



September 18, 2026

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Dear Dr. Prezant:

Thank you for your electronic mail message of July 31, 2026, entitled "Petition to Reconsider Ischemic Cardiovascular as a World Trade Center (WTC) Health Program Covered Condition" ("July 31st email"). Your email is subdivided into six sections containing observations, conclusions, and requests. This response is concentrated on the most pertinent aspects of your email.

Request for Petition to be Reopened and Reviewed by the Scientific/Technical Advisory Committee

The WTC Health Program (Program) Administrator established by regulation and policy a procedure for handling submissions and evaluating petitions for the addition of health conditions to the List of WTC-Related Health Conditions (List). When a submission is received, such as the September 3, 2023, submission from the Clinical Centers of Excellence (CCEs) for cardiovascular disease (CVD) (i.e., **Petition 047**), the Program first determines if the submission meets all requirements for a valid petition in the Program's regulations at 42 C.F.R. § 88.16(a).¹ The Program has developed a policy and procedure which further explains this process.²

If a submission is determined to be a valid petition it is then evaluated according to the applicable policy and procedure, either the *Policy and Procedures for Adding Non-Cancer*

¹ See <https://www.cdc.gov/wtc/regulations2.html>.

² See "Policy and Procedures for Handling Submissions and Petitions to Add a Health Condition to the List of WTC-Related Health Conditions" at https://www.cdc.gov/wtc/pdfs/policies/PNP_SubmissionsPetitions%2020260122-508.pdf.

*Health Conditions to the List of WTC-Related Health Conditions*³ or the *Policy and Procedures for Adding Types of Cancer to the List of WTC-Related Health Conditions*.⁴ As permitted by the Zadroga Act and Program regulations, the Administrator may choose to either (1) request a recommendation regarding a petition from the WTC Health Program's Scientific/Technical Advisory Committee (STAC) or (2) publish a determination in the Federal Register without seeking STAC input.⁵

Neither the Zadroga Act nor Program regulations specifically allow for reopening of a petition that has been evaluated with a final decision published in the Federal Register. The Administrator may, however, reopen any final decision made by the Program at the Administrator's discretion pursuant to 42 C.F.R. § 88.25.⁶ The Administrator may also initiate, at his own discretion, a proposed rule to add a health condition to the List, either by publishing such a rule or requesting a recommendation from the STAC.⁷

Where a condition that was previously reviewed by the Administrator and found not to qualify for addition to the List is the subject of a new petition, the submission will only be considered a valid new petition if it presents a new medical basis (i.e., a basis not previously reviewed) for the association between the September 11, 2001, terrorist attacks and the health condition requested to be added.⁸ Absent new medical basis, existing statutory provisions, regulations, and Program policies neither mandate nor provide a mechanism for the Administrator to refer a published final non-coverage determination to the STAC for re-evaluation.

Petition Request Addresses Ischemic Cardiovascular Disease

A valid petition must include the name of a specific health condition, or a description sufficient in detail for the WTC Health Program to identify the name of the health condition being requested.⁹

Program policy specifically states that submissions requesting a "broad category or grouping of health conditions be added to the List, e.g., cardiovascular system diseases, autoimmune system diseases, endocrine system diseases, or other body system disease grouping, will not satisfy this petition requirement."¹⁰ However, if a submission requesting a broad category or grouping of health conditions provides a valid medical basis for one or

³ See "Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions" at

https://www.cdc.gov/wtc/pdfs/policies/WTCHP_PP_Adding_NonCancer_Health_Conditions_20260514.pdf.

⁴ See "Policy and Procedures for Adding Types of Cancer to the List of WTC-Related Health Conditions" at https://www.cdc.gov/wtc/pdfs/policies/WTCHP_PP_Addn_Cancer_11182021-508.pdf.

⁵ See 42 U.S.C. § 300mm-22(a)(6)(B).

⁶ See <https://www.cdc.gov/wtc/regulations.html>.

⁷ See 42 U.S.C. § 300mm-22(a)(6)(A).

⁸ See 42 C.F.R. § 88.16(a)(5).

⁹ See 42 C.F.R. § 88.16(a)(1)(iii); *supra*, note 2, Sec. VI.C.1.

