Alcohol intake and mortality in middle aged men with diagnosed coronary heart disease

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Abstract
Objective—To examine the effects of alcohol on risk of mortality from coronary heart disease (CHD), cardiovascular disease, and all causes in men with established CHD.

Methods and results—In a population based prospective study of 7169 men aged 45–64 years followed for a mean of 12.8 years, 655 men (9.1%) had a physician diagnosis of CHD (myocardial infarction 455, angina only 200). In these 655 men, there were 294 deaths from all causes including 175 CHD deaths. Ex-drinkers had the highest risk of CHD, cardiovascular mortality, and all cause mortality even after adjustment for lifestyle characteristics and pre-existing disease. Using occasional drinkers as the reference group, lifelong teetotallers, occasional drinkers, and light drinkers all showed similar risks of mortality from CHD, cardiovascular disease, and all causes. Moderate/heavy drinkers showed increased risk of mortality from CHD, cardiovascular disease, and all causes compared to occasional drinkers. The adverse effect of moderate/heavy drinking was confined to the 455 men with previous myocardial infarction (adjusted relative risk for all cause mortality 1.50, 95% confidence interval 1.01 to 2.23). In contrast to lighter drinking, giving up smoking within five years of the start of follow up was associated with a considerable reduction in risk of all cause and cardiovascular mortality compared to those who continued to smoke.

Conclusion—Compared to occasional drinking, regular light alcohol consumption (1–14 units per week) in men with established coronary heart disease is not associated with any significant benefit or deleterious effect for CHD, cardiovascular disease or all cause mortality. Higher levels of intake (≥3 drinks per day) are associated with increased mortality in men with previous myocardial infarction. In contrast, smoking cessation in men with established CHD substantially reduces the risk of mortality.

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Keywords: coronary heart disease; alcohol consumption; mortality risk; smoking cessation

It is well established that light to moderate drinking is associated with lower risk of major coronary heart disease (CHD) events.1–12 In the majority of prospective studies relating alcohol intake to cardiovascular morbidity and all cause mortality, men with diagnosed CHD have been excluded or have been included in the large group of subjects with pre-existing disease (variously defined).3–16 Most studies which have examined the effects in men with and without pre-existing cardiovascular diseases have found the “protective” effect of light to moderate alcohol intake in both groups of men.6–15 The role of alcohol specifically in men with established CHD who are at greater increased risk of CHD mortality is therefore less certain. While clinical studies have suggested that alcohol drinking may be harmful in men with established CHD,17 evidence from population prospective studies to support this is lacking; given the consistent evidence for the beneficial effects of light to moderate alcohol intake in population studies it may even be assumed that alcohol intake plays a beneficial role in secondary prevention of CHD. Recently the US physicians’ health study reported that a light to moderate amount of alcohol in men with previous myocardial infarction is associated with “a slight but clinically important decrease in total mortality compared with those who (usually) never or rarely drank alcohol”.18 Lifelong teetotallers and ex-drinkers were not separated. In this predominantly lightly drinking population of American physicians, the effects of moderate or heavy drinking (≥3 drinks per day) could not be assessed.

Our study examines the relation between alcohol intake and risk of CHD and all cause mortality in 655 men with a history of diagnosis of CHD (myocardial infarction or angina, or both) drawn from the general population, separating lifelong teetotallers and ex-drinkers. It also compares the effects of alcohol intake and cigarette smoking cessation on CHD and all cause mortality in these men as a contrast in effect.

Subjects and methods
The British regional heart study is a prospective study of cardiovascular disease involving 7735 men aged 40–59 years selected from the age–sex registers of a single group general practice in each of 24 towns in England, Wales, and Scotland and examined from January 1978 to July 1980. Men with pre-existing cardiovascular disease or receiving regular medical treatment were not excluded and the overall response rate was 78%. The criteria for selecting the town, the general practice, and the subjects as well as the methods of data collection have been reported previously.19 Research nurses administered to each man a standard questionnaire (Q1), which included questions
on smoking habits, alcohol intake, and medical history. Several physical measurements were made and blood samples (non-fasting) were taken for measurement of biochemical and haematological variables. Five years after the initial examination (1983 to 1985), a postal questionnaire (Q5) similar to the one administered at screening was sent to all surviving men; detailed information on medical history, and changes in smoking and drinking behaviour, and in other risk factors, was obtained from 98% (n = 7275).

