ОСОБЕННОСТИ ПРИМЕНИЯ САРТАНОВ ПРИ СОЧЕТАНИИ АРТЕРИАЛЬНОЙ ГИПЕРТЕНЗИИ И ИШЕМИЧЕСКОЙ БОЛЕЗНИ СЕРДЦА

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SCIENCE NEWS
ACC.11
APRIL 2-5, 2011 | NEW ORLEANS

OSCAR

The Comparison of High-dose Angiotensin II Receptor Blocker (ARB) Monotherapy Versus Combination Therapy of ARB with Calcium Channel Blocker on Cardiovascular Events in Japanese Elderly High-Risk Hypertensive Patients: Olmesartan and Calcium Antagonists Randomized

Hisao Ogawa, MD, PhD, Fukuoka University, Fukuoka, Japan

NAGOYA HEART Study

Comparison between Valsartan and Amlodipine Regarding Cardiovascular Morbidity and Mortality in Hypertensive Patients with Glucose Intolerance

Toyoaki Murohara, MD, PhD, on behalf of Nagoya Heart Study Investigators, Department of Cardiology, Nagoya University School of Medicine, Nagoya, Japan

Rheos Trial

Baroreflex Activation Therapy Sustainably Lowers Blood Pressure in Patients with Resistant Hypertension: Results from the Rheos Pivotal Trial

John D. Bisognano, MD, PhD, University of Rochester Medical Center, Rochester, NY, University of Chicago, Chicago, IL

JACC
JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY

ACCF/AHA 2011 Expert Consensus Document on Hypertension in the Elderly: A Report of the American College of Cardiology Foundation Task Force on Clinical Expert Consensus Documents

РОВОДИТЬ АНТИГИПЕРТЕНЗИВНОЕ ЛЕЧЕНИЕ И ВТОРИЧНУЮ ПРОФИЛАКТИКУ ЛИЦАМ БЕЗ АГ?

VBWG US Chapter Meeting at ACC 2011

Saturday, April 2, 2011
New Orleans, Louisiana

Vascular Biology Working Group

Antihypertensive Treatment and Secondary Prevention of Cardiovascular Disease Events Among Persons Without Hypertension

A Meta-analysis

Angela M. Thompson, MSPH; Tian Hu, MS, BM; Carrie L. Eshelbrenner, MD; Kristi Reynolds, PhD; Jiang He, MD, PhD; Lydia A. Bazzano, MD, PhD

Conclusions Among patients with clinical history of CVD but without hypertension, antihypertensive treatment was associated with decreased risk of stroke, CHF, composite CVD events, and all-cause mortality. Additional randomized trial data are necessary to assess these outcomes in patients without CVD clinical recommendations.

ЗАКЛЮЧЕНИЕ

Outcome	Relative Risk Reduction	Absolute Risk Reduction (per 1000 persons)
Stroke	**-23%** (RR, 0.77 [95% CI, 0.61-0.98])	**-7.7** (95%CI, -15.2 to -0.3)
MI	**-20%** (RR, 0.80 [95% CI, 0.69-0.93])	**-13.3** (95% CI, -28.4 to 1.7)
CHF events	**-29%** (RR, 0.71 [95% CI, 0.65-0.77])	**-43.6** (95% CI, -65.2 to -22.0)
CVD events	**-15%** (RR, 0.85 [95% CI, 0.80-0.90])	**-27.1** (95% CI, -40.3 to -13.9)
CVD Mortality	**-17%** (RR, 0.83 [95% CI, 0.69-0.99])	**-15.4** (95% CI, -32.5 to 1.7)
All-cause Mortality	**-13%** (RR, 0.87 [95% CI, 0.80-0.95])	**-13.7** (95% CI, -24.6 to -2.8)

Thompson A, et al. JAMA 305:913-922, 2011.

ведения АГ у пожилых

Oftcjdz 2011

JACC JOURNAL OF THE AMERICAN COLLEGE OF CARIOLOGY

Principles of Hypertension Treatment

get systolic blood pressure is ≤140 mmHg in patients aged 55 to 79
Target systolic blood pressure is ≤140 mmHg in patients ≥ age
Achieved values <140 mmHg for those aged ≤79 are appropr
but for those aged ≥80, 140 to 145 mmHg, if tolerated, can b

Тиазидовые
ИАПФ
БРА
Антагонисты кальция

Lifestyle Modifications

Not at Target Blood Pressure

Initial Drug Choices

Without Compelling Indications

Stage 1 Hypertension
SBP 140 to 159 mmHg or
DBP 90 to 99 mmHg

ACEI, ARB, CA, diuretic, or combination

Stage 2 Hypertension
SBP ≥ 160 mmHg or
DBP ≥ 100 mmHg

Majority will require at least two medications to reach goal if at least 20 mmHg above target. Initial combinations should be considered. The combination of amlopidine with an RAS blocker may be preferred to a diuretic combination, though either is acceptable.

With Compelling Indications

Compelling Indication	Initial Therapy Options*
• Heart Failure	THIAZ, BB, ACEI, ARB, CA, ALDO ANT
• Post myocardial infarction	BB, ACEI, ALDO ANT, ARB
• CAD or High CVD risk	THIAZ, BB, ACEI, CA
• Angina Pectoris	BB, CA
• Aortopathy/Aortic Aneurysm	BB, ARB, ACEI, THIAZ, CA
•Diabetes	ACEI, ARB, CA, THIAZ, BB
•Chronic kidney disease	ACEI, ARB
• Recurrent stroke prevention	THIAZ, ACEI, ARB, CA
• Early dementia	Blood pressure control

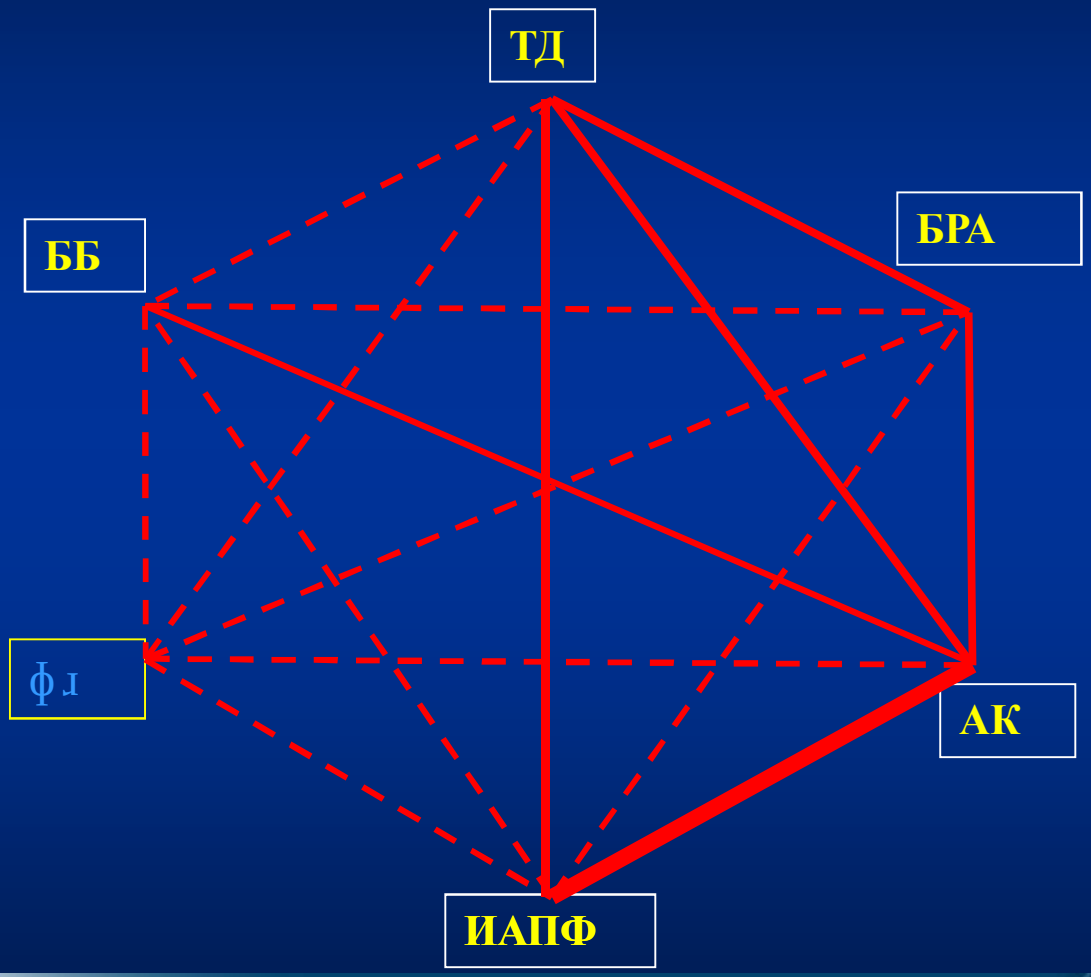
*Combination therapy

Not at Target Blood Pressure

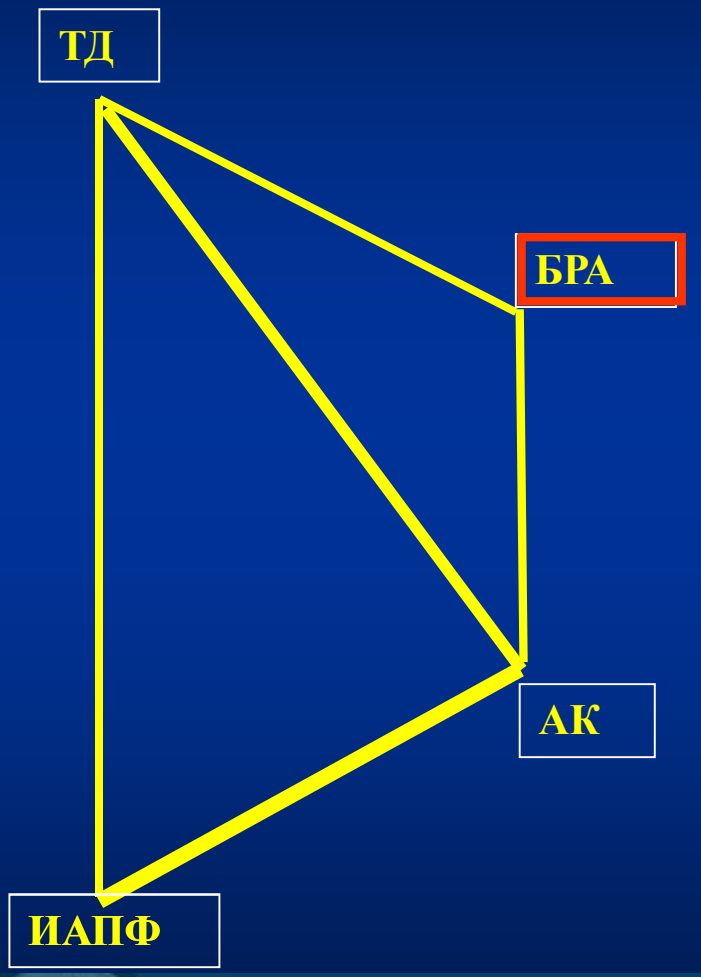
Optimize dosages or add additional drugs until goal blood pressure is achieved.
Refer to a clinical hypertension specialist if unable to achieve control.

