Facts and ideas from anywhere

VIOLENT WEATHER

Violent weather has cost the world a record $89 billion this year, more money than was lost from weather-related disasters in all of the 1980s, and human meddling may be responsible for much of it (1). The World Watch Institute put total losses from storms, floods, droughts, and fires for the first 11 months of 1998 at 48% higher than the previous 1-year record of $60 billion in 1996. Even when adjusted for inflation, the losses for the entire decade of the 1980s, at $83 billion, were still short of the first 11 months of 1998. In addition to the material losses, disasters have killed an estimated 32,000 people and displaced 300 million, more than the population of the USA.

The Institute blames a combination of deforestation and climate change for this year’s most severe disasters, among them the flooding of China’s Yangtze River, Bangladesh’s most extensive flood of the century, and Hurricane Mitch. Much of the rain forest, particularly in Central America, is being cut for more pastureland for cattle so that we in the USA can have more hamburgers to eat. For several decades, nations in Central America have lost 2% to 4% of their forest cover each year to pastureland. When the hillsides are left bare, rainfall rushes across the land or into rivers without being slowed by trees that would allow the rainfall to be absorbed by the soil or to evaporate. This leads, of course, to floods and landslides that can wipe out roads, farms, and fisheries far downstream. As one spokesman for World Watch indicated, “We are turning up the faucets . . . and throwing away the sponges, like the forests and wetlands.” Another element that has contributed to this year’s losses is the growing population pressures that have led many people to settle on vulnerable flood plains and hillsides.

The costliest disaster of 1998 was the flooding of the Yangtze River in the summer. It killed more than 3000 people, displaced about 230 million others, and incurred $30 billion in losses. While heavy summer rains are common in southern and central China, the Yangtze Basin has lost 85% of its forest cover to logging and agriculture in recent decades. Bangladesh suffered its most extensive flood of the century in the summer. Two thirds of the low-lying country at the mouth of the Ganges and Brahmaputra Rivers was flooded for months, 30 million people were left temporarily homeless, 10,000 miles of roads were heavily damaged, and the cost was at least $3.5 billion. Hurricane Mitch, the deadliest Atlantic storm in 200 years, caused >10,000 deaths in Honduras, Nicaragua, Guatemala, and El Salvador and an estimated $4 billion in damage in Honduras and $1 billion in damage in Nicaragua.

Thus, what we do to our planet can have major effects on our health—32,000 deaths and 300,000,000 displaced persons due to weather in 1 year is something of interest, not only to the people involved, but to the leaders, including physicians, of all the nations on the planet.

US POPULATION IN THE YEAR 2050

In 52 years, the US population is projected to be 394 million persons, nearly 50% more than at present (2). Texas is expected to grow by 8.5 million people in that period. The US population is now growing at 0.9% a year. Fewer people are being born and more are dying as the population ages, but the number of immigrants is increasing. The nation’s 273 metropolitan areas now contain nearly 80% of our population.
In 1995 and 1996, 16% of the population moved, down 4% from the 1950s and 1960s. Men and women are marrying later than ever. The average age at first marriage is now 27 for men and 25 for women. That is about 4 years older than the average in 1970. All of these numbers, of course, have health implications.

**TEXANS NOT AS WELL OFF AS IN 1979**

According to Dick Lavine (3), family incomes in Texas are still below 1979 levels. Adjusted for inflation, the median income for a Texas family of 4 has dropped by nearly $2900. Texas families now lag behind the national average by almost 10%. More than one third of workers in Texas make <$7.80 an hour, roughly the amount needed for a full-time worker to support 4 above the poverty line. Ten percent of Texans earn only the minimum wage. The disparity in income between the one fifth of Texans with the greatest income and the one fifth with the lowest income is the seventh worst in the USA. The current unemployment rate in Texas, namely 4.9%, is still above the state’s 1979 average unemployment rate of 4.2%. Texas consistently has higher unemployment than the national average. During the bottom of the oil bust in 1989, wages and income were even lower. Most of the recent gains enjoyed by many families have come from working more hours, an extra 6 weeks a year for the typical family, rather than from higher hourly wages. Despite the stock market’s growth in recent years, the typical middle class family had nearly 3% less wealth in 1997 than in 1989. Eighty-five percent of the growth in stock prices benefited only the richest 10% of households.

