed to achieving better prevention and control of higher-than-optimal blood pressure and recognize your accomplishments to-date in this area and the continued need for your help in achieving local and national blood pressure goals. Thank you for continuing to do what you do best.

RADM Cristina V. Beato, M.D.  
Acting Assistant Secretary for Health  
Office of Public Health and Science  
U.S. Public Health Service  
U.S. Department of Health and Human Services

## Resources for Primary Care Providers and Others

1. Chobanian AV, Bakris GL, Black HR, Cushman WC, Green LA, Izzo JL Jr, Jones DW, Materson BJ, Oparil S, Wright JT Jr, Roccella EJ; Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. National Heart, Lung, and Blood Institute; National High Blood Pressure Education Program Coordinating Committee. Seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Hypertension*. 2003 Dec;42(6):1206-52. Epub 2003 Dec 01. (<http://www.nhlbi.nih.gov/guidelines/hypertension/>).
2. Useful websites: President (<http://www.healthierus.gov/>; <http://www.whitehouse.gov/government/fbci/>); Secretary of Health and Human Services (<http://www.health.gov/>; <http://www.healthierus.gov/steps/index.html>; [http://www.ndep.nih.gov/campaigns/SmallSteps/SmallSteps\\_overview.htm](http://www.ndep.nih.gov/campaigns/SmallSteps/SmallSteps_overview.htm); <http://www.hhs.gov/news/press/2003pres/20031103a.html>); US Surgeon General (<http://www.surgeongeneral.gov/flash.htm>); Assistant Secretary for Health (<http://www.hhs.gov/ash/>) Hypertension quality measures information: [http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc\\_id=453](http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=453); <http://www.ncqa.org/Communications/State%20Of%20Managed%20Care/SOHCREPORT2003.pdf>



# HYPERTENSION LEADING CAUSE OF EXCESS CARDIOVASCULAR DEATHS

Anekwe E. Onwuanyi, M.D., F.A.C.C.

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## Abstract

Although mortality from cardiovascular diseases (CVD) has been declining, it remains the leading cause of death among urban US blacks. CVD as a group is the major contributor to excess mortality in Central Harlem (CH). However the contribution of specific CVD to this excess death is unknown. Such information could be vital in designing strategies for the reduction of CVD mortality. We reviewed the vital statistics records of the New York City (NYC) Department of Health for 1990 and identified all cases in which the cause of death was coded as cardiovascular (International Classification of Diseases—ICD, 9th Revision, codes 391,393 to 398,401 to 404,410,411,414 to 417,420 to 438 and 440 to 444). The total and disease-specific CVD mortality for NYC and CH were calculated using the appropriate 1990 census data as the denominator. CH residents aged between 25-64 years were at least twice as likely to die from cardiovascular causes compared to NYC residents. Even after controlling for socioeconomic and educational variables, CVD mortality was still two times higher in Harlem compared to similar communities. Hypertension-related deaths was the major cause of excess death for men and women in CH. These findings show the importance of hypertension as the main determinant of the excess cardiovascular mortality in urban blacks and suggest an increased risk of cardiovascular death in blacks residing in Central Harlem.

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*Both total and disease-specific cardiovascular mortality have declined in the United States in the recent past decades. However data indicates that the trend is variable in different segments of the population resulting in differences in cardiovascular disease (CVD) mortality among the different races and geographic areas within the United States.*

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## Introduction

Both total and disease-specific cardiovascular mortality have declined in the United States in the recent past decades<sup>1,2,3,4</sup>. However, data indicates that the trend is variable in different segments of the population resulting in differences in cardiovascular disease (CVD) mortality among the different races and geographic areas within the United States<sup>2,3,4,5</sup>. Blacks are reported to have a higher CVD mortality rate compared to whites with the greatest increase in risk among younger age groups<sup>6,7,8,9,10,11</sup>. There have been many suggestions to explain this observation, and they include different patterns of risk factors and access to care between blacks and whites<sup>12-16</sup>. It is, however, important to note that the black population is heteroge-

nous with regards to CVD mortality. This fact is clearly borne out in the study by Fang et. al.<sup>17</sup>, who observed a higher CVD mortality among African-Americans born in the United States compared to Caribbean-born US blacks. Likewise the study by Geronimus et. al.<sup>10</sup>, showed that even when you account for socioeconomic and racial factors, differences in CVD mortality still exist. In their study, CVD mortality in several predominantly black and white communities in the United States with different socio-economic backgrounds was analyzed. Harlem, which is predominantly black, had a higher CVD mortality compared to the other poor black and white communities.