PRE-EXISTING DISEASE
At both the initial screening (Q1) and five years later (Q5) men were asked whether a doctor had ever told them that they had angina or a myocardial infarction (heart attack, coronary thrombosis), stroke, diabetes, and a number of other disorders. They were also asked for details of any regular medication.

ALCOHOL INTAKE
Alcohol consumption was recorded at initial screening (Q1) using questions on frequency, quantity, and type, similar to those used in the 1978 general household survey. The men were questioned about frequency and quantity of alcohol intake, resulting in eight drinking categories: non-drinkers, occasional drinkers (special occasions or 1–2 drinks per month), weekend drinkers (1–2, 3–6 or > 6 drinks per day), and men drinking daily or on most days (1–2, 3–6 or > 6 drinks per day). These categories were the only choices provided; the “≥ 6 drinks per day” is an open ended category. One UK unit of alcohol (one drink) is defined as half a pint of beer, a single measure of spirits, or a glass of wine (approximately 8–10 g alcohol). Heavy drinking refers to those drinkers whose longest occupation of each man was recorded at screening and the men were grouped into one of six social classes: I, II, III non-manual, and III manual, IV, and V. Those whose longest occupation was in the Armed Forces formed a separate group.

Body mass index
At Q5 the men were asked to state their weight; body mass index (BMI, weight/height²) was then calculated (kg/m²) for each man based on their reported weight and on measured height at initial screening.

FOLLOW UP
All men, whether or not they had evidence of CHD at initial examination, were followed up for all cause mortality and for cardiovascular morbidity from the initial screening in 1978–80. All deaths occurring in the period up to December 1996 have been recorded and follow up has been achieved for 99% of the cohort. However, this report is concerned only with the men who completed the fifth year questionnaire; thus mortality follow up since the fifth year questionnaire is presented—a mean follow up period of 12.8 years (range 11.5 to 14.0 years). Information on death was collected through the established “tagging” procedures provided by the National Health Service registers in Southport (England and Wales) and Edinburgh (Scotland). Fatal CHD events included all deaths with CHD as the underlying cause (International Classification of Disease, ninth revision, codes 410–414). All death certificates relating to cardiovascular
disease were explored in detail when it appeared that coding to cardiovascular disease was not appropriate or if cardiovascular disease was not the attributed code when it might have been. In such cases, the findings were investigated by correspondence with the certifying doctor and the hospital concerned.

MEN WITH PHYSICIAN DIAGNOSED CHD

This group comprised men with a recall of a physician diagnosis of CHD (heart attack or angina) at Q1 or Q5, and those who had suffered a major non-fatal myocardial infarction event before Q5 based on biennial reviews of each patient’s general practice records, including all hospital reports and correspondence through to the end of the study, supplemented by personal questionnaires at the fifth (Q5) and 12th (Q92) years after screening. Of the 7169 men who had complete data on alcohol history at Q1 and Q5, 655 men had a history of CHD. In this cohort, validation of patient recall of a doctor diagnosis of CHD (angina or heart attack) has been established by comparison of recall with the patient’s records.26 27 This report is primarily concerned with these 655 men from the study.

STATISTICAL METHODS

The Cox proportional hazards model was used to assess the independent contributions of alcohol intake to the risk of mortality and major CHD events and to obtain the relative risks adjusted for age and the other risk factors.28 In the adjustment, age and body mass index were fitted as continuous variables and smoking (five groups), social class (seven groups), and recall of diabetes (yes/no) were fitted as categorical variables. Direct standardisation was used to obtain age adjusted rates per 1000 person years, using the study population as the standard.

Results

During the mean follow up period of 12.8 years from the fifth year questionnaire in the 655 men with history of CHD, there were 294 deaths from all causes (46.1/1000 person years), of which 208 were attributed to cardiovascular causes (32.7/1000 person years) mainly caused by CHD (175 deaths; 27.5/1000 person years).

