

Lincoln Logged Incorrectly

To the Editor: The photograph accompanying the book review by Dr Smitherman¹ is captioned as showing Abraham Lincoln at Bull Run. However, I believe that the photograph does not show Lincoln.

Not only does the man not look like Lincoln (head too big, neck too short, arms too short, stance atypical²), but there is no record that Lincoln ever visited the Bull Run battlefield.³ Furthermore, the photograph does not appear in the standard catalog of Lincoln photographs.⁴ Even the source of the photograph questions whether the subject is Lincoln.⁵

Possibly the man is Brigadier General Montgomery Meigs, who is known to have visited the battlefield³ and who has been mistaken for Lincoln by photograph historians in the past.^{4(p287)}

John G. Sotos, MD
jama2009@physical-lincoln.com
Palo Alto, California

Financial Disclosures: Dr Sotos reported receiving royalties on books about Abraham Lincoln.

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3. The Lincoln Log: a daily chronology of the life of Abraham Lincoln [entry for July 22, 1861]. <http://thelincolnlog.org/>. Accessed February 12, 2009.
4. Ostendorf L. *Lincoln's Photographs: A Complete Album*. Dayton, OH: Rockywood Press; 1998.
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In Reply: Among the holdings of the National Library of Medicine (NLM) History of Medicine division is an elaborate photograph album dating from the American Civil War. Its gilt-edged cardboard pages contain 136 photographs produced by the studios of Mathew Brady and Alexander Gardner portraying the various aspects of the United States' bloodiest conflict. The album was a gift to Miss Anna Lowell in 1864 from the attendants at Armory Square Hospital, a long-vanished Washington, DC, institution.

The prints are small; they would currently be called wallet-sized. Each fits into a precut window on the page. The back lists a caption, the studio name (Brady or Gardner), and a series number. Brady's album gallery No. 321 bears the caption "Soldiers' Graves at Bull Run" and shows a bearded man with a frock coat and tall hat looking over the fresh graves. The first Battle of Bull Run (first Manassas in the South) was fought on July 21, 1861. After this battle, both sides realized that the confrontation between Union and Confederacy would not be ended by a single battle.

I agree with Dr Sotos. While initially the figure appears to be Abraham Lincoln, closer examination reveals it is not. The tall hat is not the customary stovepipe; it has a peaked brim and the crown has a slight mushroom shape. It looks like a military shako. Moreover, the bearded man is not wearing a suit. The trousers do not match the frock coat, and they are rolled, rather like a workman might roll dungarees.

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If this is not Lincoln, who is it? Sotos suggests Montgomery Meigs, Quartermaster General of the Union Army. But the bearded man is not wearing a military uniform, as might be expected of Meigs. Moreover, photographs of Meigs at this time show much more gray hair than the man in the picture.

While the bearded man is not Lincoln, he is certainly meant to evoke Lincoln, gazing sadly over the graves. Brady's pictures are highly sentimental, and there are many in which Brady himself appears, bearing witness. By 1862, Brady rarely took pictures himself. He spent most of the war in Washington, managing his force of working photographers. Brady disliked the harsher pictures of bodies taken by his employee and later competitor Alexander Gardner. The familiar pictures of bodies at Antietam and Gettysburg are Gardner's work, not Brady's. Gardner was busy at Gettysburg as soon as the shooting stopped. Brady's team did not arrive for several days, and there is a picture of Brady surveying the battlefield.^{1,2}

I would suggest that NLM's catalog identification of the figure in the picture, with its accompanying question mark, reflects an inference that the Brady studio had carefully embedded to appeal to the sentimentality and patriotism of an audience as Brady perceived it.

Stephen J. Greenberg, MSLS, PhD
greenbes@mail.nlm.nih.gov
History of Medicine Division
National Library of Medicine
Bethesda, Maryland

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2. Panzer M. *Mathew Brady*. London, England: Phaidon Press; 2001.

RESEARCH LETTER

Association of Cardiovascular Risk Factors With Mental Health Diagnoses in Iraq and Afghanistan War Veterans Using VA Health Care

To the Editor: Studies of veterans from prior wars have found that those with posttraumatic stress disorder (PTSD) are at significantly increased risk of developing and dying from cardiovascular disease.¹⁻³ To our knowledge, cardiovascular disease risk has not been evaluated in veterans from the current conflicts in Iraq and Afghanistan. We examined the association of PTSD and other mental disorders with cardiovascular risk factors using national data from veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) who sought care at Department of Veterans Affairs (VA) facilities.