применения антигипертензивных препаратов

elines 2007: ная терапия



ESH/ESC Guidelines 2009: Комбинированная терапия



БРА для лечения АГ

ИАПФ: Снижение АД ?

CENTRAL (The Cochrane Library 2007, Issue 1), MEDLINE (1966 to February 2007), EMBASE (1988 to February 2007) and reference lists of articles.

Анализ 44 исследований
Анализ эффективности БРА в 9 двойных плацебо контролируемых рандомизированных исследованиях
13 451 пациентов АД 156/101 mm Hg

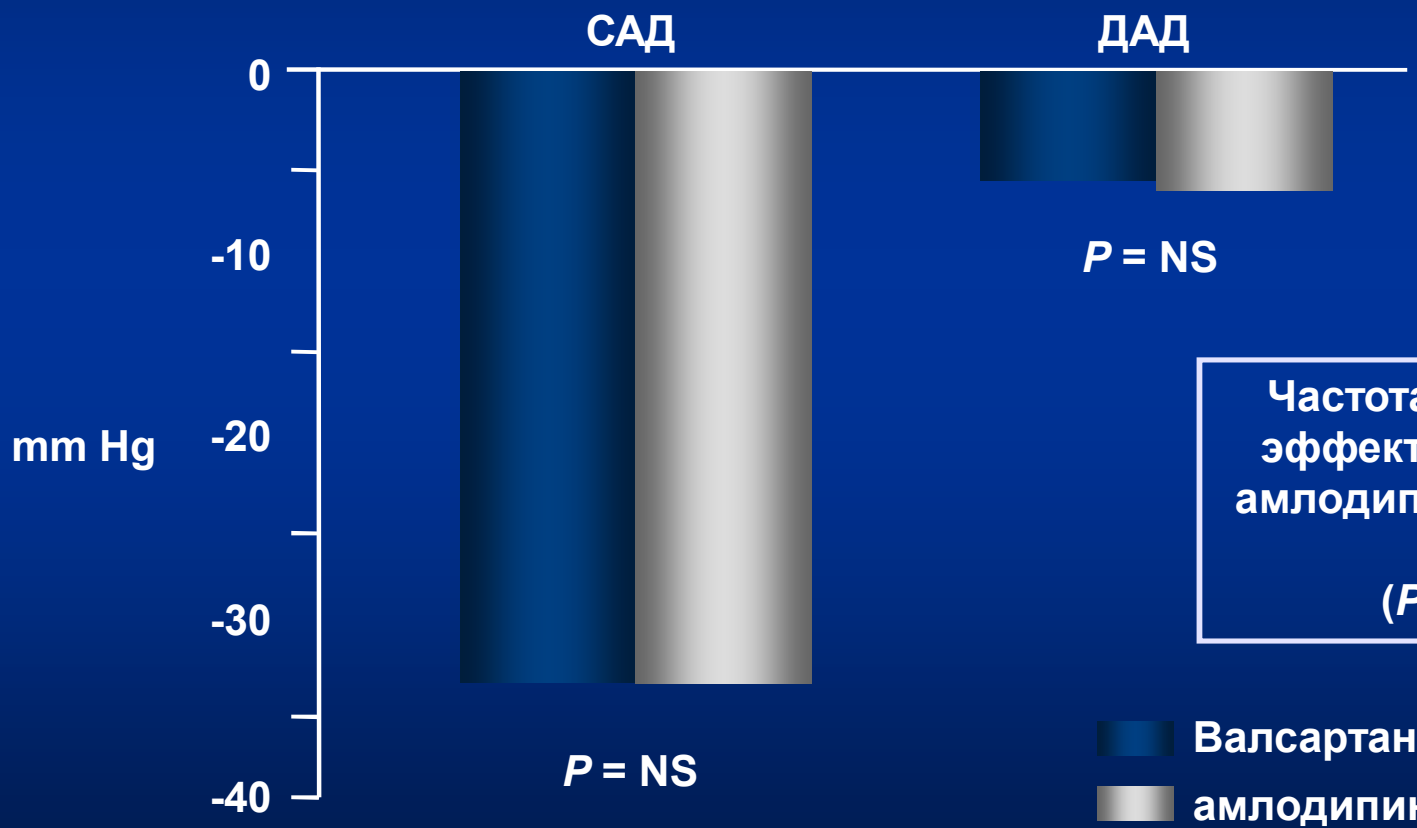
-8 mm Hg for SBP and -5 mm Hg for DBP.
ARBs reduced BP measured 1 to 12 hours after the dose by about 12/7 mm Hg.

БРА против ИАПФ: снижение АД - одинаковое

Cochrane Database Syst Rev. 2008 Oct 8;(4):CD003822.

The Val-Syst Study

Снижение АД через 24 недели

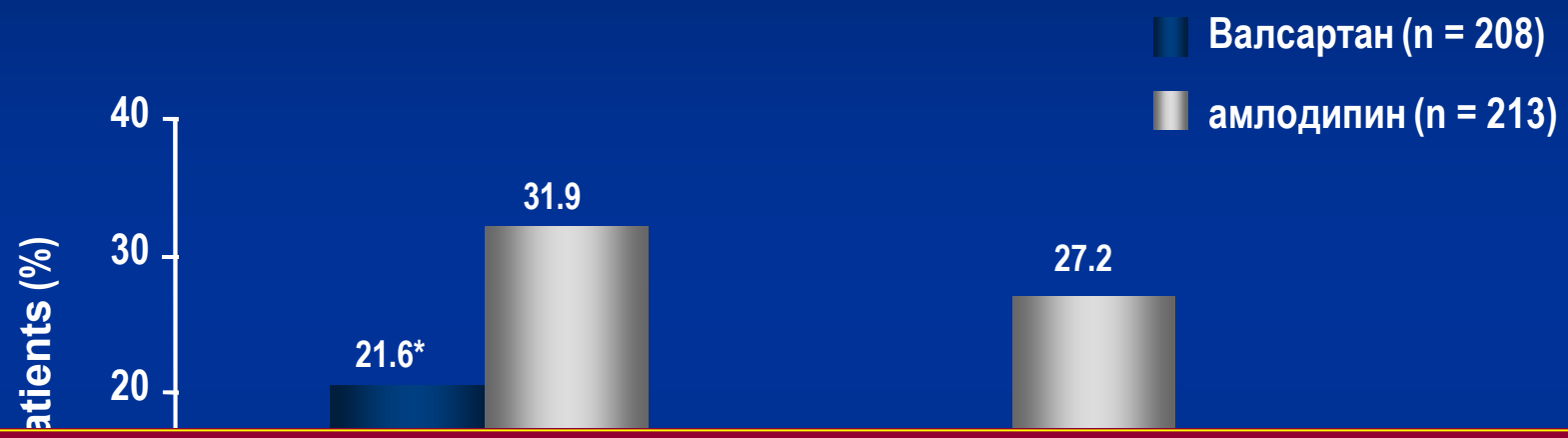


Частота побочных эффектов в группе амлодипина выше на 58%
(*P* <0.03)

- Валсартан (n = 208)
- амлодипин (n = 213)

Malacco E et al. *Clin Ther*. 2003;25:2765-2780.

h Ow ruOrjsslsOtslsj Ftso (Val-Syst)



При одинаковом контроле САД у одинакового количества пациентов (75% и 73% соответственно) Валсартан лучше переносился, чем амлодипин

*P = 0.0026; †P <0.0001.

Adapted with permission from Malacco E et al. *Am J Hypertens*. 2003;16:126A.

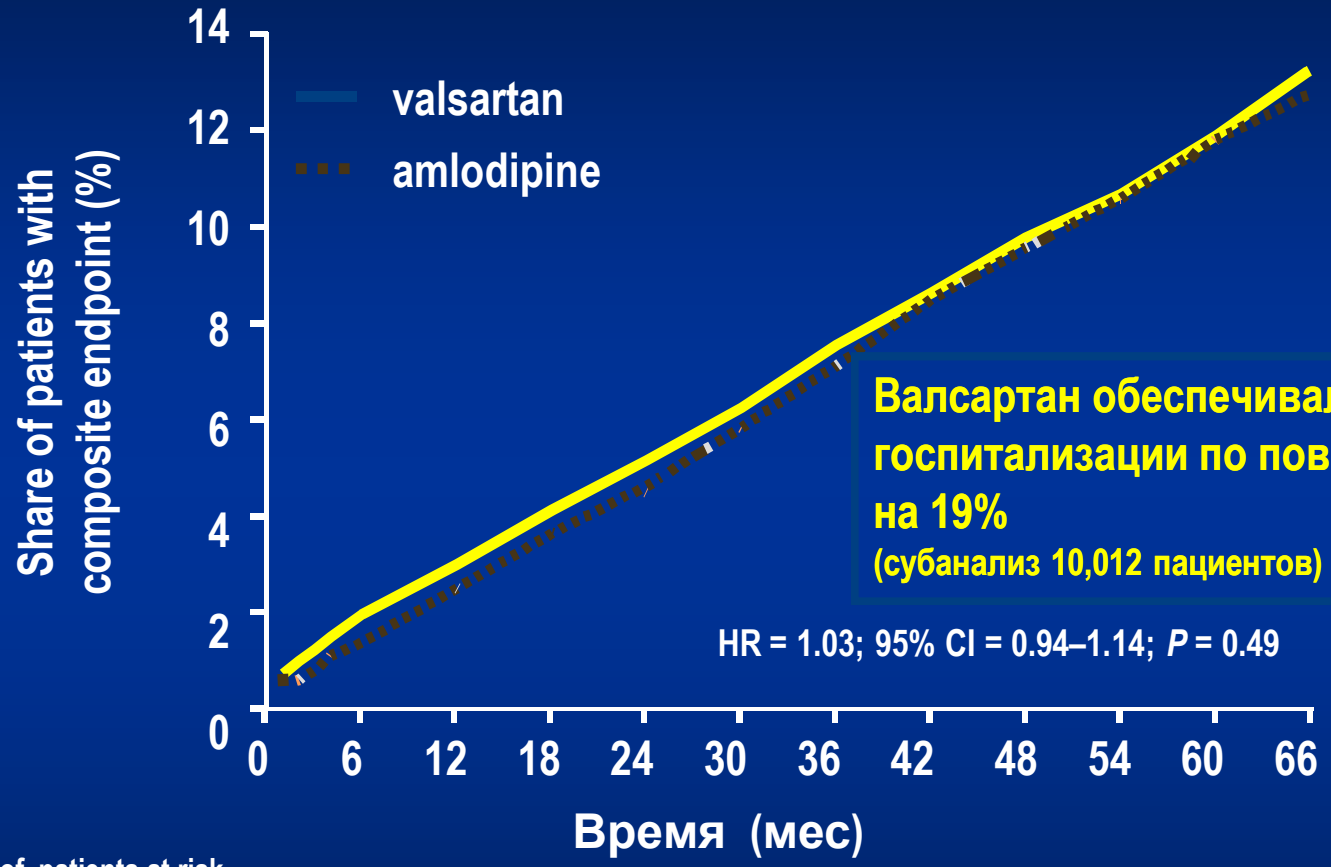
sartan Anti-hypertensive Long-term Use Evaluation

- [illegible]
- [illegible] : 15,313 ([illegible] 50 [illegible])
- [illegible] ([illegible])
- [illegible] (follow-up): 4.2 [illegible]

VALUE

Julius S, Kjeldsen SE, Weber M, et al. Outcomes in hypertensive patients at high cardiovascular risk treated with regimens based on valsartan or amlodipine: the VALUE randomised trial. Lancet 2004;363:2022–2031.

