The sensitivity analysis that included individuals with diabetes mellitus as secondary prevention did not alter the patterns seen in Figure, A, but there was a decrease in primary prevention use to 30.3% (95% CI, 26.4%-34.4%) in 2011 to 2012.

Discussion | One-third of community-dwelling very elderly individuals without vascular disease reported a statin prescription despite a lack of randomized clinical trials to support their use.1,2 Despite a lack of clear recommendation for statin use in the primary prevention of the very elderly within the Adult Treatment Panel III guideline,3 there was a large increase in use that coincided with its release. The primary limitation of our study is the change in the classification of vascular disease, which likely increased the sensitivity and decreased the specificity of vascular disease. Hence, the classification of primary prevention likely became more conservative. Although the medical community has embraced the use of statins for primary prevention in the very elderly, caution should be exercised given the potential dangers of expanding marginally effective treatments to untested populations.

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Figure 1. Incidence of Kidney Transplantation in Black and White Recipients Between 1998 and 2011

The incidence was adjusted for age, sex, end-stage renal disease (ESRD) cause, and geographic region.

Figure 2. Incidence by Donor Status of Kidney Transplantation in Black and White Recipients Between 1998 and 2011

The incidence was adjusted for age, sex, end-stage renal disease (ESRD) cause, and geographic region.

Discussion | In 2003, UNOS changed the allocation policy for kidneys from deceased donors by eliminating priority points for HLA-B matching. Because HLA shows clustering within race, and whites represent the majority demographic, most deceased donors are white; thus, kidneys from deceased donors are more likely to have favorable HLA matches with white patients. This policy change has been associated with an attenuation of the racial disparity in deceased donor kidney transplantation from 38% in the 2000-2003 period to 19% from 2006 to 2009. We found that by 2010, the overall rate of kidney transplantation was the same for blacks and whites; this change was driven wholly by increased rates of transplants from deceased donors.

Kidney transplants from living donors are associated with better outcomes than transplants from deceased donors. The persistence of lower rates of living donors among blacks limits access to the best possible transplant outcomes. Lower donation rates have been attributed to differences in socioeconomic status, personal attitudes toward transplantation, fear of surgery, and health literacy. The higher prevalence of comorbid conditions among potential black donors, such as hypertension and diabetes, may also preclude organ donation. Approaches to increasing living donor kidney transplantation rates include outreach and educational programs, better patient-physician communication, and counseling of black patients with ESRD and their families. Such measures, if effective, hold potential for expanding the overall donor pool, thus improving care for all patients with ESRD.

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The Link Between Sauna Bathing and Mortality May Be Noncausal

To the Editor Laukkanen et al found a striking inverse relationship between saunas (mean temperature, 79°C [174°F]) and fatal cardiovascular disease in Finnish men. The hazard of sudden cardiac death was more than 60% lower among men who reported 4 to 7 sauna sessions per week compared with those who reported only 1 session. For deaths from coronary heart disease, cardiovascular disease, and all causes, the corresponding hazard ratios were 40% to 50% lower. If these observed associations are causal, the risk reduction associated with frequent sauna visits would be comparable to or greater than that for traditional prevention strategies, such as lipid-lowering and antihypertensive therapy (risk reduction, 20%-50%).

We would like to highlight 2 noncausal mechanisms potentially contributing to the finding by Laukkanen et al: confounding and reverse causation bias. First, there is an extraordinarily pervasive association between socioeconomic circumstances and health, with greater affluence linked to lower risk. Men who reported 4 to 7 sauna sessions a week probably own a sauna and had the time and resources (ie, wood or electricity) to heat it frequently, which is possibly not the case for men who reported 1 sauna session a week. Adjustment for a composite socioeconomic status variable measured once at baseline might be insufficient to eliminate confounding by this socioeconomic difference.

Second, the authors note heart rate increases up to 100 beats/min during sauna sessions at moderate temperatures and up to 150 beats/min during hotter saunas. Although not an issue for healthy individuals, such a cardiac challenge may feel uncomfortable for participants with poor cardiopulmonary fitness and pre-existing disease. Simple adjustment for disease vs no disease may not entirely solve this problem since reverse causation bias (ie, health status affects the likelihood of a sauna session) operates within disease groups; the more severe the disease, the greater the fear of cardiac challenge. Consistent with this reasoning, the association between saunas and sudden cardiac death was seen in individuals with diabetes (hazard ratio [HR], 0.27; 95% CI, 0.10-0.68; P < .05) but not those without (HR, 0.90; 95% CI, 0.73-1.10; P > .05), among hypertensive (HR, 0.66; 95% CI, 0.45-0.96; P < .05) but not normotensive individuals (HR, 0.96; 95% CI, 0.75-1.23; P > .05), among patients with cardiovascular disease (HR, 0.72; 95% CI, 0.53-0.96; P < .05) but not their healthy counterparts (HR, 1.01; 95% CI, 0.76-1.33; P > .05) (eFigure 1 in the study by Laukkanen et al2). A more robust finding at reduced risk of reverse causation bias would be a graded association between number of sauna sessions and mortality in an initially healthy, cardiopulmonary fit population, but this was not observed. We urge caution against the interpretation that saunas are a major cardiovascular prophylactic.

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The Link Between Sauna Bathing and Mortality May Be Noncausal

To the Editor In their recent report, Laukkanen et al summarize a 25-year longitudinal study, indicating that regular sauna bathing (4-7 times per week) is associated with a reduced risk of cardiovascular diseases and all-cause mortality. We would like to suggest that regular sauna bathing is an indicator for a healthy lifestyle. Adopting habits of frequent physical activity, avoiding rich food high in saturated fat, and allowing for more relaxation and leisure time have been proven to be the best measures against many diseases and are also associated with improved health and longevity. Laukkanen et al do not provide data to explain this observation, but other studies suggest that regular sauna bathing lowers blood pressure, improves endothelial function, increases left ventricular ejec-