ALCOHOL AND ALL CAUSE MORTALITY

The 655 men were divided at Q5 into six categories on the basis of their average weekly alcohol intake: lifelong teetotallers (n = 43), ex-drinkers (n = 59), occasional drinkers (n = 199), light drinkers (n = 230), moderate drinkers (n = 104), and heavy drinkers (n = 20). Because of the small number of men in the heavy drinking group these men were combined with the moderate drinkers and five groups were used. There were only 86 deaths from non-cardiovascular causes. Table 1 shows the age adjusted rates and relative risks for CHD, cardiovascular, non-cardiovascular, and all cause mortality, and the relative risks adjusted in addition for lifestyle characteristics—that is, smoking, social class, BMI, and pre-existing disease (diabetes, stroke, and regular medication). Ex-drinkers had by far the highest rates of mortality from CHD, cardiovascular, non-cardiovascular, and all causes even after adjustment for lifestyle characteristics, although this was only significant for all cause mortality, probably because of the relatively small numbers involved. There was little difference in risk of CHD, cardiovascular, non-cardiovascular, and all cause mortality between lifelong teetotallers, occasional drinkers, and light drinkers. Moderate/heavy drinkers showed increased risk of CHD, cardiovascular mortality, and all cause mortality.

Table 1  Mortality from CHD, cardiovascular, non-cardiovascular, and all causes in 655 men with established CHD at Q5

<table>
<thead>
<tr>
<th>Alcohol intake (Q5)</th>
<th>Number of men</th>
<th>Number of cases</th>
<th>Rates*</th>
<th>Relative risk (95% CD)†</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHD mortality (n=175)</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Teetotallers</td>
<td>43</td>
<td>12</td>
<td>27.6</td>
<td>1.04 (0.55 to 1.95)</td>
<td>1.14 (0.60 to 2.18)</td>
<td></td>
</tr>
<tr>
<td>Ex-drinkers</td>
<td>59</td>
<td>21</td>
<td>40.8</td>
<td>1.53 (0.92 to 2.55)</td>
<td>1.47 (0.88 to 2.48)</td>
<td></td>
</tr>
<tr>
<td>Occasionals</td>
<td>199</td>
<td>52</td>
<td>26.6</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Light</td>
<td>230</td>
<td>52</td>
<td>22.5</td>
<td>0.85 (0.58 to 1.24)</td>
<td>0.93 (0.63 to 1.37)</td>
<td></td>
</tr>
<tr>
<td>Moderate-heavy</td>
<td>124</td>
<td>38</td>
<td>33.3</td>
<td>1.25 (0.82 to 1.89)</td>
<td>1.28 (0.83 to 1.96)</td>
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<tr>
<td><strong>CVD mortality (n=208)</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teetotallers</td>
<td>43</td>
<td>13</td>
<td>29.6</td>
<td>0.93 (0.51 to 1.69)</td>
<td>0.98 (0.53 to 1.82)</td>
<td></td>
</tr>
<tr>
<td>Ex-drinkers</td>
<td>59</td>
<td>24</td>
<td>46.5</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Occasionals</td>
<td>199</td>
<td>62</td>
<td>31.8</td>
<td>0.84 (0.59 to 1.20)</td>
<td>0.94 (0.65 to 1.35)</td>
<td></td>
</tr>
<tr>
<td>Light</td>
<td>230</td>
<td>62</td>
<td>26.7</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Moderate-heavy</td>
<td>124</td>
<td>47</td>
<td>41.4</td>
<td>1.31 (0.89 to 1.91)</td>
<td>1.34 (0.91 to 1.98)</td>
<td></td>
</tr>
<tr>
<td><strong>Non-CVD mortality (n=86)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teetotallers</td>
<td>43</td>
<td>5</td>
<td>11.2</td>
<td>0.90 (0.34 to 2.37)</td>
<td>0.94 (0.34 to 2.55)</td>
<td></td>
</tr>
<tr>
<td>Ex-drinkers</td>
<td>59</td>
<td>12</td>
<td>21.9</td>
<td>1.90 (0.97 to 3.94)</td>
<td>1.74 (0.84 to 3.63)</td>
<td></td>
</tr>
<tr>
<td>Occasionals</td>
<td>199</td>
<td>23</td>
<td>11.9</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Light</td>
<td>230</td>
<td>32</td>
<td>13.8</td>
<td>1.14 (0.68 to 1.95)</td>
<td>1.38 (0.79 to 2.42)</td>
<td></td>
</tr>
<tr>
<td>Moderate/ heavy</td>
<td>124</td>
<td>14</td>
<td>12.1</td>
<td>1.07 (0.55 to 2.07)</td>
<td>1.22 (0.62 to 2.41)</td>
<td></td>
</tr>
<tr>
<td><strong>All cause (n=294)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teetotallers</td>
<td>43</td>
<td>18</td>
<td>40.8</td>
<td>0.92 (0.55 to 1.53)</td>
<td>0.96 (0.57 to 1.62)</td>
<td></td>
</tr>
<tr>
<td>Ex-drinkers</td>
<td>59</td>
<td>36</td>
<td>68.4</td>
<td>1.61 (1.09 to 2.38)</td>
<td>1.50 (1.00 to 2.24)</td>
<td></td>
</tr>
<tr>
<td>Occasionals</td>
<td>199</td>
<td>85</td>
<td>43.7</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Light</td>
<td>230</td>
<td>94</td>
<td>40.5</td>
<td>0.93 (0.69 to 1.24)</td>
<td>1.05 (0.78 to 1.42)</td>
<td></td>
</tr>
<tr>
<td>Moderate/ heavy</td>
<td>124</td>
<td>61</td>
<td>53.5</td>
<td>1.24 (0.89 to 1.73)</td>
<td>1.30 (0.93 to 1.83)</td>
<td></td>
</tr>
</tbody>
</table>