McCord and Freeman<sup>18</sup> also concluded in their study on excess mortality that cardiovascular diseases as a group was the leading contributor to excess mortality before age 65 years in Harlem. This observation, while important, was limiting in the sense that specific cardiovascular diseases and their contribution to excess mortality were not reported. This study was performed to 1) compare CVD mortality in Harlem and the rest of New York City and 2) determine the contribution of specific cardiovascular diseases to excess cardiovascular deaths in Harlem. Such information could be useful in developing strategies to reduce CVD mortality.

CENTRAL HARLEM: is a community located in the northern part of Manhattan. According to the 1990 census the population is predominantly black (87.6%) and fifty-six percent of the population is aged between 20 and 65 years. Approximately forty-five percent of the population is men and 34.4% of CH population lived below the poverty line compared to 16.3% of NYC population.<sup>19-21</sup>

## Methods

The source of data for this study was the vital statistic records tabulated by the Bureau of Health Statistics of the New York City Department of Health. These were generated

from physician death certificates, compiled and coded according to the ninth revision of the International Classification of Disease (ICD-9)<sup>22</sup>. We identified all cardiovascular deaths for 1990 using the ICD-9 codes. Denominator data was obtained from the 1990 census.

Total cardiovascular disease mortality was obtained from the summation of all the relevant ICD-9 codes which are: 391, 393-398 (rheumatic heart disease), 401 (hypertension), 402 (hypertensive heart disease), 403 (hypertensive renal disease), 410 and 411 (acute myocardial infarction and subacute myocardial infarction), 414 (chronic ischemic heart disease -CIHD), 425 (cardiomyopathy), 426 (conduction disorder), 427 (dysrhythmia), 428 (heart failure), 430-438 (cerebrovascular accidents) and other cardiovascular diseases. The latter consists of ICD-9 codes 415-417 (acute and chronic pulmonary heart disease), 420 (endocarditis), 422 (myocarditis), 423 (other pericardial diseases), 424 (other endocardial diseases), 429 (ill-defined heart disease) and 440-444 (aortic aneurysm and dissection). Death coded as due to hypertension consisted of ICD-9 codes 401 (hypertension), 402 (hypertensive heart disease) and 403 (hypertensive renal disease). The total CVD mortality rates were derived for CH and NYC by dividing the total number of deaths in each category by the relevant population census figures. These rates were then stratified by age, gender and race. We also compared the cardiovascular mortality between black residents of Central Harlem and other blacks living in New York City and particularly in predominantly black neighborhoods with low socioeconomic status. We obtained the socioeconomic and educational data from the Infoshare database of the City College of New York. Mortality rates for specific cardiovascular diseases and standardized mortality ratios (SMR) for all cardiovascular disease deaths were generated for CH. A SMR of one

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TABLE 1: TOTAL CARDIOVASCULAR DISEASE MORTALITY RATES IN NEW YORK CITY AND HARLEM IN 1990

Age (yrs)	MEN		WOMEN	
	NYC	Harlem	NYC	Harlem
25-44	43.4	95.9	18.7	53.8
45-64	444.0	1021.1	223.9	520.1
> 64	2821.4	3076.0	2420.9	2420.0

Rates per 100,000

TABLE 2: TOTAL CARDIOVASCULAR DISEASE MORTALITY RATES BY RACE IN NEW YORK CITY IN 1990

Age (yrs)	MEN		WOMEN	
	White	Black	White	Black
25-44	29.9	79.3	9.7	36.9
45-64	412.4	635.9	177.2	355.1
> 64	2968.4	2720.4	2622.8	2212.7

Rates per 100,000

indicates similar mortality rates between the compared groups. We derived the excess deaths from cardiovascular causes for those aged 25-64 years residing in Central Harlem by calculating the difference between the expected and observed deaths, if the age-specific mortality rate of New York City population applied.