Methods. The data source was the VA OEF/OIF Roster, containing demographic and military service information on the 41% of eligible OEF/OIF veterans who have ac-

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Table 1. Prevalence and Adjusted Odds of Cardiovascular Disease Risk Factors in 267 311 Male OEF/OIF Veterans by Mental Health Status^a

	Mental Health Diagnoses		
	None (n = 160 517)	Mental Health Diagnoses Excluding PTSD (n = 41 191) ^b	PTSD With or Without Other Mental Health Diagnoses (n = 65 603) ^b
Cardiovascular risk factors			
Tobacco use			
Prevalence, %	9.8	26.1	30.8
Model 1 OR (95% CI) ^c	1 [Reference]	3.04 (2.96-3.13)	3.63 (3.54-3.71)
Model 2 OR (95% CI) ^d	1 [Reference]	2.28 (2.19-2.38)	2.61 (2.52-2.71)
Hypertension			
Prevalence, %	8.1	15.6	16.4
Model 1 OR (95% CI) ^c	1 [Reference]	2.42 (2.33-2.50)	2.88 (2.79-2.97)
Model 2 OR (95% CI) ^d	1 [Reference]	1.57 (1.50-1.64)	1.56 (1.50-1.63)
Dyslipidemia			
Prevalence, %	10.9	20.3	21.0
Model 1 OR (95% CI) ^c	1 [Reference]	2.33 (2.26-2.40)	2.70 (2.63-2.78)
Model 2 OR (95% CI) ^d	1 [Reference]	1.46 (1.40-1.53)	1.45 (1.39-1.50)
Obesity			
Prevalence, %	5.9	11.4	12.5
Model 1 OR (95% CI) ^c	1 [Reference]	2.05 (1.97-2.12)	2.35 (2.27-2.43)
Model 2 OR (95% CI) ^d	1 [Reference]	1.45 (1.37-1.52)	1.48 (1.42-1.55)
Diabetes			
Prevalence, %	1.1	2.4	2.0
Model 1 OR (95% CI) ^c	1 [Reference]	2.58 (2.37-2.80)	2.57 (2.37-2.78)
Model 2 OR (95% CI) ^d	1 [Reference]	1.39 (1.27-1.53)	1.07 (0.98-1.18)
Medical visits, mean (SD), No.			
Primary care visits	1.7 (2.6)	3.8 (4.3)	4.6 (4.8)
Medical subspecialty visits	2.8 (3.6)	4.3 (6.1)	4.7 (6.0)

Abbreviations: CI, confidence interval; ICD-9, *International Classification of Diseases, Ninth Revision*; OEF/OIF, Operation Enduring Freedom/Operation Iraqi Freedom; OR, odds ratio; PTSD, posttraumatic stress disorder.

^aMental health diagnoses included ICD-9 codes 290.00 through 319.00 except 305.1 (tobacco use disorder). PTSD is ICD-9 code 309.81. The most common diagnoses in the non-PTSD group included depression, 40% (ICD-9 codes 296.20-296.25, 296.30-296.35, 300.4, and 311); adjustment disorders, 35% (ICD-9 codes 309.0 to 309.9, excluding 309.81); anxiety, 28% (ICD-9 codes 300.00-300.09, 300.20-300.29, and 300.3); alcohol use disorder, 20% (ICD-9 codes 305.00-305.03 and 303); and substance use disorder, 7% (ICD-9 codes 305.20-305.93 and 304).

^bAll comparisons in models 1 and 2 to reference group of no mental health diagnoses were significant at $P < .001$ (except in model 2) except $P = .14$ for diabetes in PTSD with or without other mental health diagnoses.

^cModel 1 was adjusted for age, race (defined by self-report as white, black, Hispanic, or other), component type, rank, branch, and multiple deployments.

^dModel 2 included all covariates in model 1 plus number of primary care visits and number of medical subspecialty visits.

cessed VA health care. The study population consisted of 303 223 veterans who were new users of VA health care from October 7, 2001 (the start of OEF), to September 30, 2008. Data were linked to inpatient and outpatient VA electronic health care records. Codes from the *International Classification of Diseases, Ninth Revision (ICD-9)* were used to categorize veterans into those with (1) no mental health diagnoses, (2) mental health diagnoses excluding PTSD, and (3) PTSD with or without comorbid mental health diagnoses. Outcomes were ICD-9 codes for cardiovascular risk factors, including tobacco use, hypertension, hyperlipidemia, obesity, and diabetes mellitus.