**IN PRISON IN TEXAS**

In 1988, just 10 years ago, <40,000 persons were in Texas prisons (4). Today, the number of inmates in Texas prisons totals nearly 145,000, and Texas is the largest state prison system in the nation. The Texas Department of Criminal Justice now exercises direct control over 1 in every 20 Texans: 145,000 state prison inmates, 80,000 parolees, and 431,000 probationers. The Texas prison system costs Texans $2 billion a year at $39.51 a day to incarcerate each inmate. The incarceration rate in Texas is the highest in the world! It is much easier to build prisons (Texas voters recently approved nearly $3 billion in bonds to build more prisons) than to correct the underlying causes of crime: poverty, poor parenting, drugs, and a lack of supervision or meaningful counseling. Ninety-five percent of the 145,000 inmates now in Texas prisons will be released someday. How many will become upright citizens and how many will return to the jails are unclear. Many will visit our hospitals.

**DR. JACK KEVORKIAN AND DEATH ON TELEVISION**

Is it euthanasia? Mercy killing? Death with dignity? Murder? As our life spans continue to increase, so will the debate about dying. In 1997 in the USA, there were 2,192,813 natural deaths, 92,191 accidental deaths, 594,526 terminally ill, and 29,725 suicides (5). Dr. Kevorkian claims he has assisted in 130 suicides or planned deaths of the hopelessly ill. He obviously is on a crusade to prove that euthanasia is not a crime. Despite Dr. Kevorkian’s approach, untold thousands of terminally ill are kept alive in a state of vegetation or insufferable pain by life-support systems, often against their wishes. There are circumstances under which we, if we are able, or our families, if we are not, should decide how and when we die.

**BY-PRODUCTS OF OUR FLESH CULTURE**

New mandatory environmental rules, to take effect in year 2003, will require hog facilities that produce >2500 animals a year, cattle operations that produce >1000 a year, and poultry farms that produce >30,000 a year to develop plans for the safe storage and disposition of manure and urine (6). These by-products are fouling our nation’s waters, imperiling our drinking water, and destroying aquatic life. The
waste is washed into surface waters by rain and seeps through the ground into drinking water aquifers. This disposal problem will become progressively worse with time and will be 1 reason, in my view, why the percentage of vegetarians in our population will increase.

**BLINDNESS AND SLEEPLESSNESS**

Every 7 minutes someone in the USA becomes legally blind or visually impaired (7). Currently, 10,000,000 Americans have serious difficulty seeing (more than half a million in Texas). Because we are living longer, more Americans are experiencing vision loss. Visual impairment is most common among older people because of 4 major eye diseases associated with aging: macular degeneration, cataracts, glaucoma, and diabetic retinopathy.

Eight of 10 people who are blind report frequent bouts of trouble sleeping and maintaining alertness (8). The cyclic nature of such complaints points to their underlying cause—desynchrony in circadian, or daily, rhythms. The high prevalence of sleep-wake disorders in blind people suggests the importance to sighted persons of the cues of natural light and dark to anchor their circadian rhythms to the 24-hour day. Despite the use of alarm clocks, regular work hours, scheduled meals, and other time cues, blind persons often have circadian rhythms that “free run.” Their internal clocks follow the natural human cycle which is somewhat longer than the planetary day.