хождения в первичной точке было достигнуто



Валсартан обеспечивал снижение риска госпитализации по поводу ХСН на 19%
(субанализ 10,012 пациентов)

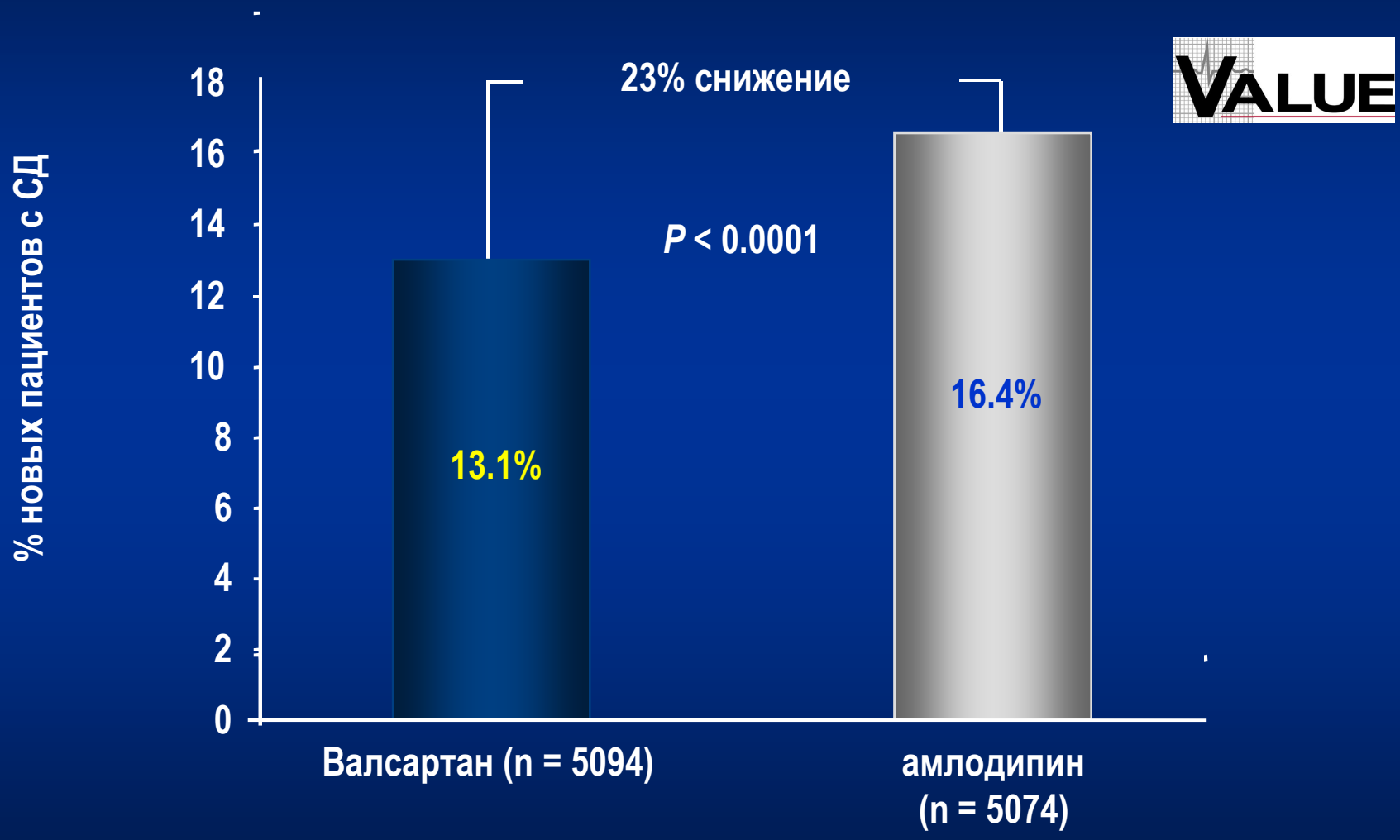
HR = 1.03; 95% CI = 0.94–1.14; *P* = 0.49

Number of patients at risk												
valsartan	7649	7459	7407	7250	7085	6906	6732	6536	6349	5911	3765	1474
amlodipine	7596	7469	7424	7267	7117	6955	6772	6576	6391	5959	3725	1474

VALUE

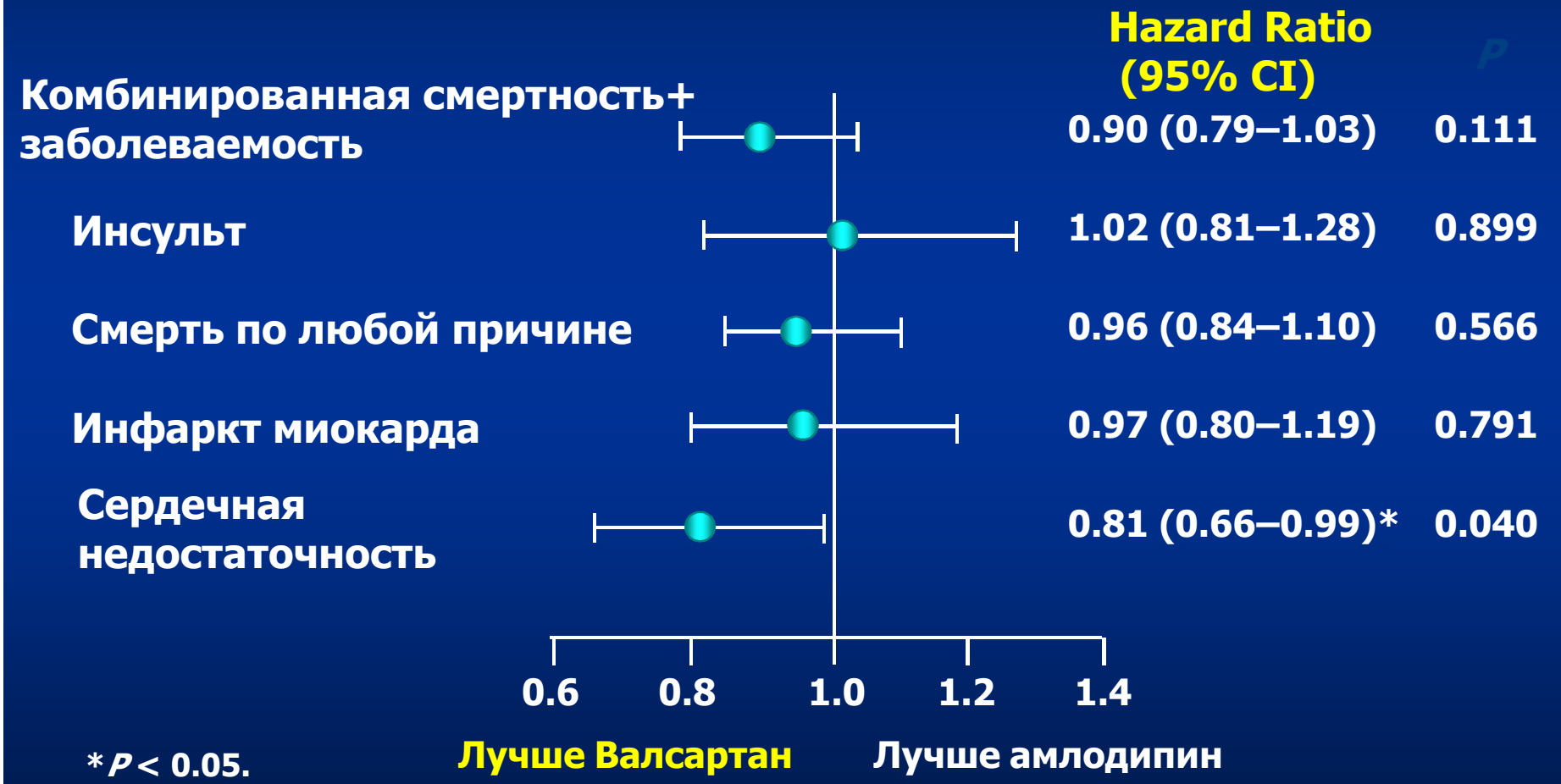
Julius S et al. *Lancet*. June 2004;363.

н снижал риск возникновения новых случаев сахарного диабета на 23%



Julius S et al. *Lancet*. June 2004;363.

...езультаты у 5006 пар больных ...) с одинаковым контролем АД



*$P < 0.05$.

Weber MA et al. *Lancet.* 2004;363:2047–49.

КАРДИОВАСКУЛЯРНЫЙ РИСК

АПФ: кардиоваскулярный риск?

61 плацебо-окнтролируемое рандомизированное исследование

MEDLINE (1966 to 2007), the Cochrane Central Register of Controlled Trials (Issue 2, 2006), and selected reference lists were searched for relevant English-language trials

ACE inhibitors and ARBs had similar long-term effects on blood pressure (50 studies; strength of evidence, high).