## Results

The population in NYC and CH in 1990 was 7,322,564 and 115,483 respectively. There were 648 CVD deaths in CH in 1990 with a mortality rate of 552.5 per 100,000 while 31,265 CVD deaths occurred in NYC (excluding CH deaths) with a mortality rate of 427.0 per 100,000. Total cardiovascular disease mortality rates for NYC and CH (Table 1) increased with age in all groups for both men and women. The total CVD mortality in CH

was disproportionately higher compared to NYC as a whole. Men in CH had CVD mortality rate two times as high as the rate for NYC population in age groups 25-44 and 45-64 years. The difference in mortality rates in those 65 years or older was less marked. The same pattern was observed for women, with the exception of the age group 25-44 years, for which the mortality rate in CH residents was almost three times higher than in NYC. In Table 2, the total CVD mortality for the blacks, whites and Hispanics in NYC is shown. In general, black men and women recorded higher CVD mortality rates compared to whites and Hispanics. The difference in total CVD mortality appears to be less marked in those older than 64 years. The above description of black-white total CVD mortality difference is consistent with the observation by others<sup>9,10</sup>. The

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TABLE 3: STANDARDIZED MORTALITY RATIOS FOR ALL CARDIOVASCULAR DEATHS 25–64 YEARS IN CENTRAL HARLEM

	Deaths	25–44 yrs	45–64 yrs	Total	SMR (CI)	P value
MEN	Expected	14.3	76.6	90.9	2.32 (2.02-2.66)	< 0.001
	Observed	34.0	177.0	211.0		
WOMEN	Expected	6.7	57.0	57.7	2.53 (2.15-2.95)	< 0.001
	Observed	24.0	137.0	161.0		

SMR: Standardized mortality ratios  
CI: Confidence interval

TABLE 4: AGE ADJUSTED MORTALITY RATES FOR SPECIFIC CARDIOVASCULAR DISEASES IN CENTRAL HARLEM AND NEW YORK CITY IN 1990.

Disease	MEN		WOMEN	
	NYC	Harlem	NYC	Harlem
Hypertension	15.3	66.3	14.1	45.2
Acute Myocardial Infarction	118.3	72.4	117.2	83.6
Chronic Ischemic Heart Disease	168.8	172.9	201.7	162.2
Cardiomyopathy	7.1	19.5	4.2	9.4
Arrhythmia and conduction disorders	14.9	42.4	13.7	37.7
Heart Failure	14.1	15.4	17.9	33.6

Rates per 100, 000

NYC—New York City

N: Number

Other CVD: Includes deaths from stroke, valvular heart disease, pulmonary heart disease, peripheral vascular disease, endocarditis, myocarditis and aortic dissection.

Minus sign(-): Fewer deaths in central Harlem compared to NY City.

TABLE 5: SOCIOECONOMIC FACTORS AND REGIONAL CARDIOVASCULAR MORTALITY RATES IN NYC

	Percent Black	Per Capita Income	Educational Status < High School	Total CVD Mortality Rate
Central Harlem	88.1	\$8,906	43.8	35.2
East Flatbush	88.2	\$12,743	30.6	12.6
Brownsville	81.4	\$7,296	48.6	18.8
Crown Heights	82.4	\$10,302	42.2	12.7
Bedford Stuyvesant	83.6	\$8,210	41.2	18.7

Rates per 100, 000

TABLE 6: CAUSES OF EXCESS CARDIOVASCULAR DEATHS FOR AGES 25-64 YEARS IN CENTRAL HARLEM IN 1990

Diseases	MEN			WOMEN			Total excess Deaths n (%)
	Observed Deaths	Expected Deaths	Excess Deaths n (%)	Observed Deaths	Expected Deaths	Excess Deaths n (%)	
Hypertension	19	4	15 (23.8)	13	2	11 (25)	26 (24.3)
Acute Myocardial Infarction	10	12	-2 (0)	13	7	6 (13.6)	4 (3.7)
Chronic Ischemic Heart Disease	24	14	10 (15.0)	14	9	5 (11.4)	15 (14.0)
Cardiomyopathy	4	1	3 (7.7)	1	1	0(0)	3 (2.8)
Arrhythmia and conduction disorders	7	2	5 (7.9)	3	1	2 (4.5)	7 (6.5)
Heart Failure	4	1	3 (4.8)	0	1	-1(0)	2 (18.7)
Other Cardiovascular Diseases (CVD)	43	14	29 (46)	31	10	21 (47.7)	50 (46.7)