Eighty-three percent of blind French adults responding to a large national survey reported at least 1 sleep problem, including difficulty falling asleep, frequent awakenings, early awakenings, poor sleep quality, and shortened sleep duration. The same study indicated that blind persons were twice as likely as the control population to show variations in times of going to bed, arising, meals, peak alertness, and other indicators of disordered circadian rhythms. Of 28 totally blind persons whose sleep was monitored in the laboratory, 14 slept <5 hours and only 1 slept >7 hours, still less than the 7.5 hours typical for sighted adults. Blind persons on average have a 75% sleep efficiency, a measure of time asleep in relation to time in bed; sighted persons ordinarily achieve an 85% to 90% sleep efficiency. Six of the 28 totally blind persons had a sleep efficiency below 55%. Similar findings were found in 79 totally blind children. About 1 in 3 blind children, compared with 1 in 5 sighted children, have insomnia. Some blind persons apparently find the circadian rhythm dysfunctions more burdensome than the blindness.

**TOBACCO AND ALCOHOL USE AMONG MEDICAL SCHOOL GRADUATES**

Of 1001 questionnaires sent to fourth-year medical students at 8 US medical schools in 4 different regions of the country (9), 548 (55%) were returned. Among the graduating students, 2% reported currently being smokers, and 13% reported having been smokers. Frequent alcohol use (3 days a week) was reported by 18% of the students, and 21% of the students reported at least 1 episode of binge drinking (5 drinks in 1 sitting) in the past 30 days. Eighteen percent of women and 11% of men in the study believed that their alcohol intake increased while they were in medical school. This survey shows a sharp decline in the prevalence of tobacco use among medical students. The pattern of physician alcohol intake, however, has increased slightly since 1987. As physicians age, their alcohol intake tends to increase, in contrast to that of the general population, which tends to decrease with age. Estimates of physician impairment due to alcoholism are as high as 10% (12% in the nonphysician population). The patterns of alcohol intake for this sample of senior medical students are similar to those for the age-related general population. Men tended to drink more often and more heavily than their female peers and were significantly more likely to have engaged in an episode of binge drinking within the past 30 days. Women, however, were more likely than their male peers to report an increase in alcohol intake while in medical school.
RESEARCH FUNDING BY THE NATIONAL INSTITUTES OF HEALTH (NIH)

Table 1 shows the numbers of deaths, the direct and indirect cost estimates, and the NIH support in fiscal year 1996 in millions of dollars for our most common diseases (10). A brief study of the table indicates some evident disparities in NIH funding.

<table>
<thead>
<tr>
<th>Disease or condition</th>
<th>No. of deaths (in thousands)</th>
<th>Cost estimate (in $ billions)</th>
<th>NIH support (in FY 1996)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>732</td>
<td>$71</td>
<td>$55</td>
</tr>
<tr>
<td>Cancer</td>
<td>534</td>
<td>27</td>
<td>69</td>
</tr>
<tr>
<td>Stroke</td>
<td>153</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease and allied conditions</td>
<td>102</td>
<td>116</td>
<td>11</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>81</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>57</td>
<td>45</td>
<td>47</td>
</tr>
<tr>
<td>HIV infections and AIDS</td>
<td>42</td>
<td>10</td>
<td>—</td>
</tr>
<tr>
<td>Chronic liver disease and cirrhosis</td>
<td>25</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Kidney and urologic diseases</td>
<td>23</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>Septicemia</td>
<td>20</td>
<td>4</td>
<td>—</td>
</tr>
</tbody>
</table>


DEMENTIA AND ISOLATED SYSTOLIC HYPERTENSION

A double-blind, placebo-controlled trial in Europe examined patients with systolic blood pressures of between 160 and 219 mm Hg and diastolic blood pressure of <95 mm Hg and treated them with either a placebo (1180 patients) or with a drug (1238 patients) using nitrendipine with or replaced by enalapril + hydrochlorothiazide for 2 years (11). Compared with the placebo group, active treatment reduced the incidence of dementia by 50%, from 7.7 to 3.8 cases per 1000 patient years. Thus, the treatment of 1000 hypertensive patients aged 60 years or older with antihypertensive drugs for 5 years would prevent 19 cases of dementia.