ОТСУТСТВУЕТ РАЗНИЦА В НАБЛЮДАЕМЫХ ИСХОДАХ ВКЛЮЧАЯ СМЕРТЬ, КАРДИОВАСКУЛЯРНЫЕ СОБЫТИЯ, КАЧЕСТВО ЖИЗНИ, УРОВЕНЬ ЛИПИДОВ, ПРОГРЕСИРОВАНИЯ ДИАБЕТА, ГИПЕРТРОФИИ ЛЖ, ЗАБОЛЕВАНИЯ ПОЧЕК

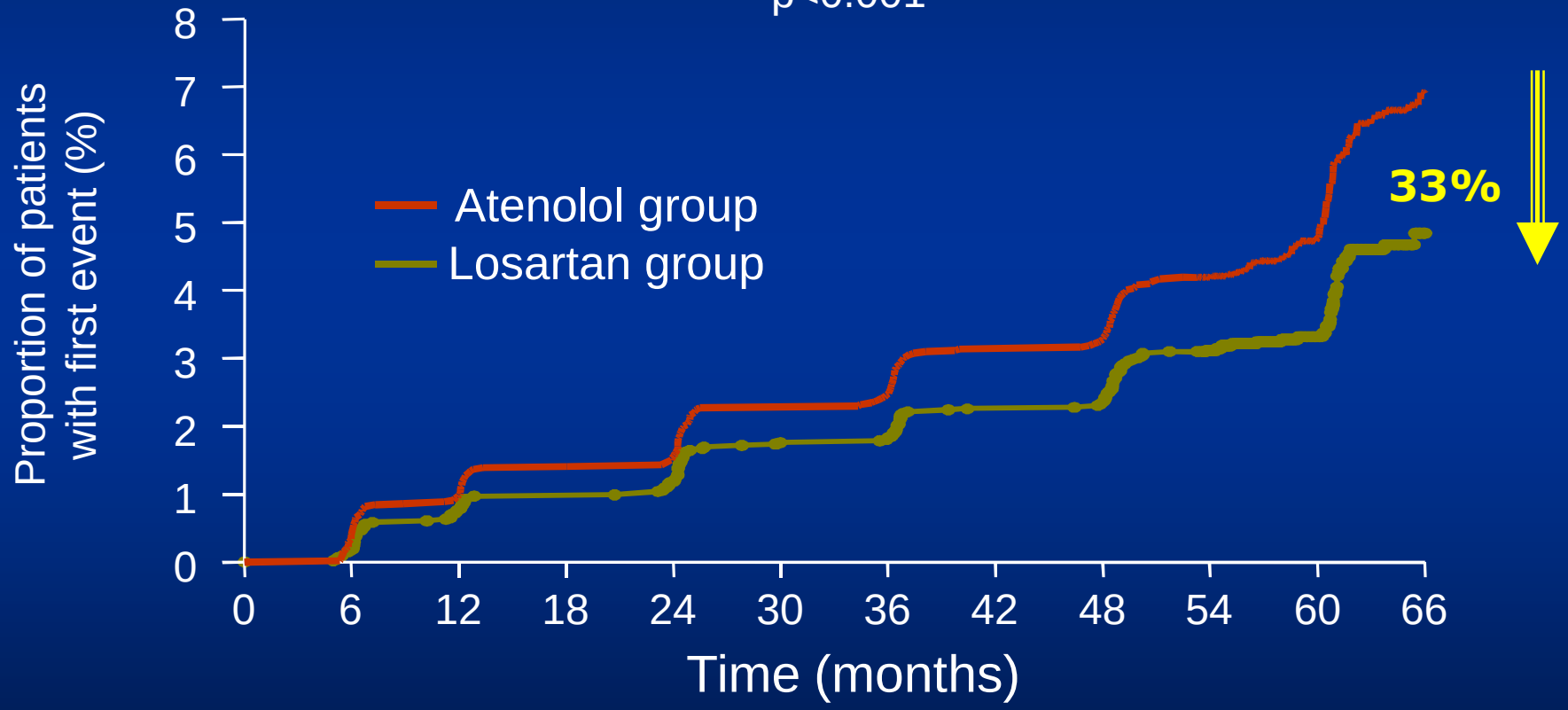
ACE inhibitors have higher rates of cough than ARB

Systematic review: comparative effectiveness of angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers for treating essential hypertension

Ann Intern Med. 2008 Jan 1;148(1):76-7.

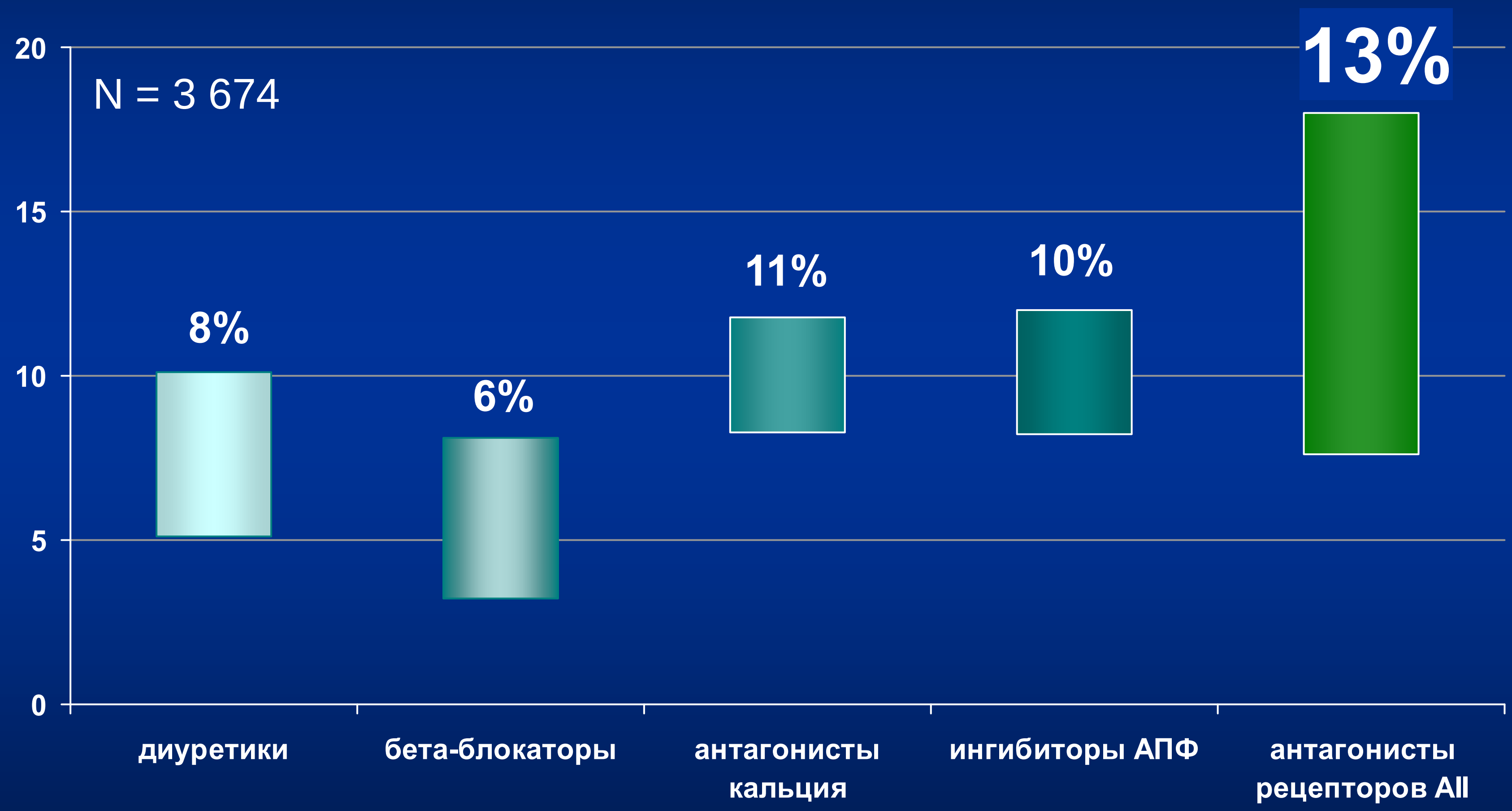
ARBs reduce risk of AF in humans (LIFE Study)

Adjusted hazard ratio: 0.67 [95% CI: 0.55ï 0.83]
p<0.001



CI = confidence interval

Wachtell et al *J Am Coll Cardiol* 2005;45:712ï 719.

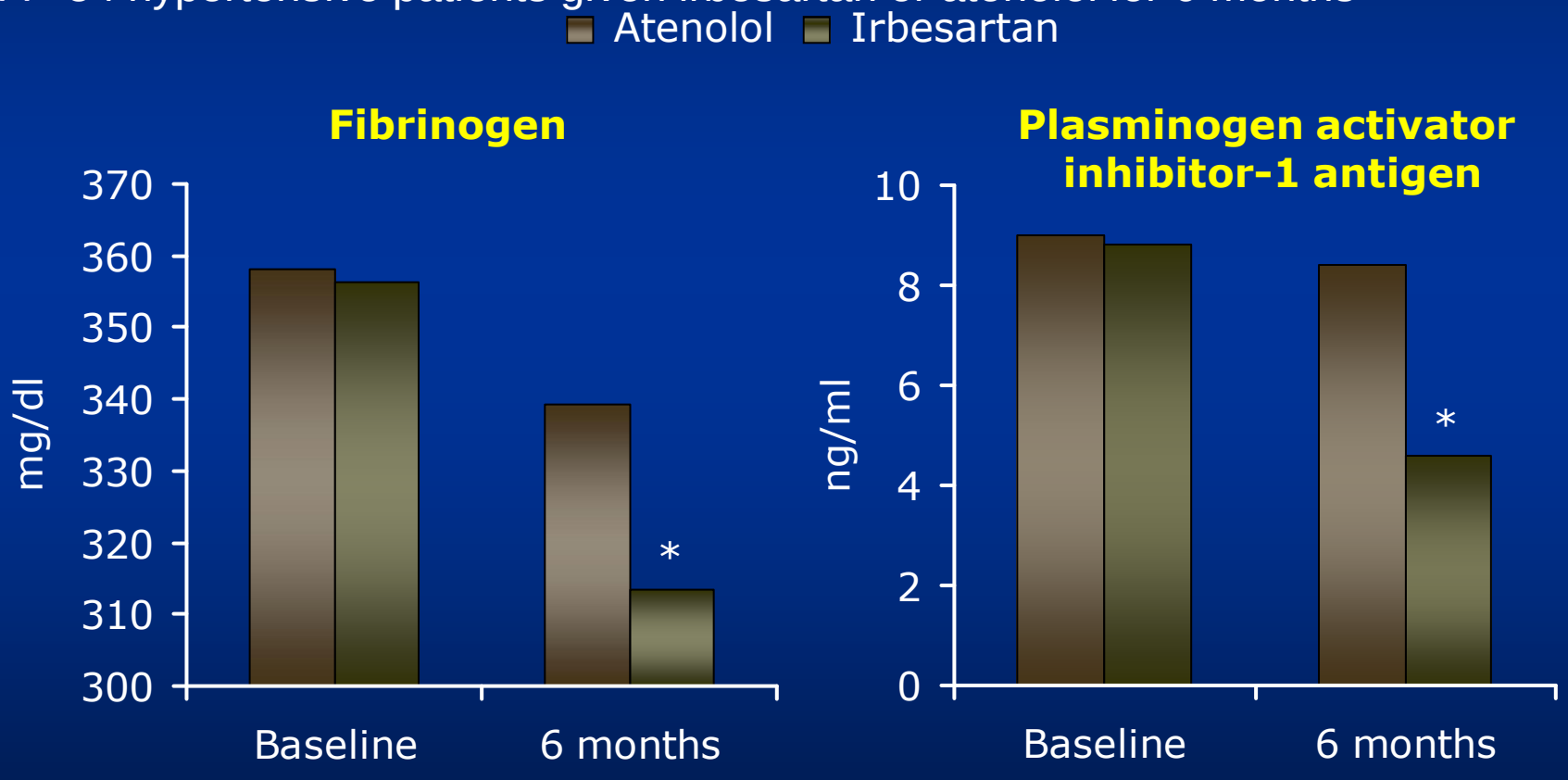


Schmidt and Schmieder; Hypertension and LVH: How much attention should we pay to the RAAS; Dialogues on Cardiovascular Medicine- Vol. 10. No1.2005; page 36

бриногенез и фибринолиз

БРА улучшают фибринолитические /гемолитические возможности

Å 54 hypertensive patients given irbesartan or atenolol for 6 months



* p < 0.05 vs atenolol

Makris et al. *Am J Hypertens* 2000;13:783–788.