¹⁰ See *supra*, note 2, Section VI.C.3.a.

more of the health conditions included within the broad category or grouping of health conditions, the submission will be considered to meet the medical basis requirement for those specific health conditions.¹¹

The Administrator has the discretion to review the name of the health condition in conjunction with relevant medical sources, including the information provided as the medical basis in the submission, to determine the health condition requested and may limit the scope of the requested health condition to align with the health condition described in the medical basis in the submission.¹² When a single petition requests the addition of more than one health condition to the List, and the petition provides sufficient medical basis for each requested health condition, Program policy permits the Administrator to separately evaluate each requested health condition.¹³

As explained in the evaluation for ischemic heart disease (IHD), the Administrator exercised his discretion to separate the scientific evaluation of the eight health conditions provided in **Petition 047** into three separate evaluations: (1) "myocardial infraction (*sic*), unstable angina, obstructive coronary artery disease, ischemic cardiomyopathy, ischemic congestive heart failure, arrhythmias (due to any of the above);" (2) "stroke," which became Petition 048; and (3) "peripheral vascular disease," which became Petition 048a.¹⁴ To ensure a comprehensive scientific evaluation of each of the specific health conditions requested in **Petition 047**, the Administrator directed the Science Team to review the scientific evidence for the requested health conditions in three separate evaluations pertaining to conditions: (1) affecting oxygen supply to the heart (i.e., ischemia);¹⁵ (2) affecting blood supply to the brain (i.e., ischemic and hemorrhagic stroke);¹⁶ and (3) affecting the peripheral artery system.¹⁷

The Administrator determined that although those portions of Petition 047 regarding "myocardial infraction (*sic*), unstable angina, obstructive coronary artery disease, ischemic cardiomyopathy, ischemic congestive heart failure, arrhythmias (due to any of the above);" and the other seven petitions requesting the addition of a type or types of cardiovascular

¹¹ *Id.* at Sec. VI.C.3.c.

¹² *Id.* at Sec. VI.C.2.

¹³ *Id.* at Sec. VII.C.2.

¹⁴ See "Evaluation of Scientific Evidence Supporting the Addition of Ischemic Heart Disease to the List of WTC-Related Health Conditions," Sec. 2, page 6, <https://www.cdc.gov/niosh/docket/archive/pdfs/niosh-094/2026-white-paper-eval-evidence-supporting-ischemic-v7rw-0622.pdf>.

¹⁵ See Federal Register, Vol. 91, No. 124, Tuesday, June 30, 2026, 39616-39624, <https://www.govinfo.gov/content/pkg/FR-2026-06-30/pdf/2026-13176.pdf>.

¹⁶ See Federal Register, Vol. 91, No. 177, Tuesday, September 15, 2026, 58447-58452, <https://www.govinfo.gov/content/pkg/FR-2026-09-15/pdf/2026-18900.pdf>.

¹⁷ See Federal Register, Vol. 91, No. 177, Tuesday, September 15, 2026, 58452-58455, <https://www.govinfo.gov/content/pkg/FR-2026-09-15/pdf/2026-18901.pdf>.

disease,¹⁸ it is not possible to adequately assess causal associations involving the aggregate outcome of "cardiovascular disease" due to widely varying etiology within a large system of the body like the cardiovascular system. Thus, in accordance with the *Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions*, the WTC Health Program's Science Team reviewed the information provided by petitioners, including the medical basis information and other scientific references submitted with each petition, and determined that the health condition of interest for the evaluation was ischemic heart disease (IHD). This determination is further explained in detail in the "Evaluation of Scientific Evidence Supporting the Addition of Ischemic Heart Disease to the List of WTC-Related Health Conditions."¹⁹

Scientific Issues

Below I separated the 12 scientific issues raised in your July 31, 2026 email, and provide a response to each.

Comment 1. The July 31st email states that the scientific evidence for ischemic cardiovascular disease is stronger than the evidence provided to support the addition of multiple types of cancer to the List.