ALTERATION OF THE “NOTHING AFTER MIDNIGHT” RULE

Physicians often use the term NPO from the Latin phrase nil per os (meaning, of course, “nothing by mouth”), setting a deadline of midnight to begin fasting the day of surgery. For most surgical patients that meant they could not eat or drink anything 8 to 12 hours before surgery. The American Society of Anesthesiologists (34,000 members) recently released medical guidelines on preoperative fasting (12). These guidelines suggest that patients undergoing elective surgery may drink limited quantities of clear liquids up to 2 hours before surgery with permission from their physicians. Clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee, but no alcohol. There are significant benefits of allowing patients to drink clear liquids up to 2 hours before surgery, including less anxiety, better hydration, and fewer headaches and nausea after surgery. Clear liquids are digested
quickly, so the amount of liquid drunk before anesthesia is not as important as what is drunk. The guidelines are strict regarding breast milk, nonhuman milk, and solid food. Breast milk is more easily digested than nonhuman milk but should not be given to babies <4 hours before surgery. Surgical patients need to avoid solid food, nonhuman milk, and infant formula for at least 8 hours before surgery.

**CAROTID ENDARTERECTOMY**

Jesse Thompson started vascular surgery at Baylor, and from the beginning, it has been outstanding. I attend the weekly vascular surgical conference and also examine 4 or 5 carotid endarterectomy specimens each week. The lumen of the internal carotid artery in some of them is almost totally occluded. Previous studies have shown that carotid endarterectomy in patients with symptomatic severe stenosis (70% to 99% diameter reduction) is beneficial up to 2 years after the procedure. In a recent trial, Barnett and colleagues (13) from the North American Symptomatic Carotid Endarterectomy Trial collaborators assessed the benefit of carotid endarterectomy in patients with symptomatic moderate stenosis (50% to 69% diameter narrowing), and also the 8-year benefit of endarterectomy in patients with severe stenosis. Patients with moderate carotid stenosis and transient ischemic attacks or disabling strokes on the same side as the stenosis (ipsilateral) within 180 days before study entry were stratified according to the degree of stenosis (<50% or 50% to 69%) and randomly assigned either to carotid endarterectomy (1108 patients) or to medical care alone (1118 patients). The average follow-up was 5 years, and complete data on outcome events were available for all patients. Among patients with stenosis of 50% to 69%, the 5-year rate of any ipsilateral stroke (failure rate) was 16% among patients treated surgically and 22% among those treated medically. To prevent 1 ipsilateral stroke during the 5-year period, 15 patients would have to be treated with carotid endarterectomy. Among patients with <50% stenosis, the failure rate was similar in the group treated with endarterectomy (15%) and in the medically treated group (19%). Among the patients with severe stenosis who underwent endarterectomy, the 30-day rate of death or disabling ipsilateral stroke persisting at 90 days was 2%; this rate increased to only 7% at 8 years. Thus, endarterectomy in patients with symptomatic moderate carotid stenosis yielded a moderate reduction in the incidence of stroke. Patients with stenosis of <50% did not benefit from surgery. Patients with severe stenosis had a durable benefit from endarterectomy for at least 8 years.

**PHYSICIANS ARE ALSO PHARMACISTS IN JAPAN**

In Japan, patients buy medications directly from physicians (14). Thus, some physician income is provided from the drugs they prescribe and then sell to their patients. The Japanese Medical Association is proposing that physicians no longer sell prescription drugs to their patients. I doubt they will be successful.