но ли эффективно и безопасно применять пациентов, перенесших ИМ с подъемом сегмента ST на фоне СН и/или систолической дисфункции ЛЖ: результаты исследования VALIANT?

The effect of valsartan, captopril, or both on atherosclerotic events after acute myocardial infarction: an analysis of the Valsartan in Acute Myocardial Infarction Trial (VALIANT).

McMurray J, Solomon S, Pieper K, Reed S, Rouleau J, Velazquez E, White H, Howlett J, Swedberg K, Maggioni A, Køber L, Van de Werf F, Califf R, Pfeffer M.

Department of Cardiology, Western Infirmary, Glasgow, Scotland, United Kingdom. j.mcmurray@bio.gla.ac.uk

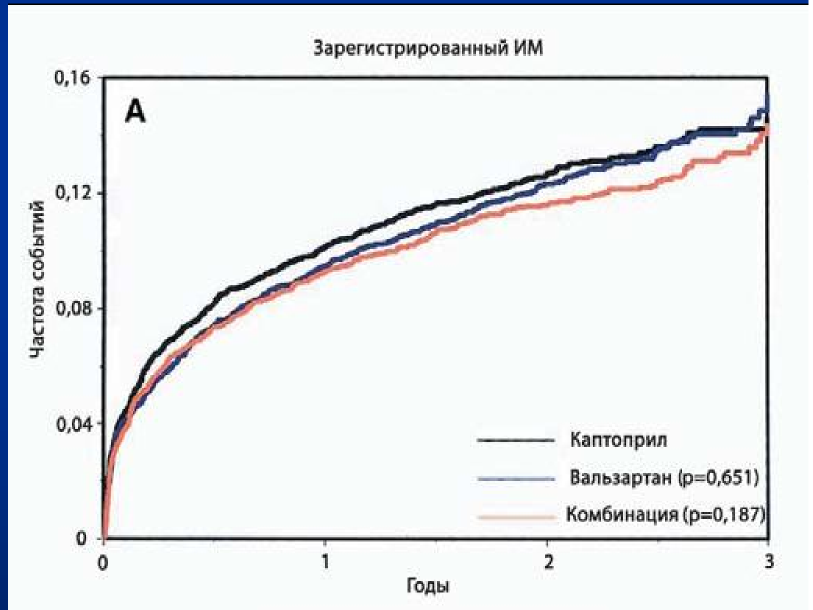
Comment in:

J Am Coll Cardiol. 2006 Oct 3;48(7):1471; author reply 1471.

RESULTS: The number of individuals adjudicated as having a fatal or non-fatal MI in the captopril group was 559 (total investigator reported events 798), 587 (796) in the valsartan group, and 554 (756) in the combination group; valsartan versus captopril, p = 0.651 (0.965); combination versus captopril, p = 0.187 (0.350). Overall, all atherosclerotic events examined occurred at a similar frequency in the captopril and valsartan groups.

CONCLUSIONS: Angiotensin receptor blockers appear to be as effective as ACE inhibitors in reducing atherosclerotic events, even when used in addition to other secondary preventive treatments. These data, although not conclusive, also support the hypothesis that adding an ARB to an ACE inhibitor may have a small additional anti-infarction effect, a possibility that needs to be prospectively tested.

…ANT (Valsartan in Acute Myocardial Infarction Trial)



Терапия валсартаном позволяет снизить риск смерти от любой причины на 25%

J Am Coll Cardiol 2006; 47 (4).

apanese population with hypertension iovascular disease (Jikei Heart Study): open-label, blinded endpoint morbidity-mortality study

Seibu Mochizuki, Björn Dahlöf, Mitsuyuki Shimizu, Katsunori Ikewaki, Makoto Yoshikawa, Ikuo Taniguchi, Makoto Ohta, Taku Yamada, Kazuhiko Ogawa, Kiyoshi Kanae, Makoto Kawai, Shingo Seki, Fumiko Okazaki, Masayuki Taniguchi, Satoru Yoshida, Naoko Tajima, for the Jikei Heart Study group*

Lancet 2007; 369: 1431–39

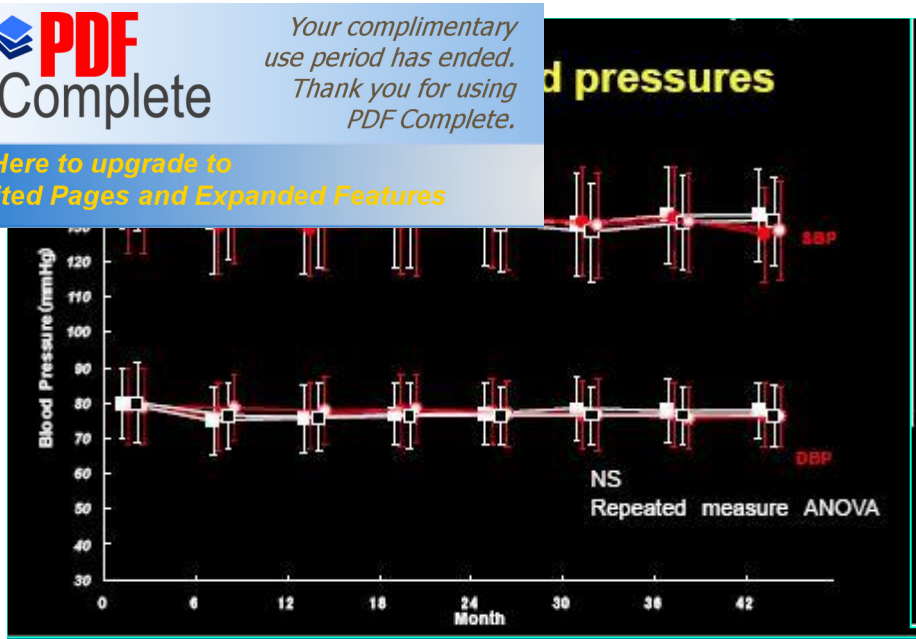
JIKEI

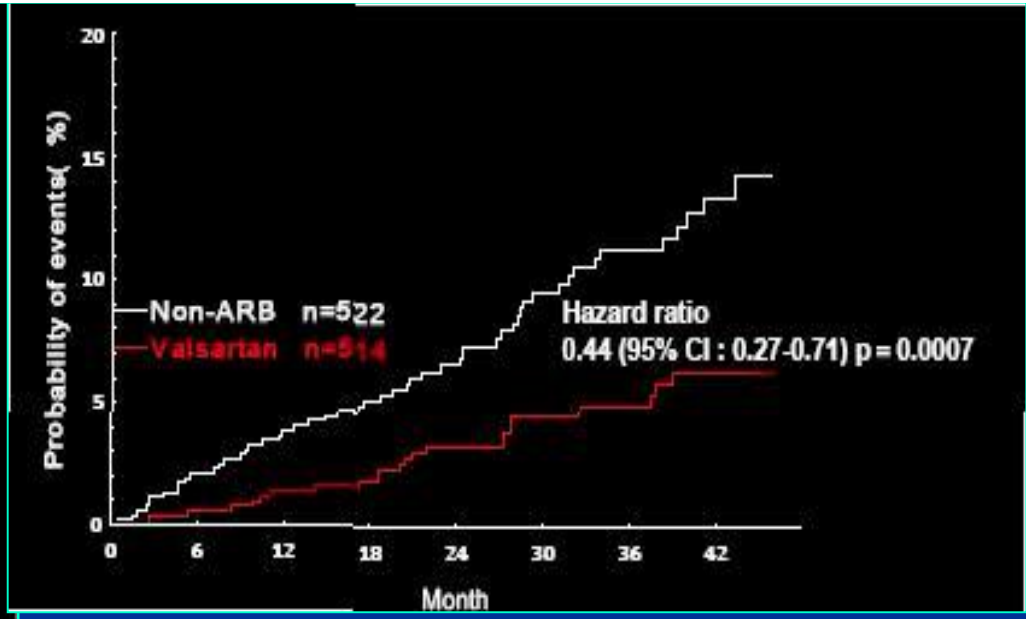
Effect of valsartan in Japanese hypertensive patients with coronary artery disease

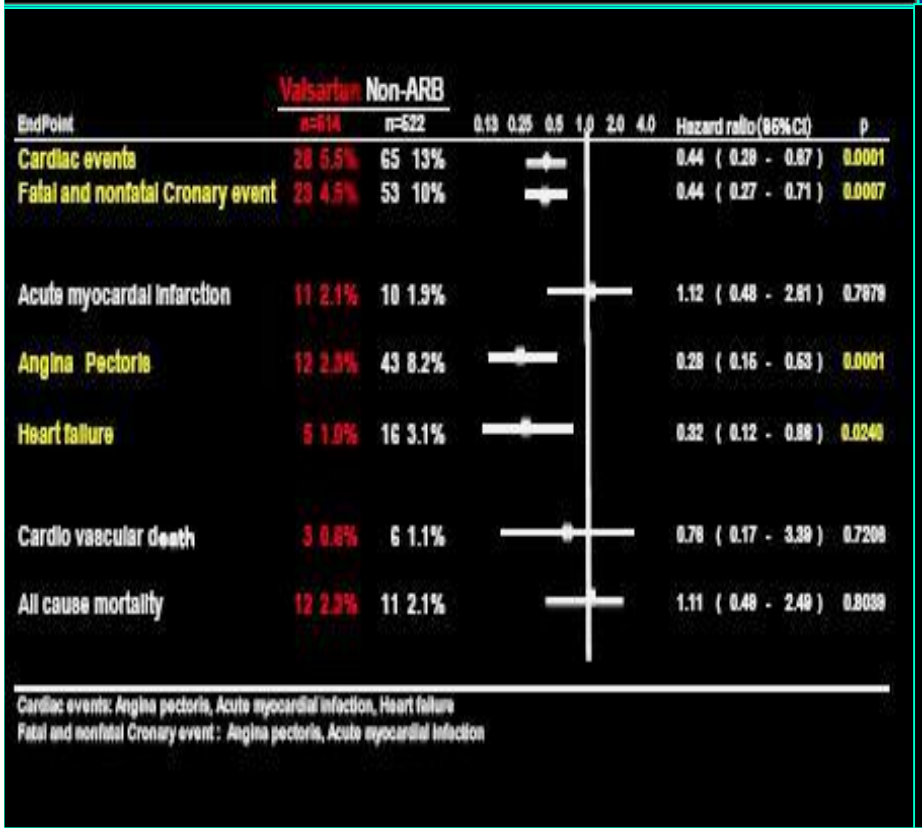
AIM

The risk of cardiac events in hypertensive patients with coronary artery disease (CAD) was higher than in those without CAD. We here report the result of a sub-analysis of a large-scale trial [JIKEI HEART Study (JHS)] which demonstrated that the addition of the angiotensin II receptor blocker (ARB) valsartan to standard cardiovascular treatments significantly reduced the primary composite endpoint of cardiovascular complications as compared with conventional treatments without ARB in Japanese patients.