Response 1. While causal association in epidemiology for malignant and non-malignant health conditions are evaluated by the WTC Health Program using two different *Policy and Procedures*, i.e., one for cancer and the other for non-cancer conditions, both policies use the Bradford Hill criteria of causality²⁰ to evaluate the evidence regarding the association of 9/11 exposures with the health condition requested in a petition.²¹ The Science Team applies the Bradford Hill criteria to help distinguish associations that may reflect causal relationships from those attributable to correlation alone, thereby supporting conclusions grounded in a comprehensive evaluation of the available evidence. In addition, the Science Team identifies and evaluates study limitations to assess whether a causal association between 9/11 exposures and the health condition can be explained by chance, bias, confounding, or any other alternative explanation.

¹⁸ A total of eight petitions were received requesting the addition of various cardiovascular conditions falling under the general category of ischemic heart disease (IHD); in addition to Petition 047, Petitions 024, 042, 046, 051, 056, 058, and 067 were included in the IHD scientific evaluation.

¹⁹ See <https://www.cdc.gov/niosh/docket/archive/pdfs/niosh-094/2026-white-paper-eval-evidence-supporting-ischemic-v7rw-0622.pdf>, Sec. V, pages 14-15.

²⁰ Hill AB. The environment and disease: Association or causation? *Proc Royal Soc Med.* 1965;58(5):295-300. See <https://doi.org/10.1177/003591576505800503>.

²¹ See "Policy and Procedures for Adding Types of Cancer to the List of WTC-Related Health Conditions," Sec. IV.A., at https://www.cdc.gov/wtc/pdfs/policies/WTCHP_PP_Addn_Cancer_11182021-508.pdf; "Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions," Sec. IV.A., https://www.cdc.gov/wtc/pdfs/policies/WTCHP_PP_Adding_NonCancer_Health_Conditions_20260514.pdf.

Comment 2. The July 31st email posed the query, “is a clear and transparent evidentiary threshold being applied when determining whether the available scientific evidence is sufficient to support the addition of a condition?”

Response 2. No predetermined risk threshold is applied when evaluating whether the available scientific evidence is sufficient to support the addition of a condition. Rather, the Science Team evaluates the evidence from individual studies and across the body of available scientific literature in 9/11 populations to characterize the strength of evidence supporting a causal association between 9/11 exposures and the non-cancer health condition under consideration. This evidentiary standard is clearly explained in the *Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions*.²²

Comment 3. The July 31st email also notes that the “White Paper uses language from the Bradford Hill criteria, which have not been described as NIOSH policy in these matters.”

Response 3. As stated above, the use of Bradford Hill criteria is explained in both the *Policy and Procedures for Adding Types of Cancer to the List of WTC-Related Health Conditions* and the *Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions*.²³ The most recent update of the *Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions*, which was used to conduct the IHD evaluation, was presented to the STAC for their review prior to publication and was the subject of STAC review and discussion over the course of three separate meetings.²⁴ The public also had the opportunity to comment on the *Policy and Procedures* on each of these occasions, including on the Program’s use of the Bradford Hill criteria as the basis for assessing causal relationships. No substantial objections were raised to the Program’s use of these criteria in its causality assessment procedures.

Comment 4. The July 31st email suggests that the petition evaluation “should use a transparent, hazard-based approach consistent with the methodology used to add cancers to the WTC covered condition list.”

Response 4. While the *Policy and Procedures* governing the evaluation of cancer and non-cancer health conditions differ in some respects, both policies utilize similar evaluation procedures to evaluate the scientific evidence for causal association based on the Bradford Hill criteria. The Program’s consideration of the probability of actual

²² See “Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions,” Sections III, IV, and V, https://www.cdc.gov/wtc/pdfs/policies/WTCHP_PP_Adding_NonCancer_Health_Conditions_20260514.pdf.

²³ See *supra*, note 21.

²⁴ See STAC Meetings held Feb. 9, 2023; June 21-22, 2023; and September 23, 2024, at https://www.cdc.gov/wtc/stac_meeting.html.

exposure is an important component of the Program's causal association and is consistent with the Zadroga Act. A hazard-based approach would be inconsistent with the *Policy and Procedures for Adding Non-Cancer Health Conditions to the List of WTC-Related Health Conditions*. Instead, this *Policy and Procedures* uses a risk-based approach.²⁵

Comment 5. The first table in the July 31st email suggests that when self-reported outcomes are considered as sufficient scientific evidence of a causal association, there is a consistent and statistically significant dose-response association between CVD and 9/11 exposure.