**TOBACCO DOCTORS**

An article by Allen Breed (15) indicates that at least 760 physicians across the country profit from owning federal tobacco growing rights, known as allotments or quotas. They practice in 23 states. Some physicians own rights to grow as little as 21 pounds annually; one physician in South Carolina can grow 932,000 pounds. All total, these physicians control the production of >7 million pounds of tobacco, enough to make 193 million packs of cigarettes a year. They also grow nearly 290,000 pounds of the varieties of leaf used in chewing tobacco and cigar wrappers. At last year’s sales prices, their leaf would be worth $13 million. Some physicians apparently make more money from their tobacco profits than from their practices. It would be difficult to advise a patient to discontinue smoking, I suspect, if the advisor is growing tobacco for his/her own profit.
FOOD HANGOVER

Have you ever felt lousy after eating at a fine restaurant? According to Michelle Green, the problem is fairly common and is getting more common (16). There are reasons why one might feel lousy after a restaurant meal. The most common culprit is the surprisingly high fat content of some haute cuisine portions. Another reason is the “new,” usually foreign, ingredients, including nettles, star fruit, and chickweed that chefs toss on certain dishes. Government oversight has not kept up with all the new ingredients. Escolar, an oily fish native to the tropics, was added to some dishes in 1992 and caused mild diarrhea in many diners. This fish is actually used as a laxative in another country. Wild mushrooms are unrestricted in many mushroom-producing states, and wild mushroom foragers sell directly to restaurants. Another reason for feeling lousy is simply from eating too much. Sometimes it is difficult to tell how much one has eaten because some fancy restaurants use sauces and stocks that have been “reduced,” meaning they have been simmered and concentrated dramatically so that a small portion is actually astonishingly rich.

As exotic new ingredients proliferate, the job of keeping food safe is becoming more challenging. Oils flavored with garlic cloves, the rage at some upscale eateries, can harbor botulism spores. The Food and Drug Administration (FDA) requires commercial producers of these so-called infused oils to take steps, including adding acid, to stop spore growth. The agency, however, has no control over chefs who prefer to whip up their own oils. Other bacteria, usually known for causing serious illness, can lead to grogginess or malaise when ingested in minor amounts. Campylobacter jejuni, found in poultry and believed to be responsible for the most food-borne illnesses in the USA, and Salmonella enteritidis, more commonly known for causing diarrhea and fever, are 2 examples.

In some ways, the food hangover issue is reminiscent of the controversy over monosodium glutamate (MSG), an additive frequently found in Chinese food. Introduced into the USA around 1900, the flavor enhancer spurred a government investigation in the 1960s when people complained that it gave them headaches. The FDA declared the additive safe when consumed at “normal levels” (about 500 mg a day). The agency, however, subsequently reported that some persons react badly to these “normal levels.”

And, finally, some food hangovers may result from the stress produced by paying high prices for a single meal.

THE REDUCTION IN CORONARY EVENTS BY STATIN DRUGS IS DIRECTLY PROPORTIONAL TO THE REDUCTION OF LOW-DENSITY LIPOPROTEIN CHOLESTEROL LEVELS

There are now 5 placebo-controlled, double-blind, cholesterol-lowering trials using statin drugs. Two of them (the West of Scotland Coronary Prevention Study [WOSCOPS] and the Air Force Texas Coronary Atherosclerosis Prevention Study [AFCAPS/TexCAPS]) are primary prevention trials, meaning, of course, that the populations studied had no clinical evidence of myocardial ischemia before entering the trial. The other 3 (Scandinavian Simvastatin Survival Study [4S], Cholesterol and Recurrent Events [CARE], and Long-term Intervention with Pravastatin in Ischaemic Disease [LIPID]) are secondary prevention trials, meaning, of course, that the patients included had already had Š1 coronary event(s). The percentage of low-density lipoprotein (LDL) reduction by the 3 statin drugs studied, namely, lovastatin, pravastatin, and simvastatin, ranged from 25% to 35%; the percentage of coronary-event reduction during the 5 or so years of the trials ranged from 24% to 34%. In other words, as shown in Table 2, the percentage of coronary-event reduction was virtually identical to the percentage of LDL reduction. In only 1 of these 5 trials was the final mean LDL cholesterol level <100. Trials are now under way with the goal of reducing LDL cholesterol to <80 mg/dL. These more aggressive statin-lowering drugs have the capacity to reduce coronary events by 50% or more, thus delaying death and promoting health. The cost of
1 coronary stent will provide the drug to a patient for well over 1 year!