SMR (with NYC as the reference population) for all cardiovascular deaths combined for ages 25-64 years in CH was 2.32, (confidence interval 2.02-2.66,  $p < 0.001$ ) for men and 2.53, (confidence interval 2.15-2.95,  $p < 0.001$ ) for women (Table 3). Table 4 shows higher age-adjusted mortality rates for men and women in Harlem for hypertension, heart failure, cardiomyopathy and dysrhythmias. The age-adjusted mortality rate for acute myocardial infarction is lower for Harlem compared to New York City. In table 5, we compare five poor, predominantly black communities with less than fifty percent of individuals having a high school diploma. Even though these communities were similar with regards to the variables stated, CVD mortality was two times greater in Harlem

A total of 107 excess deaths resulting from cardiovascular diseases occurred in Central Harlem in 1990. Hypertension was the overall leading cause of excess deaths in men and women aged 25-64 years in Harlem, 23.8% and 22.9% respectively (Table 6). The contributions

of hypertension to excess CVD death may have been underestimated since those stroke deaths resulting directly from hypertension are not included under hypertension.

## Discussions

The findings of this study are consistent with prior epidemiological observations that cardiovascular disease (CVD) mortality is higher for blacks as compared to whites and Hispanics<sup>1,3,4,5,8,10,17,18</sup>. The higher CVD mortality in blacks in 1990 was particularly noticeable in the young and middle age groups while mortality rates for the elderly population were largely similar. Also, we found that the excess mortality from CVD was almost entirely under age 65 years. The mortality for acute myocardial infarction was lower than expected among black men in CH and that most of the observed excess mortality was related to hypertension. The largest difference in mortality between CH and NYC for specific cardiovascular disease was observed for hypertension in both men and

women. Hypertension is prevalent, more severe and less well treated in blacks<sup>23</sup>. It is also an important cause of left ventricular hypertrophy (LVH)<sup>23,24</sup>, an independent predictor of cardiovascular morbidity and mortality. Studies have shown both hypertension and LVH to be more prevalent in blacks compared to whites<sup>25</sup>. The exact mechanisms by which LVH leads to an increased frequency of death have not been fully determined, however, the susceptibility of the hypertrophied left ventricle to dysrhythmia, especially in hypertensive individuals has been suggested as a possible mechanism<sup>26-31</sup>.

We also observed considerable excess deaths due to chronic ischemic heart disease in both men and women. However, unlike in men there was excess death attributable to AMI in women in CH compared to NYC women. The low AMI death rate in CH men compared to NYC men is consistent with previous observations<sup>3,5,6,7</sup>. Some of the reasons that have been suggested for this observation include the possible protection from ischemic heart disease of high levels of high-density lipoprotein (HDL) in blacks coupled with the competing mortality from other non-coronary causes. This explanation appears to be relevant only for men as black women have a higher rate of AMI deaths compared to their white counterparts.

Our observation that residence in Harlem appears to be associated with an increased risk for cardiovascular deaths is supported by the findings in the study by Geronimus et. al. and McCord and Freeman. We are struck that within New York City, similar populations with regard to key health predictor variables could have such differences in CVD mortality. It is noteworthy that only Harlem suffered this disadvantage. (Table 5) Therefore it can be surmised that the differences in black-white CVD mortality data cannot be fully explained on the basis of race, education and socioeconomic differences. The issue of acculturation has been proposed as one more factor that may play a significant role

in the presence and severity of diseased states in general and cardiovascular diseases in particular. We did not obtain information regarding place of birth in our study, therefore we cannot speculate on its possible impact on CVD mortality in this study. In summary, this study corroborates the finding of an increased risk of CVD death in blacks that reside in Central Harlem and underscores the importance of hypertension as a major contributor to CVD deaths.