*Age adjusted rates/1000 person years.
†Adjusted relative risks, by alcohol intake at Q5: A, age adjusted; B, adjusted for age, smoking, social class, BMI, pre-existing diabetes, stroke, and regular medication.
Table 2  Mortality from all causes, cardiovascular and non-cardiovascular disease in men with previous myocardial infarction (n=450) and men with angina only (n=200) by alcohol intake at Q5

<table>
<thead>
<tr>
<th>Alcohol Intake</th>
<th>Number of men (n=455)</th>
<th>Number of cases</th>
<th>Rates*</th>
<th>Adjusted RR*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teetotallers</td>
<td>33</td>
<td>44</td>
<td>46.4</td>
<td>1.00 (0.55 to 1.82)</td>
</tr>
<tr>
<td>Ex-drinkers</td>
<td>47</td>
<td>31</td>
<td>80.5</td>
<td>1.75 (1.12 to 2.73)</td>
</tr>
<tr>
<td>Occasional drinkers</td>
<td>139</td>
<td>62</td>
<td>45.3</td>
<td>1.00 (0.50 to 1.50)</td>
</tr>
<tr>
<td>Light</td>
<td>153</td>
<td>70</td>
<td>47.2</td>
<td>1.09 (0.77 to 1.56)</td>
</tr>
<tr>
<td>Moderate/heavy</td>
<td>83</td>
<td>45</td>
<td>61.2</td>
<td>1.50 (1.01 to 2.23)</td>
</tr>
</tbody>
</table>

Men with previous MI (n=200)

<table>
<thead>
<tr>
<th>Alcohol Intake</th>
<th>Number of men (n=200)</th>
<th>Number of cases</th>
<th>Rates*</th>
<th>Adjusted RR*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teetotallers</td>
<td>10</td>
<td>4</td>
<td>35.1</td>
<td>0.97 (0.31 to 3.01)</td>
</tr>
<tr>
<td>Ex-drinkers</td>
<td>12</td>
<td>5</td>
<td>42.8</td>
<td>0.94 (0.31 to 2.80)</td>
</tr>
<tr>
<td>Occasional drinkers</td>
<td>60</td>
<td>23</td>
<td>39.4</td>
<td>1.00 (0.50 to 1.50)</td>
</tr>
<tr>
<td>Light</td>
<td>77</td>
<td>24</td>
<td>30.3</td>
<td>1.03 (0.56 to 1.92)</td>
</tr>
<tr>
<td>Moderate/heavy</td>
<td>41</td>
<td>16</td>
<td>38.5</td>
<td>0.96 (0.48 to 1.91)</td>
</tr>
</tbody>
</table>