Table 2. Comparison of percent reduction in low-density lipoprotein cholesterol to the percent reduction in coronary events by statin drugs

<table>
<thead>
<tr>
<th>Trial</th>
<th>Drug (mg)</th>
<th>Baseline LDL (mg/dL) (mean)</th>
<th>Final LDL (mg/dL) (mean)</th>
<th>Percent LDL reduction</th>
<th>Percent coronary-event reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOSCOPS</td>
<td>pravastatin (40)</td>
<td>197</td>
<td>142</td>
<td>20%</td>
<td>31%</td>
</tr>
<tr>
<td>AFCAPS/TexCAPS</td>
<td>lovastatin (20-40)</td>
<td>150</td>
<td>115</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>4S</td>
<td>simvastatin (20-40)</td>
<td>188</td>
<td>122</td>
<td>35%</td>
<td>34%</td>
</tr>
<tr>
<td>CARE</td>
<td>pravastatin (40)</td>
<td>139</td>
<td>97</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>LIPID</td>
<td>pravastatin (40)</td>
<td>150</td>
<td>113</td>
<td>25%</td>
<td>24%</td>
</tr>
</tbody>
</table>

WOSCOPS = West of Scotland Coronary Prevention Study
AFCAPS/TexCAPS = Air Force Texas Coronary Atherosclerosis Prevention Study
4S = Scandinavian Simvastatin Study
CARE = Cholesterol and Recurrent Events
LIPID = Long-term Intervention with Pravastatin in Ischaemic Disease

HIGH-DOSE STATIN THERAPY MAY EQUAL ANGIOPLASTY IN STABLE CORONARY ARTERY DISEASE

At the American Heart Association 71st Scientific Sessions in Dallas in November 1998, Bertram Pitt presented the results of the Atorvastatin Versus Revascularization Treatments (AVERT) study. The study included 341 patients with 1 native coronary artery narrowed 50% in diameter, LDL cholesterol levels 115 mg/dL, triglyceride levels 500 mg/dL, left ventricular ejection fractions 40%, and the ability to complete 4 minutes of the Bruce protocol exercise treadmill or a 20-minute bicycle test without 2 mm ST segment depression on electrocardiogram. The patients then were randomized to either atorvastatin, 80 mg/day, plus the usual medical therapy, or to coronary angioplasty plus the usual care, which could include lipid-lowering therapy. The treatment groups were comparable at baseline. Follow-up information was collected on all patients at 18 months. In the atorvastatin-treated group, 22 (13%) of the 164 patients had 1 ischemic event(s) (death, resuscitated cardiac arrest, nonfatal acute myocardial infarction, cerebrovascular accident, coronary bypass, coronary angioplasty, and/or worsening angina). In the angioplasty/usual care–treated group, 37 (21%) of the 177 had 1 myocardial ischemic event(s). Thus, there was a 36% difference (13% versus 21%) between the treatment groups in favor of atorvastatin ($P = 0.054$). Of the patients in the atorvastatin arm, 87% were adequately managed for up to 18 months with medical therapy alone; of the 177 patients in the angioplasty/usual-care arm, 130 (73%) received lipid-lowering therapy at some time during the study.

In the patients randomized to atorvastatin, LDL cholesterol levels decreased from a mean baseline of 145 mg/dL to 77 mg/dL at the end of the study (69%), total cholesterol levels decreased from 323 mg/dL to 251 mg/dL (25%), triglyceride levels decreased from 168 mg/dL to 139 mg/dL (10% ), and high-density lipoprotein cholesterol levels decreased from 45 mg/dL to 47 mg/dL (8%). In contrast, in patients randomized to angioplasty/usual care, LDL cholesterol levels decreased from a mean baseline of 147 mg/dL to 119 mg/dL (18%), total cholesterol levels decreased from 222 mg/dL to 197 mg/dL (10% ), triglycerides levels increased from 161 mg/dL to 165 mg/dL (10%).
levels increased from 43 mg/dL to 46 mg/dL (11% ).