Interpretation The addition of valsartan to conventional treatment prevented more cardiovascular events than supplementary conventional treatment. These benefits cannot be entirely explained by a difference in blood pressure control.







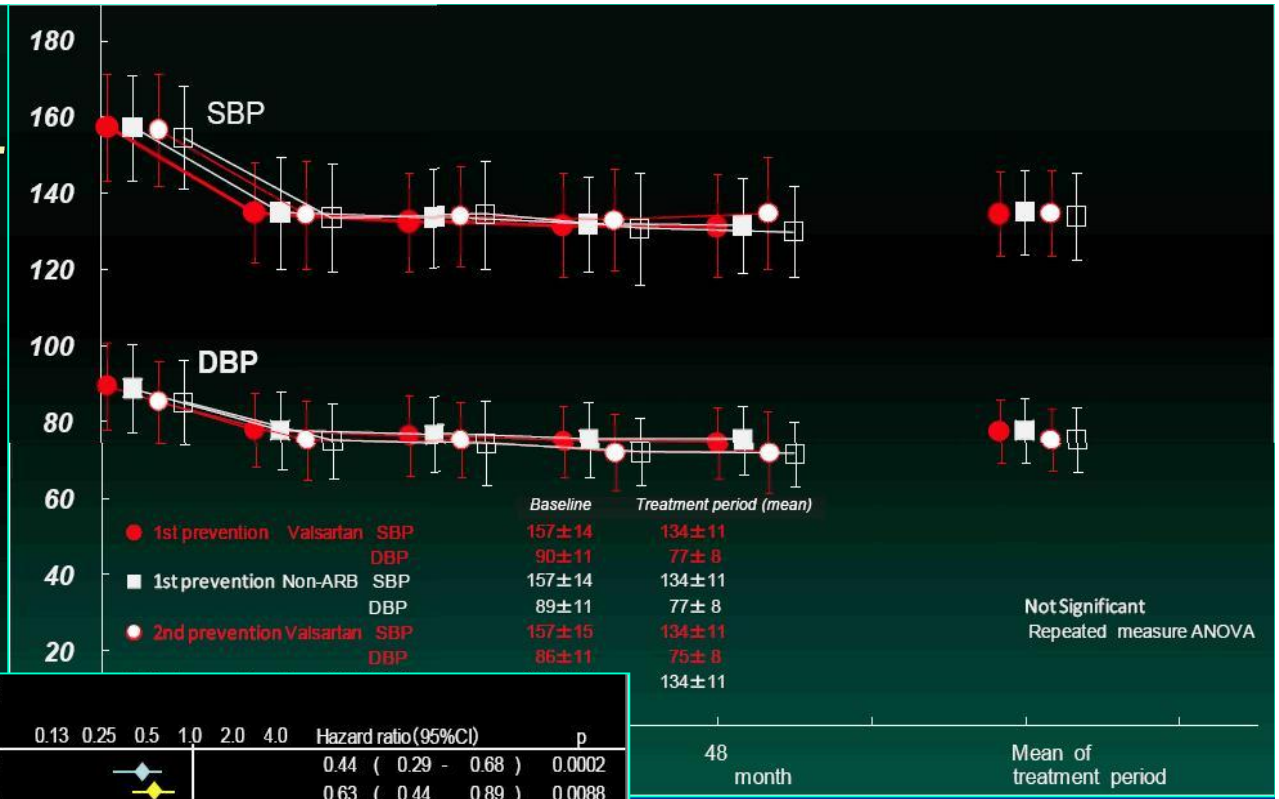
Conclusion

remodeling.

Представленное исследование доказывает, что БРА Валсартан значительно уменьшает случаи стенокардиии и ХСН у пациентов высокого кардиоваскулярного риска

rtan on ith high- risk hypertension: updated ancillary analyses

KYOTO HEART study

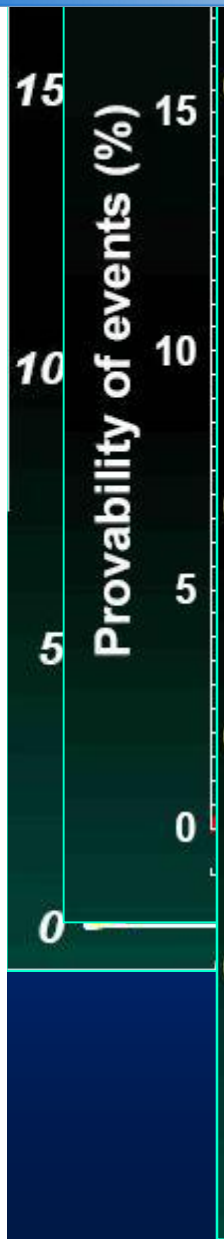


EndPoint	Prevention	Valsartan n=1065		Non-ARB n=1051		Hazard ratio (95%CI)	p
Primary endpoint	1st	32	3.0%	70	6.7%	0.44 (0.29 - 0.68)	0.0002
	2nd	52	11.5%	84	17.0%	0.63 (0.44 0.89)	0.0088
Acute myocardial infarction	1st	3	0.3%	4	0.4%	0.74 (0.17 - 3.30)	0.6931
	2nd	4	0.9%	7	1.4%	0.59 (0.17 - 1.99)	0.3902
Angina Pectoris	1st	8	0.8%	15	1.4%	0.53 (0.22 - 1.25)	0.1483
	2nd	14	3.1%	29	5.9%	0.51 (0.27 - 0.97)	0.0397
Heart failure	1st	2	0.2%	5	0.5%	0.39 (0.08 - 2.03)	0.2659
	2nd	11	2.4%	20	4.1%	0.59 (0.28 - 1.23)	0.1594
Stroke	1st	14	1.3%	29	2.8%	0.45 (0.24 - 0.86)	0.0152
	2nd	11	2.4%	17	3.4%	0.65 (0.30 - 1.40)	0.2708
Dissecting aneulism of aorta	1st	2	0.2%	4	0.4%	0.49 (0.09 - 2.69)	0.4141
	2nd	1	0.2%	1	0.2%	1.02 (0.06 - 16.3)	0.9864
Lower limb arterial obstruction	1st	1	0.1%	4	0.4%	0.25 (0.03 - 2.20)	0.2103
	2nd	10	2.2%	8	1.6%	1.47 (0.56 - 3.87)	0.4352
Transition to dialysis or doubling serum creatinine level	1st	3	0.3%	9	0.9%	0.32 (0.09 - 1.20)	0.0912
	2nd	3	0.7%	5	1.0%	0.61 (0.15 - 2.56)	0.5033
All cause mortality	1st	9	1.2%	14	1.3%	0.73 (0.31 - 1.73)	0.4730
	2nd	13	0.7%	18	3.7%	0.74 (0.36 1.52)	0.4071
Cardio vascular death	1st	3	0.5%	5	0.5%	0.59 (0.14 - 2.47)	0.4722
	2nd	5	1.1%	8	1.6%	0.64 (0.21 2.01)	0.4494

Cardiovascular events: Angina pectoris, Acute myocardial infaction, Heart failure

11.0%

TIA SAH Bleeding Infarction* Total



- Valsartan was more effective for both primary prevention (3.0% vs 6.7%) and secondary prevention (11.5% vs

Валсартан более эффективен для первичной и вторичной профилактики инсульта

Комбинация валсартана +БКК показывает более выраженное снижение первичной КТ, чем без валсартана

Предупреждение инсульта с помощью валсартана более эффективно снижает частоту церебральных инфарктов без усиления кровотечения

Валсартан значительно эффективен для предупреждения стенокардии напряжения, но не для нестабильной стенокардии