Of the 655 men with established CHD the majority had a history of myocardial infarction (n = 455). We examined the relation between alcohol intake and all cause mortality and cardiovascular mortality separately in men with myocardial infarction and men with angina only (n = 200). In both groups, there was little difference in outcome between lifelong teetotallers, occasional drinkers, and light drinkers. In men with previous myocardial infarction, ex-drinkers showed a significant increase in risk of all cause mortality and moderate/heavy drinking was associated with a significant increase in cardiovascular mortality (marginal) and all cause mortality compared to occasional drinking (table 2). The number of men in the angina only group was small and no consistent relation was seen with all cause mortality or cardiovascular mortality, but there appeared to be no adverse effect associated with moderate/heavy drinking in men with angina only. There were only 57 deaths from non-cardiovascular causes in the myocardial infarction group but regular drinking (light or moderate/heavy) showed higher risk of non-cardiovascular deaths than occasional or lifelong teetotallers. No such increase in risk was seen for the angina only group (n = 19 deaths).

Table 3   Mortality from CHD, cardiovascular disease (CVD), and all causes in 655 men with established CHD at Q5 by smoking status at Q5

<table>
<thead>
<tr>
<th>Smoking Status</th>
<th>Number of men</th>
<th>Number of cases</th>
<th>Rates*</th>
<th>Adjusted RR*</th>
<th>Number of cases</th>
<th>Rates*</th>
<th>Adjusted RR*</th>
<th>Number of cases</th>
<th>Rates*</th>
<th>Adjusted RR*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Never</td>
<td>91</td>
<td>19</td>
<td>19.0</td>
<td>1.00</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Long term ex-smoker</td>
<td>250</td>
<td>62</td>
<td>23.7</td>
<td>1.18 (0.70 to 2.00)</td>
<td></td>
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<td></td>
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<tr>
<td>Quit last 5 years</td>
<td>122</td>
<td>35</td>
<td>30.4</td>
<td>1.55 (0.87 to 2.74)</td>
<td></td>
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<tr>
<td>Current smoker</td>
<td>192</td>
<td>59</td>
<td>35.9</td>
<td>1.89 (1.11 to 3.22)</td>
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<tr>
<td>CVD mortality</td>
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<tr>
<td>Never</td>
<td>91</td>
<td>21</td>
<td>22.0</td>
<td>1.00</td>
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</tr>
<tr>
<td>Long term ex-smoker</td>
<td>250</td>
<td>73</td>
<td>27.8</td>
<td>1.27 (0.77 to 2.08)</td>
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<tr>
<td>Quit last 5 years</td>
<td>122</td>
<td>39</td>
<td>33.8</td>
<td>1.55 (0.90 to 2.60)</td>
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<tr>
<td>Current smokers</td>
<td>192</td>
<td>75</td>
<td>46.2</td>
<td>2.19 (1.33 to 3.60)</td>
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<tr>
<td>All cause mortality</td>
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<td></td>
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<tr>
<td>Never</td>
<td>91</td>
<td>31</td>
<td>32.8</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Long term ex-smoker</td>
<td>250</td>
<td>93</td>
<td>35.2</td>
<td>1.08 (0.72 to 1.64)</td>
<td></td>
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</tr>
<tr>
<td>Quit last 5 years</td>
<td>122</td>
<td>63</td>
<td>54.5</td>
<td>1.67 (1.08 to 2.60)</td>
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<td></td>
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<tr>
<td>Current smoker</td>
<td>192</td>
<td>107</td>
<td>65.5</td>
<td>2.04 (1.35 to 3.09)</td>
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</tbody>
</table>

*Age adjusted rates/1000 person years.
†Relative risk (95% CI) adjusted for age, smoking, social class, BMI, pre-existing diabetes, stroke, and regular medication.