We used sex-stratified, multivariable logistic regression models to examine the association between mental health diagnoses and cardiovascular risk factors (using a separate model for each cardiovascular risk factor), adjusted for age, race, military component (active duty vs National Guard/Reserve), rank, branch, and whether a veteran had multiple deployments. Race was included because of racial variation in mental health diagnoses and cardiac risk factor prevalence and was categorized by patient self-report. Veterans with mental disorders have higher use of medical ser-

vices (such as primary care), which could lead to ascertainment bias if these veterans had more frequent assessment of cardiovascular risk factors.⁴⁻⁶ Therefore, we conducted a sensitivity analysis with additional adjustment for each veteran's number of primary care and medical subspecialty visits.

All tests were 2-tailed with $\alpha = .05$ and performed using SAS version 9.1 (SAS Institute Inc, Cary, North Carolina). Estimated study power was 80% to detect odds ratios of 1.1 to 1.4 in men (depending on the cardiac risk factor) and 1.4 to 1.6 (except 3.0 for diabetes) in women. The use of deidentified administrative data met criteria for exemption from consent; the study was approved by the institutional review boards of the San Francisco VA and the University of California, San Francisco.

Results. The mean (SD) age of the study population was 31 (9) years and 88% were men. The most common mental health diagnosis was PTSD (24% prevalence). The majority of patients with PTSD had comorbid mental health diagnoses, including depression (53%), anxiety disorder (29%), adjustment disorder (26%), alcohol use disorder (22%), substance use disorder (10%), and other psychiatric diagnoses (33%).

Table 2. Prevalence and Adjusted Odds of Cardiovascular Disease Risk Factors in 35 912 Female OEF/OIF Veterans by Mental Health Status^a

	Mental Health Diagnoses		
	None (n = 21 634)	Mental Health Diagnoses Excluding PTSD (n = 7314) ^b	PTSD With or Without Other Mental Health Diagnoses (n = 6964) ^b
Cardiovascular risk factors			
Tobacco use			
Prevalence, %	7.0	19.2	21.7
Model 1 OR (95% CI) ^c	1 [Reference]	2.97 (2.74-3.22)	3.58 (3.30-3.88)
Model 2 OR (95% CI) ^d	1 [Reference]	2.17 (1.95-2.40)	2.29 (2.06-2.54)
Hypertension			
Prevalence, %	4.3	8.1	10.4
Model 1 OR (95% CI) ^c	1 [Reference]	2.31 (2.06-2.59)	2.99 (2.67-3.33)
Model 2 OR (95% CI) ^d	1 [Reference]	1.48 (1.28-1.70)	1.59 (1.38-1.82)
Dyslipidemia			
Prevalence, %	5.9	11.2	13.9
Model 1 OR (95% CI) ^c	1 [Reference]	2.12 (1.92-2.33)	2.68 (2.44-2.95)
Model 2 OR (95% CI) ^d	1 [Reference]	1.26 (1.22-1.42)	1.37 (1.22-1.54)
Obesity			
Prevalence, %	6.5	15.1	16.9
Model 1 OR (95% CI) ^c	1 [Reference]	2.59 (2.37-2.82)	3.01 (2.76-3.28)
Model 2 OR (95% CI) ^d	1 [Reference]	1.72 (1.55-1.91)	1.69 (1.52-1.89)
Diabetes			
Prevalence, %	0.7	1.3	1.7
Model 1 OR (95% CI) ^c	1 [Reference]	2.17 (1.66-2.83)	2.86 (2.21-3.71)
Model 2 OR (95% CI) ^d	1 [Reference]	1.23 (0.91-1.66)	1.43 (1.07-1.92)
Medical visits, mean (SD), No.			
Primary care visits	2.6 (3.9)	6.0 (6.1)	7.5 (7.3)
Medical subspecialty visits	3.4 (4.1)	5.2 (6.9)	6.5 (8.6)

Abbreviations: CI, confidence interval; ICD-9, *International Classification of Diseases, Ninth Revision*; OEF/OIF, Operation Enduring Freedom/Operation Iraqi Freedom; OR, odds ratio; PTSD, posttraumatic stress disorder.