An unavoidable limitation of this study is the utilization of death certificates and census data. The inaccuracies of these data sources are well known<sup>32,33</sup>. An example is chronic ischemic heart disease as a cause of death. It is uncertain what disease entities are included in this category. This limitation is especially important in blacks who are reported to have an increased incidence of normal epicardial coronary arteries on angiography despite angina symptoms compared to whites<sup>34</sup>. The death of such individuals may be erroneously coded as chronic ischemic heart disease. These considerations may contribute to the emergence of chronic ischemic heart disease as one of the major determinants of excess death in CH population.

Also the deaths from stroke were not included under hypertension and this potentially could underestimate the impact of hypertension on excess cardiovascular deaths. Despite the aforementioned limitations we do not believe that a systematic error occurred in our analysis. Finally, while CVD mortality rates for blacks remain higher than for whites it is important to note that areas of very high CVD mortality exist in the black communities and such areas require special attention. Hypertension related deaths accounted for the majority of excess cardiovascular deaths in Harlem and any strategy for the reduction of this cardiovascular death gap must include the early detection, effective treatment and control of hypertension.

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## Notes

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## GENTLEMEN ARE NEVER OBESE

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According to the Centers for Disease Control 61% of adults and 25% of children and adolescents in the United States are overweight. This is primarily due to overeating and to the fact that 40% of us do not engage in leisure physical activities. The dramatic change in overall physique from the past to present can be readily seen by comparing family photos from the past with photos from today.

Although the media focus has been on the even higher rates of overweight and obesity among African-American women, men also suffer from high rates of excess weight. Are there no gentlemen left? Is chivalry dead?

This excess weight substantially increases the risks of diabetes, stroke, cancer and even arthritis. In fact, obese adults have twice the rate of premature death and disability than those less endowed. The high rate of obesity among men is unhealthy. Americans over seventy years old are not obese. What do you think happened to those who were obese? There is no such thing as an old fool.

Instead of experimenting with fad diets to lose weight and joining health clubs that you never use, it is a better idea to do a little exercise throughout the day and eat a little less. When it comes to exercise, every time you move your muscles, it helps a little bit and every time you resist eating something (particularly anything with sugar) it helps a little bit. The difference between what an average-sized person and what an obese person consumes is just 150 excess calories per day. That difference is just about a small bag of potato chips, an order of French fries or a can of soda. It takes

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*What is it to be a gentleman? Is it to be honest, to be gentle, to be generous, to be brave, to be wise, and, possessing all these qualities, to exercise them in the most graceful outward manner? Ought a gentleman to be a loyal son, a true husband, an honest father? Ought his life to be decent, his bills to be paid, his taste to be high and elegant, his aims lofty and noble?*

—Thackeray

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less than 500 calories to add an extra pound of fat. At that rate, this adds up to more than 50,000 extra calories per year or an extra ten pounds of fat. Over 20 years, the person who is consuming just 150 extra calories per day will have added an extra 200 pounds.

Society encourages us to avoid exertion and become sluggards, to take elevators instead of walking up stairs. If there are more than six steps, we put in an escalator. Older people, who are quite capable of walking, cannot make their way through an airport without repeated offers to push them in a wheelchair. Even when we try to walk somewhere, someone is always offering to drive us. But gentlemen like to stroll and sometimes even strut our stuff. Golfers cannot walk anymore. Carts are required. We live in a

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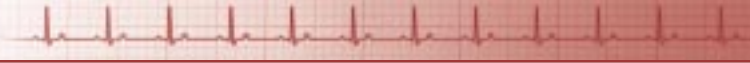
time when people walk their dogs while driving their cars and drive to the end of their driveways to pick up the daily newspaper. Exercise has also become expensive. We used to make a living by the sweat of our brow but now pay health clubs, golf clubs, tennis clubs and even walking clubs just to get our heart rate up a little.