Four patients (2.4%) in the atorvastatin-treated group had persistent levels >3 times the upper limits of normal in hepatic enzymes (alanine aminotransferase and aspartate aminotransferase). None were reported in the angioplasty/usual care–treated patients. No patient in either treatment group had elevations in creatinine kinase >10 times the upper limit of normal. Thus, high-dose statin therapy may give the balloon catheter considerable competition!

**ESTROGEN/PROGESTIN THERAPY FOR CORONARY ARTERY DISEASE**

Many observational studies, such as the Nurses’ Health Study, have indicated that women who “self-selected” to take hormone replacement therapy (HRT) have a 50% lower risk of subsequent coronary artery disease (CAD) events than those not on HRT. Estrogen improves the lipid profile, coronary vasomotor tone, and vascular compliance. The Heart and Estrogen/Progestin Replacement Study (HERS) was carried out to determine if estrogen plus progestin therapy altered the risk for CAD in postmenopausal women with established CAD (17). HERS was the first randomized, double-blind, placebo-controlled trial of HRT. Its total cost was $40 million. It enrolled 2763 postmenopausal women (average age 67) at 20 academic sites in the USA. Participants were randomized to either conjugated estrogen (0.625 mg) plus medroxyprogesterone acetate (2.5 mg) or to a placebo taken daily. Only women with a uterus were included. Participants were <80 years old and had established CAD. They had to have had an acute myocardial infarction, a coronary bypass, or a coronary angioplasty >6 months before randomization, or an angiogram demonstrating at least 1 coronary artery narrowed >50% in diameter.

The major outcome of the trial was the occurrence of CAD death or nonfatal acute myocardial infarction. To the surprise of many, HRT did not prevent coronary events in these women with previous CAD events over the average follow-up of 4.1 years of the trial. There were 172 CAD events in the HRT group and 176 in the placebo group. Hormone replacement therapy appeared to increase the risk of CAD during the first year of therapy and then to decrease the risk after 2 years. There were 57 CAD events in the HRT group and 38 in the placebo group during the first year. In years 4 and 5, however, there were 33 events in the HRT group and 49 in the placebo group. Thus, there was a trend for benefit if the patients tolerated the therapy for at least 2 years without an intercurrent event.

The patients in this study will continue to be followed for at least the next 2 years. The trial was underpowered. Thus, the present answer from this trial may not be the final answer to this important question.

**175 YEARS OF THE LANCET**

*The Lancet*, a sister journal of *The American Journal of Cardiology* because both are published by Elsevier-Science, is now 175 years old. The October 3, 1998, issue of *The Lancet* provides a brief biography of its 12 editors during its existence (18). The first editor was Thomas Wakley who served for 39 years (1823–1862). He founded *The Lancet* “to expose and combat the corruption and nepotism” that he found in the medical profession, and it was his inspiration and indefatigable work that led to the journal’s success. Wakley was a great social reformer who also relished confrontation. His life was littered with court cases. As a member of Parliament, he took up many causes. His influence went far beyond his own term as editor, as the journal was handed first to 1 son, then to the other, and finally to a grandson. The Wakley dynasty ran the journal for 85 years. The editor from 1944 to 1964 was Theodore “Robbie” Fox; his son, Robin Fox, was the editor from 1990 to 1995. It was the latter who reestablished peer review for *The Lancet*. Ian Douglas Wilson, who was editor from 1964 to 1976, was an outspoken opponent of routine peer review, believing that it resulted in an overcautious approach. His own
preference was for a swift response to events, and he was responsible for reducing the long delays between acceptance and publication of manuscripts. All but 1 of Lancet’s editors “rose through the ranks.”

William Clifford Roberts, MD
Editor in Chief

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