Response 5. The use of self-reported outcome data may lead to biased findings. The "Evaluation of Scientific Evidence Supporting the Addition of Ischemic Heart Disease to the List of WTC-Related Health Conditions" noted that when compared to findings using self-reported outcome data, associations based on objectively confirmed outcomes were attenuated and not statistically significant (Alper et al. 2021;²⁶ Jordan et al. 2013;²⁷ Mueller et al. 2024²⁸). There is potential for upward bias from overreporting by self-report. Without an assessment of potential bias, ascertainment error cannot be ruled out as alternative explanation of study findings using self-reported outcome data. In its "Evaluation of Scientific Evidence," the WTC Health Program's Science Team wrote "future research that examines IHD risk separately and specifically in the 9/11 population using objective outcome measures is needed to elucidate a causal association between 9/11 exposure and IHD."²⁹

Comment 6. The July 31st email states that the IHD evaluation engaged in "underweighting of dose-response evidence from FDNY and GRC cohorts."

²⁵ A hazard-based approach focuses on whether an agent has the inherent capacity to cause harm, generally without fully considering the magnitude of exposure or the probability that harm will occur under specific exposure conditions. In contrast, a risk-based approach considers both the hazard and the magnitude of exposure to characterize the likelihood of adverse effects. Unlike a hazard-based approach, a risk-based approach incorporates a dose-response and exposure assessment. A risk-based approach is generally preferred for decision-making because it distinguishes between an agent's potential to cause harm and the risk posed under actual exposure conditions. See Scheer D, Benighaus C, Benighaus L, et al. [2014]. The distinction between risk and hazard: Understanding and use in stakeholder communication. *Risk Anal.* 34(7):1270–1285. <https://doi.org/10.1111/risa.12169>.

²⁶ Alper HE, Brite J, Cone JE, Brackbill RM [2021]. Comparison of prevalence and exposure-disease associations using self-report and hospitalization data among enrollees of the World Trade Center Health Registry. *BMC Med Res Methodol* 21(162), <https://doi.org/10.1186/s12874-021-01358-y>.

²⁷ Jordan HT, Stellman SD, Morabia A, et al. [2013]. Cardiovascular disease hospitalizations in relation to exposure to the September 11, 2001 World Trade Center disaster and posttraumatic stress disorder. *J Am Heart Assoc* 2(5):e000431, <https://doi.org/10.1161/JAHA.113.000431>.

²⁸ Mueller AK, Cohen H, Singh A, et al. [2024]. Self-reported cardiovascular disease in career firefighters with and without World Trade Center exposure. *J Occup Environ Med* 66(2):135140, <https://doi.org/10.1097/JOM.0000000000003007>.

²⁹ See "Evaluation of Scientific Evidence Supporting the Addition of Ischemic Heart Disease to the List of WTC-Related Health Conditions," page 62, <https://www.cdc.gov/niosh/docket/archive/pdfs/niosh-094/2026-white-paper-eval-evidence-supporting-ischemic-v7rw-0622.pdf>.

Response 6. The dose-response evidence from FDNY and GRC cohorts involved composite CVD outcomes and not IHD-specific outcomes. Composite outcomes, which are a collection of outcomes related to health conditions not exclusive to ischemic heart disease, are not suitable for establishing causal association for a discrete health condition. The plausibility of separate and distinctly different CVD outcomes within the composite outcome analyzed having similar exposure-related risks is suspect. Rather, it is more likely for the findings of these analyses to be indicative of the most common outcome or a less frequent outcome with much greater exposure-related risk. In either event, findings from analyses using grouped outcomes are largely uncertain and merit cautious interpretation in causal inference.³⁰

Comment 7. The July 31st email states there was “omission of strong mechanistic evidence from particulate toxicology.”

Response 7. The WTC Health Program’s Science Team reviewed this evidence and concluded “the coherence between observations in populations exposed to air pollution and the 9/11-exposed population is largely uncertain given substantial differences in exposure composition, duration, and intensity”³¹ between general air pollution versus the dust and debris cloud arising from the 9/11 terrorist attacks.