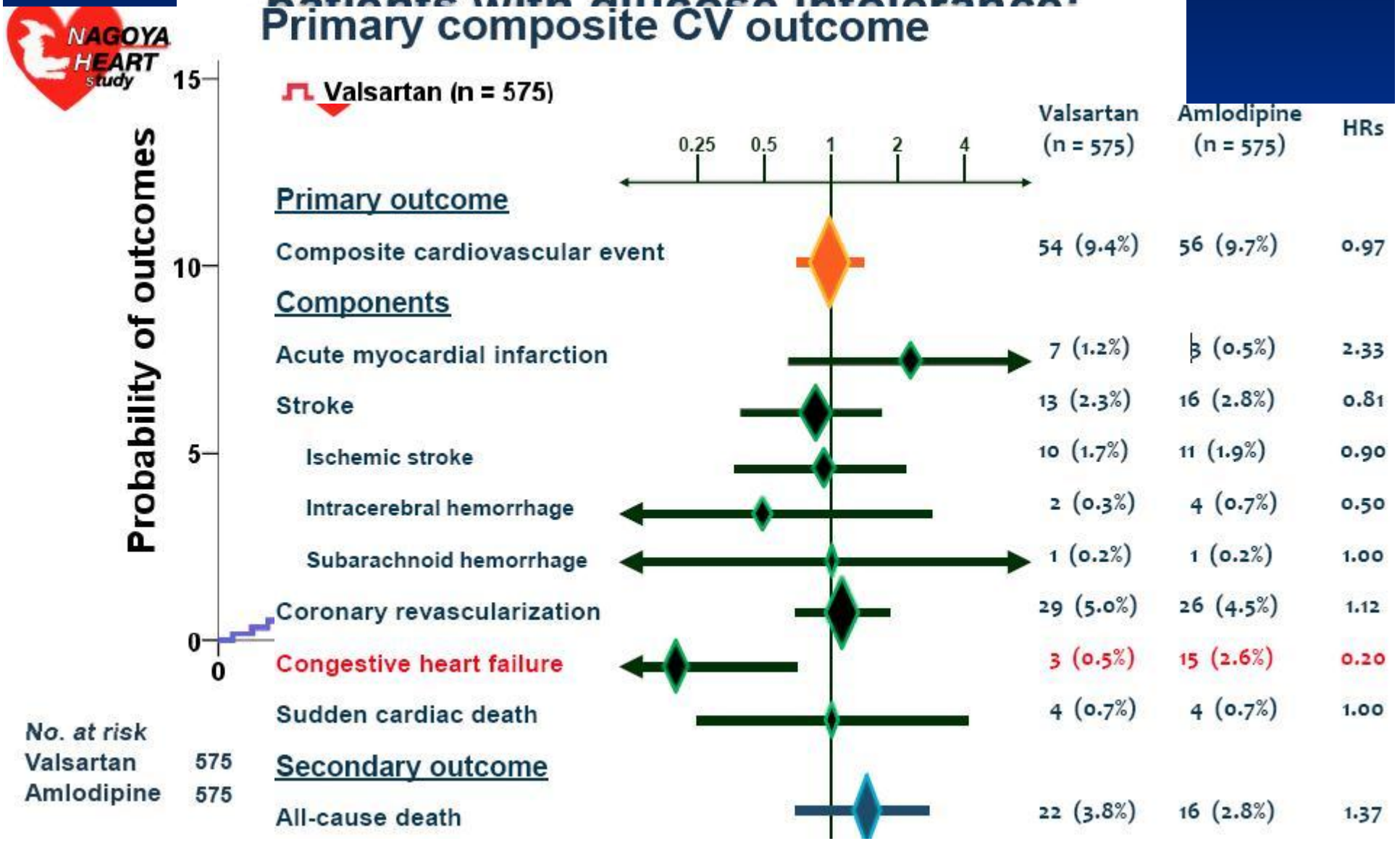
ЛОКАТОРОВ РАС У ПАЦИЕНТОВ С АГ+СД 2 тип

	NC7 2003	ADA 2004	ESC-ESH 2007	JSH 2009
ACEIs	◎	◎	◎	◎
ARBs	◎	◎	◎	◎
CCBs				
β-blockers				
α-blockers				
Diuretics				

Trials	n	DM	Control	CV outcomes	HRs	(95% CIs)
LIFE DM-subgroup (2001)	1195	100%	BB	**Composite**	**0.76**	**(0.6-0.98)**
				CV death	0.63	(0.4-0.95)
				Acute MI	0.83	(0.6-1.3)
				Stroke	0.79	(0.6-1.1)
IDNT CV outcomes-analysis (2003)	1146	100%	CCB	**Composite**	**0.90**	**(0.7-1.1)**
				CV death	1.36	(0.9-2.1)
				Acute MI	1.54	(0.97-2.5)
				PCI/CABG	0.93	(0.6-1.6)
				Heart Failure	0.65	(0.5-0.9)
				Stroke	1.55	(0.8-2.9)
VALUE (2004)	15245	34%	CCB	**Composite**	**1.04**	**(0.9-1.2)**
				CV death	1.01	(0.9-1.2)
				Acute MI	1.20	(1.0-1.4)
				Heart Failure	0.89	(0.8-1.03)
CASE-J (2008)	4728	43%	CCB	**Composite**	**1.01**	**(0.8-1.3)**
				Sudden death	0.73	(0.3-1.6)
				Acute MI	0.95	(0.5-1.8)
				Stroke	1.28	(0.9-1.9)
				Angina	0.57	(0.2-1.4)
				Heart Failure	1.25	(0.7-2.4)

arison between valsartan and pine regarding cardiovascular rbidity and mortality in hypertensive patients with glucose intolerance:

Primary composite CV outcome



	Valsartan (n = 575)	Amlodipine (n = 575)	HRs
Primary outcome			
Composite cardiovascular event	54 (9.4%)	56 (9.7%)	0.97
Components			
Acute myocardial infarction	7 (1.2%)	3 (0.5%)	2.33
Stroke	13 (2.3%)	16 (2.8%)	0.81
Ischemic stroke	10 (1.7%)	11 (1.9%)	0.90
Intracerebral hemorrhage	2 (0.3%)	4 (0.7%)	0.50
Subarachnoid hemorrhage	1 (0.2%)	1 (0.2%)	1.00
Coronary revascularization	29 (5.0%)	26 (4.5%)	1.12
Congestive heart failure	3 (0.5%)	15 (2.6%)	0.20
Sudden cardiac death	4 (0.7%)	4 (0.7%)	1.00
Secondary outcome			
All-cause death	22 (3.8%)	16 (2.8%)	1.37

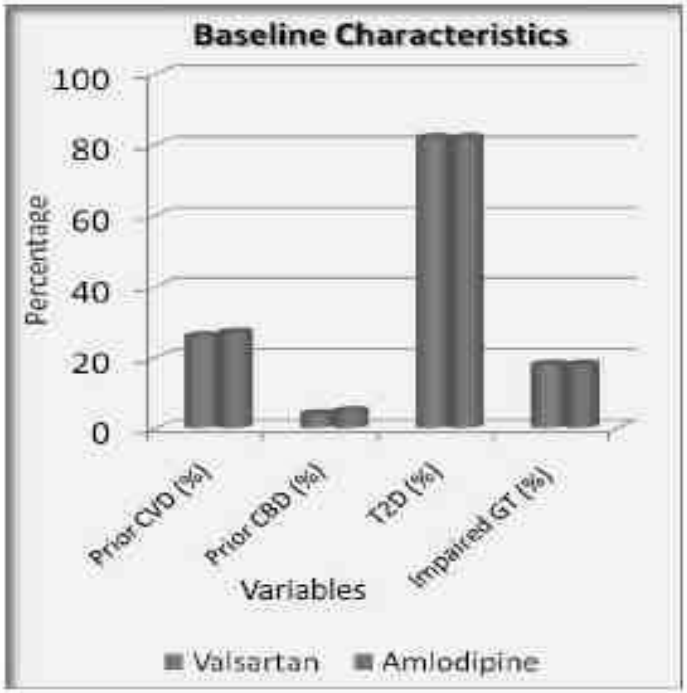
ДУ ВАЛСАРТАНОМ И АМЛОДИПИНОМ В УМЕНЬШЕНИИ НОЙ ЗАБОЛЕВАЕМОСТИ И СМЕРТНОСТИ У ПАЦИЕНТОВ С САХАРНЫМ ДИАБЕТОМ

NAGOYA HEART

Comparison between Valsartan and Amlodipine regarding Cardiovascular Morbidity and Mortality in Hypertensive Patients with Glucose Intolerance

BACKGROUND: Various guidelines recommended angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor-1 blockers (ARBs) for hypertensive patients with diabetes on the basis of the cardiac- and reno-protective effects of these drugs. Despite these recommendations, these guidelines could not be extrapolated to Japanese patients, because Japan has been known as a country with a low incidence of coronary artery disease and a high incidence of cerebrovascular disease.

PURPOSE: To test whether ARBs or CCBs are superior in treating Japanese diabetic hypertensive patients.



DESIGN: A prospective randomized open-label blinded-endpoint study to compare valsartan and amlodipine, and their effectiveness on cardiovascular morbidity and mortality in 1150 Japanese hypertensive patients with glucose intolerance.

PRIMARY ENDPOINT: Composite cardiovascular events - myocardial infarction, stroke, admission due to heart failure, coronary intervention and sudden cardiac death.

SECONDARY ENDPOINTS: Total death; cardiac function evaluated by ultrasonography; incidence of atrial fibrillation/flutter; control of blood glucose; and renal function.

RESULTS: Study showed no difference between valsartan-based and amlodipine-based antihypertensive treatment in preventing composite cardiovascular outcomes. Valsartan-based treatment significantly reduced risk of CHF when compared to the amlodipine-based treatment.

CONCLUSION: Results highlight the safety and efficacy of an ARB valsartan in preventing HF and support current recommendations for hypertensive diabetic patients.

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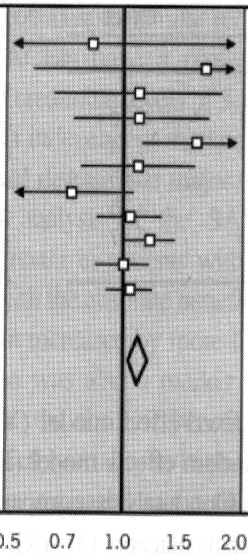
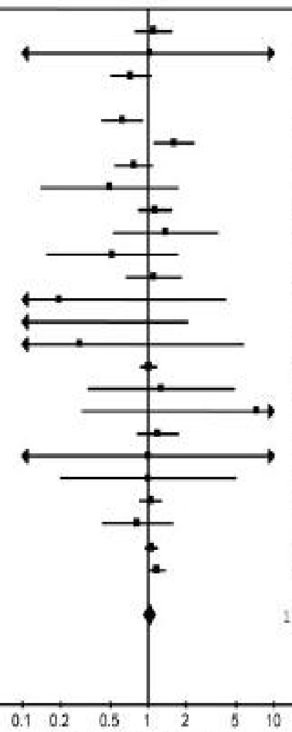
Trial	ARB n/N (MI)	Control n/N (MI)	Weight %	Odds Ratio 95% CI
ELITE	3 / 352	4 / 370	0.25	0.79 (0.17 to 3.54)
DETAIL	9 / 120	6 / 130	0.34	1.68 (0.58 to 4.86)
ELITE II	31 / 1,578	28 / 1,574	1.78	1.11 (0.66 to 1.85)
IDNT	39 / 579	66 / 1,136	2.69	1.17 (0.78 to 1.76)
CHARM-Alt	75 / 1013	48/ 1,015	2.87	1.61 (1.11 to 2.34)
SCOPE	70 / 2,477	63 / 2,460	3.97	1.11 (0.78 to 1.56)
RENAAL	50 / 751	68 / 762	4.08	0.73 (0.50 to 1.06)
LIFE	198 / 4,605	188 / 4,588	11.66	1.05 (0.86 to 1.29)
VALUE	369 / 7,649	313 / 7,596	19.34	1.18 (1.01 to 1.38)
OPTIMAAL	384 / 2,744	379 / 2,733	21.13	1.01 (0.87 to 1.18)
VALIANT	587 / 4,909	559 / 4,909	31.84	1.06 (0.93 to 1.20)
TOTAL	26,777	27,273		



Total (95% CI)
Total Events: 1,826 (ARB), 1,722 (Control)
Test for heterogeneity. Chi^2 = 11.7 df=10 (p=0.32), I^2 = 14.6%
Test for overall effect: Z = 2.18 (p=0.03)

"Angiotensin Receptor Blockers Do Not Increase Risk of Myocardial Infarction"
Tsuyuki RT, McDonald MA- Circulation-2006-114-855-860

