



INTERNAL
CORRESPONDENCE

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Epidemiology
EHA

UNION CARBIDE CORPORATION OLD RIDGEBURY ROAD, DANBURY, CT 06817

To (Name) Dr. Carol Stack
Division Chemical Manufacturers Association
Location 2501 M Street, NW
Area Suite 200
Washington, DC 20037

Date November 4, 1983

Originating Dept.

Area

Copy to

Subject

EHA Phase II Proposal
on Vinyl Chloride Study
(UCC South Charleston and
Texas City)

Dear Carol:

As a follow-up to our phone conversation of October 31, 1983 I shall set my comments on the EHA Phase II Proposal to paper. In order of concern they are as follows:

1. I do not feel that persons previously classified as exposed should be considered "unexposed" on the basis of available information in 1983. The EHA proposal contains a suggestion to analyze the data two ways, using the original classification as well as the revised classification. The substantial number of reclassified individuals for some companies is definitely a cause for concern, however, I do not feel this will be resolved simply by re-analyzing the data and contrasting it with results obtained using the original classification. I feel that this will only create problems in interpretation if the results are different.

Union Carbide's plant in West Virginia was affected by this reclassification problem. By searching the memories of those who were involved in selecting the original cohort for the 1972 study, I am not convinced that they did not have good reason to assume that persons selected for the exposed group were indeed exposed. It is very likely that they had data available to them which is no longer to be found. While it is true that we cannot confirm the exposure status on the basis of records available to us today, it is entirely possible and even likely that if we were to start de novo in creating an exposed cohort, this cohort would contain some individuals not included in the original study.

Therefore, I conclude that only one of two approaches is justified under the circumstances; 1) analyze the original cohort using the original classification criteria, and 2) start de novo and independently identifying an exposure cohort using records available today. Under the EHA proposed approach, individuals included in the original cohorts could only be excluded; there is no provision for the inclusion of employees found to be inadvertently omitted from the original cohort. This could lead to substantial bias.

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2. The coding of contributory causes from the death certificate is a worthwhile endeavor. All death certificates should be coded in this manner, not just those obtained in the Phase II study.
3. Is the national death index (NDI) a reliable source for determining individuals known to be "alive"? Is it valid to assume that if the person does not appear as a death after 15 months have elapsed, that this person must be alive? I state these simply as questions as I do not have the necessary information to provide any answers.
4. I would prefer to see deaths which occurred during the time period of the 8th and the 9th revisions of the International Classification of Diseases used in preference to coding back to the 7th revision. The "Monson" program allows for the conversion of codes from the 8th to the 7th or from the 7th to the 8th. It is always preferable to be as up to date as is practicable.

I am sorry that I was unable to attend the last meeting. I look forward to seeing you at the next one!

Sincerely,



Susan G. Austin, Sc.D.
Corporate Director of Epidemiology

SGA/pmb

cc: Mr. J. H. Barrett
Mr. H. L. Greenberg
Mr. T. E. Lawrence
Dr. T. A. Lincoln
~~Mr. W. E. Whitcomb~~
Dr. O. Wong