Discussion

While there is some evidence from clinical studies to suggest that heavy drinking is harmful in subjects with coronary artery disease,17
the effect of light to moderate drinking in such 
subjects has not been clearly established. The 
clinical studies suggest that alcohol may aggra-
vate angina and that even low to moderate 
doses may impair left ventricular performance 
in patients with recent or old myocardial 
infarction. In our study involving middle 
aged and older men with established CHD, 
light alcohol intake (1–15 units per week) was 
not associated with any significant effect, 
deterritorious or beneficial, compared to occa-
sional drinkers (< 1 unit per week) or lifelong 
eteetotallers. There is an indication that higher 
levels (> 3 drinks per day) may be harmful in 
those men with a history of previous myocar-
dial infarction, which supports the findings of 
the clinical studies. This adverse effect at 
higher levels was seen even if heavy drinkers 
(> 6 drinks per day on a daily basis; > 42 units 
per week) were excluded. Some of those classi-
fied as light drinkers at Q5 might have been 
heavier drinkers in the past. This might have 
increased the risk of mortality in those 
classified as light drinkers. However, the 
confirmation in this study of the benefits of 
light to moderate drinking on CHD mortality 
in men with no diagnosis of CHD supports the 
validity of the findings in men with the diagno-
sis of CHD.

The effects of alcohol on subsequent risk of 
CHD has seldom been assessed in men with 
established CHD. Several prospective studies 
into alcohol related outcomes have examined 
the effects of alcohol in men with and without 
pre-existing disease (variously defined) and in 
most of these a U shaped or inverse relation has 
been observed between alcohol intake and 
outcome. In the recent US cancer prevention 
II study involving 490 000 men and 
women, using non-drinkers as the baseline, 
regular drinking was associated with a greater 
reduction in CHD mortality in those with 
cardiovascular related conditions, which in-
cluded CHD, stroke, diabetes, and hypertension. 
These high risk subjects consti-
tuted one third of all subjects and contributed 
three quarters of all cardiovascular deaths. The 
reduction in risk was seen in those drinking less 
than daily but at least three times a week and 
was similar at all levels of alcohol intake—that 
is, there was no dose–response effect. It was 
suggested that alcohol may confer greater ben-
efit on those at high risk of cardiovascular dis-
ease. This study did not examine specifically 
the outcome in men with established CHD 
(definite myocardial infarction or angina), who 
are at much higher risk of death than men with 
hypertension or diabetes. In our study, when 
we examined the effect of alcohol on CHD 
mortality in men with and without cardiovas-
cular related conditions using similar criteria, 
the same pattern emerged in that the reduction 
in CHD mortality was greater in those with 
cardiovascular related conditions than in those 
without. However, when our analysis is 
restricted to men with established CHD no ben-
efit is evident.

In contrast to our study, the recent US physi-
cians health study showed that “men with a 
history of myocardial infarction with light to 
moderate intake of alcohol have a slight but 
clinically important decrease in total mortality 
compared with those who never or rarely drink 
alcohol”. In that baseline group of never/ 
rarely drinkers at the time of inquiry no 
distinction was made between lifelong teetot-
allers and ex-drinkers. In men aged 40–84 years 
usually drinking 2–6 drinks per week, total 
mortality was decreased by 28%, cardiovas-
cular mortality by 24%, and non-
cardiovascular mortality by 39% after adjust-
ment for age, smoking, diabetes, physical 
activity, and BMI. The subjects were elderly 
(69% were over 65 years old) and no account 
was taken of ill health or medication which 
might have led to reduction in alcohol intake 
other than for recall of hypercholesterolaemia 
or hypertension. The average intake in these 
high social class subjects was low and there 
were very few heavy drinkers in whom to 
examine the effects of heavier drinking (> 3 
drinks per day) on mortality.