Food pushers (particularly mothers and grandmothers) are always anxious to express their love for us by making our favorite dishes and take great offence and get their feelings hurt if you don't clean your plate, eat a big slice of the birthday cake, don't ask for thirds and generally insist that we stuff ourselves. "I cook my fingers to the bone for you and that is all you are going to eat?" "If you enjoy it, eat it!" "A little piece of cake is certainly not going to hurt you." "You used to like my cooking, what's wrong?" "Is that all you are going to eat?" Sometimes this is even accompanied by tears. Have you noticed that we used to have a few occasions to splurge and celebrate (Thanksgiving, Christmas, New Years and birthdays), we can now find an occasion to celebrate with extra food and drink every week. We no longer have the option of buying a small cola or small order of fries. At fast food restaurants, for a mere 25 cents you can super size. A gentleman is not persuaded. We never eat more than we need or buy what we don't need because it is a bargain—even if it's only 25 cents!

A gentleman is never obese for many reasons. First of all, gentlemen never eat in fast-food restaurants—how uncivilized! Other than forgiving others for their transgressions, gentlemen generally do not do things quickly. A gentleman has "slow hands". We like to savor the moment, smell the roses and enjoy God's gifts to us. Gentlemen cannot be talked into doing something that we know is unhealthy or unwise. We also keep ourselves in shape to have the endurance to perform up to expectations regardless of the task at hand. Can you imagine a gentleman not being able to recover a lady's pocketbook that some thief has liberated from her because he got winded and couldn't catch the thief? That would not be a good day.

In addition to regular exercise and a prudent diet, men can easily burn up an extra 150 calories per day performing gentlemanly deeds. Actively tipping his hat and greeting others, opening car doors, pulling out chairs, putting on coats, carrying packages and luggage (even when checking into hotels), grooming ourselves, cutting the grass, sprucing up the place, keeping our cars, shoes and clothes clean and presentable—all of these little courtesies burn calories. Gentleman readily give up their seats and stand on trains, buses, and boats but never on planes, helicopters, and cars . . . even to little old ladies. When a gentleman drops his lady at a restaurant, runs around the car to open the car and restaurant doors, drives to the parking lot and walks back, he has burned up 10 calories . . . times 2 for repeating this sequence after dinner. At the same time he is trying to save money by checking the prices on the menu and ordering less for himself. Drinking water saves both money and calories. He demonstrates that he is willing to splurge and shower his lady with "anything her heart desires." He is overheard saying "You can order anything you like my dear." As a result, her meal is 1,200 calories and his is less than 1,000. And yes, a gentleman always has his wits about him. More than one drink is out of the question. His judgment and performance are never impaired by excess alcohol or drugs.

Old men are fond of telling young men to always smile at ladies and find opportunities to be helpful and courteous. They delight in rescuing damsels in distress, changing tires and helping to put that heavy suitcase in the overhead compartment on the airplane. You may suspect that they do this to win favor with the ladies only to discover that the true motivation is to burn those 150 calories per day so they will continue to look sharp and debonair. A sure sign that you are in the presence of a gentleman is if his lady is obese, because a gentleman does everything for his lady. On the other hand, if he is obese and she is not, this is no gentleman. The lady is just doing too much!



### Two-for-One Pill Targets Both Hypertension and Dyslipidemia

According to the results of the Gemini trial, the recently approved fixed-dose combination pill, combining amlodipine and atorvastatin (two of the most important components of the so-called “poly-pill”) is an effective tool for managing patients with dual diagnosis (hypertension and dyslipidemia) in the primary care setting. Senior investigator Roy Blank, MD, believes it’s a giant step in achieving both goals (cholesterol and blood pressure control). Multiple dosing possibilities allowed treatment for patients to be individually tailored. After 14 weeks, 57.7% of patients reached both their blood pressure and LDL cholesterol level to therapeutic goals.

### Fitness Most Important Factor in Assessing Cardiac Mortality Risk in Women

Researcher Martha Gulati, M.D., M.S., recently announced exercise capacity is as good—if not better—a predictor of cardiac mortality as the exercise stress test in asymptomatic women. The St. James Women Take Heart Project, initiated in 1992, involved 5,721 women older than 35 years at baseline. Subjects had no history of heart disease, were asymptomatic, and had blood pressure less than 170/110 mm Hg at enrollment. The investigators calculated by measuring exercise time and time to angina as well as measuring age, total and high density lipoprotein cholesterol, diabetic status, smoking history and blood pressure. The findings may affect current AHA/ACC guidelines for exercise testing in asymptomatic women which call for a treadmill test. The test may no longer be necessary for asymptomatic women.

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### Hypertension

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