Comment 8. The July 31st email stated:

WTC dust contained extreme concentrations of PM_{2.5}, a pollutant with well-documented causal links to myocardial infarction, stroke, and atherosclerosis; WTC Exposure was *far more intense* than chronic PM_{2.5} exposure. Ambient PM_{2.5} studies typically examine exposures in the 5–35 µg/m³ range (refs 9, 14). The WTC collapse produced PM_{2.5} concentrations near 100,000 µg/m³ for hours—an exposure level *orders of magnitude higher*, and of a type known to trigger acute cardiovascular instability (ref 10, 15–17). If chronic PM_{2.5} at low levels raises CVD risk slightly, extreme PM_{2.5} exposure at WTC levels would reasonably increase risk *far more*, not less. These larger and chemically caustic particles caused immediate airway injury and heightened systemic inflammation that lingered. The “petition” cited a 2013 study by Trasande et al. (reference 21) that demonstrated metabolic and increased risk factors for Ischemic Cardiovascular Diseases.

Response 8. The WTC Health Program’s Science Team reviewed all exposure evidence as referenced in the July 31st email. Although a causal relationship between environmental exposures to PM_{2.5} and CVD is well recognized, few studies have examined the temporality

³⁰ See *Id.* at page 60, <https://www.cdc.gov/niosh/docket/archive/pdfs/niosh-094/2026-white-paper-eval-evidence-supporting-ischemic-v7rw-o622.pdf>.

³¹ See *Id.* at pages 64–65, <https://www.cdc.gov/niosh/docket/archive/pdfs/niosh-094/2026-white-paper-eval-evidence-supporting-ischemic-v7rw-o622.pdf>.

of the exposure and response, which is an important area of uncertainty. Most short-term exposure studies have examined the association between air pollution events and hospital admissions or emergency room visits to treat relatively immediate cardiovascular effects (i.e., appearing within 0–5 days of exposure). There is no information on the relevant biologic period for potential delayed effects arising from short-term exposure, which are of greater interest in the 9/11 population. Moreover, PM_{2.5} exposures found in environmental air pollution markedly differ both chemically and physically from 9/11 exposures. Persons exposed to the dust and debris cloud on September 11, 2001, were acutely exposed to a unique mixture of chemicals and PM consisting mostly of pulverized cement, glass, and building materials as coarse particles in an alkaline (pH 9.0–11.0) matrix. After careful consideration of the available evidence, the WTC Health Program’s Science Team concluded “the coherence between observations in populations exposed to air pollution and the 9/11-exposed population is largely uncertain given substantial differences in exposure composition, duration, and intensity.”³²

Comment 9. The July 31st email states that “NIOSH ignored ‘Mechanistic Bioplausibility & Environmental Toxicology. WTC dust contained high concentrations of alkaline particulates, heavy metals, combustion byproducts, and fine/ultrafine particles known to induce inflammation, endothelial dysfunction, and accelerated atherosclerosis—recognized pathways toward Ischemic Cardiovascular Disease.”

Response 9. The WTC Health Program’s Science Team did not find information refuting the biological plausibility of WTC dust as a causal agent. However, as discussed earlier in my response, there is large uncertainty in an analogy comparing a proposed causal association between WTC dust exposure and IHD and the established causal relationship between PM_{2.5} and IHD. In Section X of the “Evaluation of Scientific Evidence Supporting the Addition of Ischemic Heart Disease to the List of WTC-Related Health Conditions,”³³ the WTC Health Program’s Science Team concluded that a causal association between 9/11 exposures and IHD is considered biologically plausible; however, the current evidence is not sufficient to support a reasonable conclusion that there is a substantial or high likelihood of a causal association.

Comment 10. The July 31st email states that there was a “failure to account for under-ascertainment bias. The observed positive associations occurred despite likely under-ascertainment. IHD is not a WTC covered condition, members have little incentive to report these diagnoses to the Program. This ascertainment bias was not addressed in the federal analysis.”

Response 10. Studies using data from the State hospital discharge reporting system, managed by the Statewide Planning and Research Cooperative System (SPARCS), are not susceptible to this type of under-ascertainment bias. The three studies that used SPARCS

³² See *Id.* at pages 64–65.

