

Identifying myocardial infarction risk factors in the Wisconsin Longitudinal Survey

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March 26, 2015

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Abstract

Introduction

Coronary artery disease (CAD) is a leading cause of death in the United States and much of North America and Europe. In 2011, one American died of CAD every 40 seconds, on average, and 155,000 of those deaths were people aged less than 65 years (Mozaffarian et al. 2015). One manifestation of CAD is a myocardial infarction (MI), which is also called a “heart attack”. A MI results from a clot in a coronary artery that diminishes blood flow to the heart muscle, or myocardium. If blood flow disruption persists for a sufficiently long time, the muscle may die, or infarct. The irreparable dead heart muscle diminishes the overall ability of the heart to pump blood. Severe MIs may lead to a patient’s death.

Epidemiologists have identified modifiable and non-modifiable risk factors that contribute to CAD risk. Smoking is among the strongest modifiable risk factors, and is thought to elevate CAD risk by triggering elevations in inflammatory molecules in the bloodstream. _____

What is mechanism for smoking causing CAD?

. Diabetes mellitus and hypertension (systolic or diastolic) are typically considered non-modifiable risk factors, although their contribution to CAD risk may be reduced in patients who undertake dramatic lifestyle interventions, such as exercise programs and diet with weight loss. Non-modifiable risk factors include age, a family history of CAD and presence of certain genetic variants

what are other known risk factors?

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Our collaborators at the Wisconsin Longitudinal Study (WLS) have undertaken an investigation on a subset of WLS participants with the goal of identifying CAD risk factors in the WLS study population. The ultimate goal of this project is to develop an intervention program to reduce CAD morbidity and mortality in Wisconsin. The investigators would like to extend such an intervention program to Wisconsin residents who are not WLS subjects. Our goal in this report is to identify risk factors for MI among WLS participants.

Study design

The Wisconsin Longitudinal Study (WLS) is a long-term study of a random sample of 10,317 men and women who graduated from Wisconsin high schools in 1957. According to the WLS website “WLS provides an opportunity to study the life course, intergenerational transfers and relationships, family functioning, physical and mental health and well-being, and morbidity and mortality from late adolescence through 2011.” (“Wisconsin Longitudinal Study” 2015)

need more info on WLS?

Our collaborators collected data from the original respondents or their parents in 1957, 1964, 1975, 1992, 2004, and 2011; from a selected sibling in 1977, 1994, 2005, and 2011; from the spouse of the original respondent in 2004; from the spouse of the selected sibling in 2006; and from widow(er)s of the graduates and siblings in 2006.

Data description

Our collaborators shared with us a data set that contains records for 19095 individuals (including original subjects and siblings) with 310 variables per subject. 2209 subjects responded (with yes or no) to the 2011 question of whether they had ever had a heart attack.

Exploratory data analyses

Statistical modeling

We used statistical modeling to try to identify covariates that associated with six distinct outcomes: 1) HA2004, 2) HA2011, 3) DOC2004, 4) DOC2011, 5) new self-reported heart attacks (from 2004 to 2011) and 6) new heart attack per doctor’s report (from 2004 to 2011). For a subject to qualify as a “new” self-reported heart attack, they must have responded “No” in 2004 and “Yes” in 2011. Analogous definition applies for “new” doctor-reported heart attack.

We found that HA2004 had 1695 non-missing responders (with 665 responding “Yes” and 1030 responding “No”). Further response counts are provided in

Statistical modeling with Framingham study predictors

We identified those variables in the WLS that closely match those in the Framingham study (D’Agostino et al. 2008) (Table ??). It’s important to note that the Framingham study used survival analysis methods, including Cox proportional hazards regression, to identify risk factors for a cardiovascular event. Thus, their study design, analysis, and purpose differ from ours.

Leek (2015)

References

D’Agostino, Ralph B, Ramachandran S Vasan, Michael J Pencina, Philip A Wolf, Mark Cobain, Joseph M Massaro, and William B Kannel. 2008. “General Cardiovascular Risk Profile for Use in Primary Care the Framingham Heart Study.” *Circulation* 117 (6). Am Heart Assoc: 743–53.

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Framingham study variable	WLS Variable
Sex	Sex
Quantitative total cholesterol	highchol2011 or highchol2004
Quantitative HDL cholesterol	None
Smoking	Columns 61 to 87 aim to quantify smoking
Diabetes	diabetes2004, diabetes2011, diabdiag2004, diabdiag2011
Age	Age
Systolic BP	highbp2004, highbp2011*
Treated for high blood pressure	None

Table 1: Framingham study variables and their closest analogs in WLS. (* SBP not available, so we used reported "high BP".)

Mozaffarian, Dariush, Emelia J Benjamin, Alan S Go, Donna K Arnett, Michael J Blaha, Mary Cushman, Sarah de Ferranti, et al. 2015. "Executive Summary: Heart Disease and Stroke Statistics—2015 Update a Report from the American Heart Association." *Circulation* 131 (4). Am Heart Assoc: 434–41.

"Wisconsin Longitudinal Study". 2015. <http://www.ssc.wisc.edu/wlsresearch/>.