Critical to the comparison of the present 
study with previous studies is the issue of 
the baseline group used. In the physician health 
study, current non-drinkers constitute the 
baseline and we have shown that this mixed 
group of lifelong teetotallers and ex-drinkers is 
not appropriate for the evaluation of the effects 
of alcohol on cardiovascular or all cause 
mortality. There is little doubt that 
ex-drinkers have characteristics which greatly 
increase their mortality risk and they almost 
avways have the highest mortality rates of any of 
the alcohol categories. Combining ex-drinkers 
and lifelong teetotallers, groups which vary in 
their proportions in different populations, can 
only lead to a base group with characteristics 
which cannot be adequately taken into account 
by adjustment procedures and which increase 
the risk of mortality.

In our present study, ex-drinkers had the 
highest risk of cardiovascular and all cause 
mortality compared to other groups, while life-
long teetotallers had a similar risk to occasional 
drinkers. Although light drinkers showed the 
lowest risk, the difference was very small com-
pared to occasional drinkers. If the physician 
health study had used occasional drinkers (1–4 
drinks per month) as their baseline comparison 
group, the reduction in total mortality in men 
with a previous myocardial infarction on 2–6 
drinks per week would be 15%, for cardiovas-
cular mortality the reduction would be 18%, 
and for non-cardiovascular mortality it would 
be 5%, none of which would be significantly 
different from baseline. If we had restricted the 
analyses to men with definite myocardial 
infarction and used all non-drinkers (lifelong 
eteetotallers and ex-drinkers combined) as the 
comparison group, our results would be similar 
to those of the physicians health study, with 
both occasional drinkers (1–2 per month) and 
light drinkers showing lower mortality rates 
than non-drinkers. Our data suggest that the 
magnitude of benefit associated with light 
drinking (2–6 drinks per week) in the physi-
cians health study has been exaggerated by the 
use of an inappropriate comparison group.
In our study, moderate/heavy drinking in men with a history of previous myocardial infarction is associated with a marginally significant increase in risk of cardiovascular death and a significant increase in all-cause mortality. In the men with angina only and no history of myocardial infarction, albeit a very small group, there appears to be no adverse effect from moderate/heavy drinking. These findings may reflect the direct effect of alcohol on the damaged heart muscle of those with definite myocardial infarction, and may justify the comment that “in patients with pre-existing cardiovascular disease the use of alcohol is contraindicated, particularly where ventricular function is impaired”. Our data suggest that light drinking may not be contraindicated but that moderate/heavy drinking may increase risk. In our moderate/heavy group, 84% were moderate drinkers with an intake of 16–42 UK units per week.

By contrast with the effects of alcohol, smoking cessation in men with established CHD was associated with a reduction in death from CHD, cardiovascular disease, and all causes, and for cardiovascular mortality the reduction was significant. Those who continued to smoke showed over a twofold increase in risk compared with those who had never smoked. Long term ex-smokers (who had given up for more than five years before the start of the follow up period) showed risk levels comparable to those of never smokers. Using the relative risks calculated in the cancer prevention II study, the authors have estimated the probability of death from any cause in the general US population aged 35–69 years. In both men and women, in drinkers and non-drinkers, smoking doubled the risk of death compared with non-smoking. The risk of death was slightly less in drinkers than non-drinkers; about 16% less in non-smokers and 6% less in smokers. They conclude that “the benefits of moderate alcohol consumption (1–2 drinks per day) are much smaller than the hazards of tobacco use”.15

Conclusion
When an appropriate baseline group—that is, occasional drinkers—is used, regular light alcohol consumption (1–14 UK units per week) in men with established CHD is not associated with any significant benefit or deleterious effect for CHD, cardiovascular mortality, or all-cause mortality. Higher levels of intake (≥ 3 drinks per day) are associated with increased mortality in men with previous myocardial infarction. By contrast, giving up smoking in men with established CHD halves the risk of mortality. Given the high absolute rate of death in men with established CHD, the absolute benefit of giving up smoking in men surviving a myocardial infarction is substantial. Time would be better spent assisting such men to stop smoking than trying to encourage the lifelong teetotallers or ex-drinkers among them to drink.

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