^aICD-9 codes for mental health diagnoses are listed in Table 1. The most common diagnoses in the non-PTSD group included depression, 61%; anxiety, 34%; adjustment disorders, 33%; alcohol use disorder, 7%; and substance use disorder, 3%.

^bAll comparisons in models 1 and 2 to reference group of no mental health diagnoses were significant at $P < .001$ (except in model 2) except $P = .18$ for diabetes in mental health diagnoses excluding PTSD and $P = .02$ for diabetes in PTSD with or without other mental health diagnoses.

^cModel 1 was adjusted for age, race (defined by self-report as white, black, Hispanic, or other), component type, rank, branch, and multiple deployments.

^dModel 2 included all covariates in model 1 plus number of primary care visits and number of medical subspecialty visits.

Veterans with mental health diagnoses had a significantly higher prevalence of all cardiovascular risk factors (TABLE 1 and TABLE 2). Adjustment for demographic and military factors changed these associations minimally. Further adjustment for primary care and subspecialty visits reduced effect sizes, but associations between mental health diagnoses and cardiovascular risk factors remained significant except for some associations with diabetes.

Comment. After adjustment for several potential confounding factors, male and female OEF/OIF veterans with mental health diagnoses had significantly greater rates of tobacco use, hypertension, hyperlipidemia, and obesity than those without mental health diagnoses. Study limitations include potential lack of generalizability to non-VA enrolled veterans; possible misclassification, underdiagnosis, or overdiagnosis of mental disorders or cardiovascular risk factors due to reliance on ICD-9 codes; and inability to determine causality due to the cross-sectional design. Despite these limitations, this study highlights the need for prospective studies to further investigate the association of specific mental health

disorders with cardiovascular risk factors and the possible development of cardiovascular disease as these younger veterans age.

Beth E. Cohen, MD, MAS

beth.cohen@va.gov

Department of Medicine

Charles Marmar, MD

Department of Psychiatry

Li Ren, MS

Department of Medicine

Daniel Bertenthal, MPH

Health Services Research Enhancement Award Program

Karen H. Seal, MD, MPH

Department of Medicine

San Francisco Department of Veterans Affairs Medical Center

San Francisco, California

Author Contributions: Dr Seal had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Cohen, Bertenthal, Seal.

Acquisition of data: Bertenthal, Seal.

Analysis and interpretation of data: Cohen, Marmar, Ren, Bertenthal, Seal.

Drafting of the manuscript: Cohen.

Critical revision of the manuscript for important intellectual content: Cohen, Marmar, Ren, Bertenthal, Seal.

Statistical analysis: Ren.

Obtaining funding: Cohen, Seal.

Administrative, technical, or material support: Seal.

Study supervision: Marmar, Bertenthal, Seal.

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CORRECTION

Incorrect Wording: In the Review article titled "Interaction Between the Serotonin Transporter Gene (*5-HTTLPR*), Stressful Life Events, and Risk of Depression: A Meta-analysis" by Risch et al, published in the June 17, 2009, issue of *JAMA* (2009; 301[23]:2462-2471), incorrect wording occurred. The third sentence of the "Analytic Methods" subsection on page 2464 should have read, "Second, we investigated the associations between stressful life events alone (entered as an ordinal variable) and the number of *S* alleles alone on depression as the response variable." On page 2468, the last sentence of the first full paragraph of the first column should have read, "However, the meta-analysis yielded no significant differences in the β coefficients between those with and without depression across studies (β , -0.001; SE, 0.047) and sexes, indicating a lack of gene environment interaction." And the second sentence in the second paragraph in the middle column of page 2469 should have read, "The most likely explanation for an interaction without a main effect would require a reversal in the direction of the life events-by-genotype association, with the risk of depression increasing with the number of *S* alleles in the presence of stressful life events and decreasing with the number *S* alleles in the absence of life events. Our analysis showed there was no such decrease."

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The International Committee of Medical Journal Editors (ICMJJE) is seeking two new member journals to be represented by their editors in chief. Information about the ICMJJE is available at www.icmjje.org. The ICMJJE anticipates selection of new members by November 1, 2009. Candidate journals should meet the following criteria:

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