³³ *Ibid.*, page 79.

data to examine IHD did not find statistically significant associations with 9/11 exposures [Jordan et al. 2013;³⁴ Remch et al. 2018;³⁵ Alper et al. 2021³⁶]. Mortality studies are also not susceptible to this under-ascertainment bias. However, a limitation of those mortality studies that reported findings from internal analyses is the use of composite CVD outcomes rather than IHD-specific outcomes.

Comment 11. The July 31st email raised concerns about the healthy worker effect. Specifically, the email states:

The Administrator’s decision likely stemmed from interpretation of adjusted models, many of which did not adjust for baseline healthy worker effect and occupational health differences, thereby suppressing true exposure effects. Alternatively, the analyses might have been over-adjusted by including variables influenced by WTC exposure (e.g., PTSD, inflammation, hypertension) that are potential mediators or colliders, leading to nullified associations; and the decision to deny IHD as a covered condition misapplied the “healthy worker effect”—a known artifact in occupational epidemiology—by relying on mortality studies showing fewer Ischemic Cardiovascular Disease deaths compared with the general population.

Response 11. The WTC Health Program’s Science Team understands that internal analyses do not suffer from baseline healthy worker effects and occupational health differences. Instead, the primary limitation of the studies that used internal analyses is that the outcomes assessed were not specific to IHD but instead were composite CVD outcomes. The Science Team agrees that the possibility of model-form misspecification cannot be dismissed. This type of error occurs when the mathematical structure of the assumed causal model does not accurately represent the true biological exposure and response relationship and will likely cause an overvaluing of estimate precision. Additional research is needed to clarify and account for the role of variables (e.g., post-traumatic stress disorder) in the proposed association between 9/11 exposure and IHD. Furthermore, the Science Team acknowledges that overadjustment can bias the effect estimate, often toward the null. On the other hand, residual confounding may remain due to uncontrolled factors that do not lie on the causal pathway between 9/11 exposures and IHD, such as family history, hypercholesterolemia, and dyslipidemia.

³⁴ Jordan HT, Stellman SD, Morabia A, et al. [2013]. Cardiovascular disease hospitalizations in relation to exposure to the September 11, 2001 World Trade Center disaster and posttraumatic stress disorder. *J Am Heart Assoc* 2(5):e000431, <https://doi.org/10.1161/JAHA.113.000431>.

³⁵ Remch M, Laskaris Z, Flory J, et al. [2018]. Post-traumatic stress disorder and cardiovascular diseases: A cohort study of men and women involved in cleaning the debris of the World Trade Center complex. *Circ Cardiovasc Qual Outcomes* 11(7):e004572, <https://doi.org/10.1161/CIRCOUTCOMES.117.004572>

³⁶ Alper HE, Brite J, Cone JE, Brackbill RM [2021]. Comparison of prevalence and exposure-disease associations using self-report and hospitalization data among enrollees of the World Trade Center Health Registry. *BMC Med Res Methodol* 21(162), <https://doi.org/10.1186/s12874-021-01358-y>.

Comment 12. The July 31st email states that studies referenced in the evaluation “demonstrate consistent associations between WTC exposure and cardiovascular outcomes.” Furthermore, the email indicated that even though consistency is a Hill criterion, the Science Team did not discuss or weigh on this issue.

Response 12. Section IX.B.1. and Table 21 of the evaluation addressed the lack of consistency in findings across high-quality studies. The Science Team concluded that “(m)ixed findings might result from differences in the definitions of health conditions, exposure measures, populations at risk, case ascertainment, as well as observing modest effects, among other possible explanations.”³⁷

Future Engagement About Scientific Issues Impacting Petition Evaluation

Many of the issues raised in the July 31, 2026, email message concerning the IHD evaluation involve complex scientific questions that can be difficult to fully explore by way of emails and letters. The WTC Health Program is planning a research conference in 2027 that will provide an opportunity to engage in discussion of many of the scientific issues raised in the July 31st email. The WTC Health Program’s Science Team looks forward to the opportunity for continued dialogue and a thoughtful exchange of perspectives on these important topics.

Sincerely,

John J.
Howard -S

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John Howard, MD
Administrator

³⁷ See *Id.* at pages 57-58 and page A-23 (Table 21).