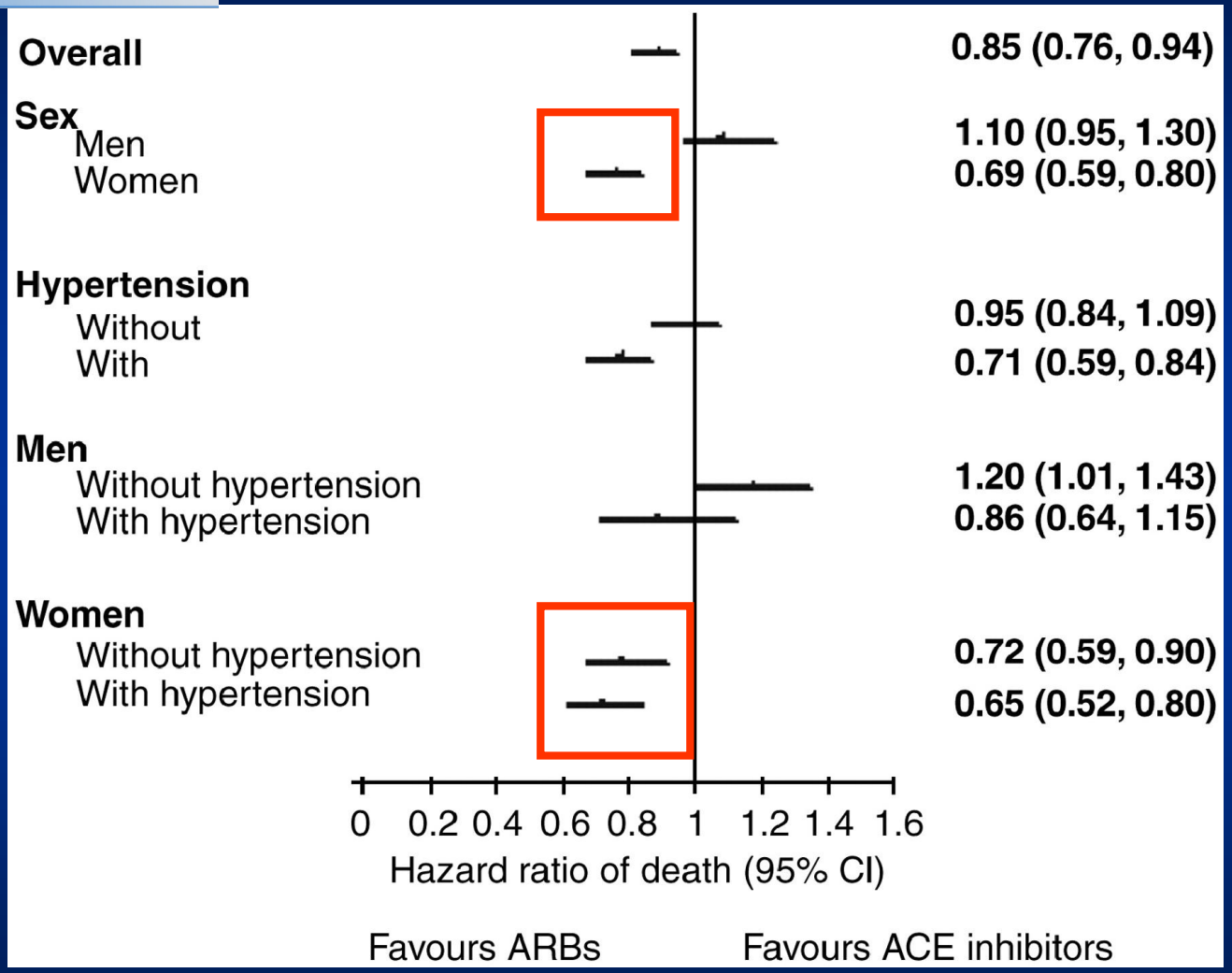
Study	ARB Group n/N	Control Group n/N	Weight %	OR (random) 95% CI
SCOPE (2003)	70/2477	63/2460	5.60	1.11 [0.78, 1.56]
Haneda et al. (2004)	1/95	0/32	0.09	1.03 [0.04, 25.96]
RENAAL (2001)	50/751	68/762	4.83	0.73 [0.50, 1.06]
ARCH-J (2003)	0/148	0/144		Not estimable
CHARM-Added (2003)	44/1276	69/1272	4.71	0.62 [0.42, 0.92]
CHARM-Alternative (2003)	75/1013	48/1015	4.97	1.61 [1.11, 2.34]
CHARM-Preserved (2003)	57/1514	73/1509	5.39	0.77 [0.54, 1.10]
SPICE (2000)	5/179	5/91	0.54	0.49 [0.14, 1.75]
Val-HeFT (2001)	89/2506	78/2494	6.57	1.14 [0.84, 1.55]
DETAIL (2004)	10/120	8/130	0.92	1.39 [0.53, 3.64]
ELITE (1997)	4/352	8/370	0.59	0.52 [0.16, 1.74]
ELITE II (2000)	31/1578	28/1574	2.91	1.11 [0.66, 1.85]
HEAVEN (2002)	0/70	2/71	0.10	0.20 [0.01, 4.18]
REPLACE (2001)	0/301	1/77	0.09	0.08 [0.00, 2.10]
Di Pasquale et al. (1999)	0/23	3/50	0.10	0.29 [0.01, 5.82]
OPTIMAAL (2002)	384/2744	379/2733	14.04	1.01 [0.87, 1.18]
Spinar et al. (2000)	5/100	4/101	0.48	1.28 [0.33, 4.90]
Bakris et al. (2002)	1/118	0/287	0.09	7.34 [0.30, 181.49]
IDNT (2003)	40/579	73/1136	4.67	1.20 [0.81, 1.77]
ALPINE (2003)	1/196	1/196	0.11	1.00 [0.06, 16.10]
Kondo et al. (2003)	3/203	3/203	0.34	1.00 [0.20, 5.01]
LIFE (2002)	198/4605	188/4588	10.91	1.05 [0.86, 1.29]
MOSES (2005)	17/710	20/695	1.90	0.83 [0.43, 1.59]
VALIANT (2003)	587/4909	559/4909	16.12	1.06 [0.93, 1.20]
VALUE (2004)	369/7649	313/7596	13.96	1.18 [1.01, 1.38]
Total (95% CI)	34216	34495	100.00	1.03 [0.93, 1.13]



Total events: 2045 (ARB Group), 1994 (Control Group)
Test for heterogeneity: Chi^2 = 31.08, df = 23 (P = 0.12), I^2 = 26.0%
Test for overall effect: Z = 0.55 (P = 0.58)

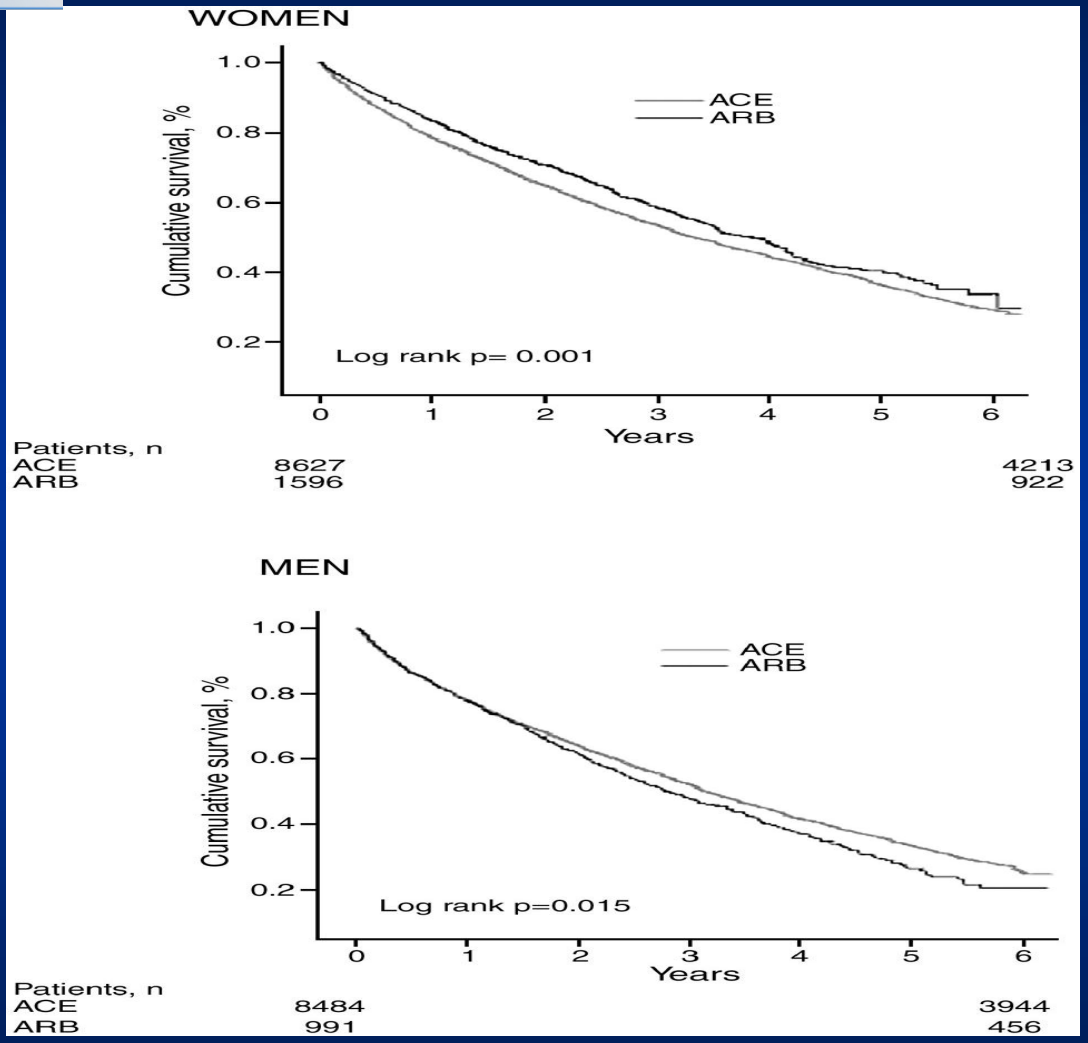
Strauss M., Hall A. Angiotensin Receptor Blockers May Increase Risk of Myocardial Infarction: Unraveling the ARB-MI Paradox // Circulation. — 2006. — Vol. 114. — P. 838-854.

os and 95% confidence intervals of survival in patients with CHF ns for ARBs compared to ACE inhibitors according to sex and the presence or absence of hypertension.



Hudson M et al. Eur J Heart Fail 2007;9:602-609

er curves for women and men prescribed an ARB or an ACE inhibitor of discharge from an admission for congestive heart failure.



Hudson M et al. Eur J Heart Fail 2007;9:602-609

БЕЗОПАСНОСТЬ БРА: где миф, а где реальность

ET Oncology

Angiotensin-receptor blockade and risk of cancer: meta-analysis of randomised controlled trials

Methods

We searched Medline, Scopus (including Embase), Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and the US Food and Drug Administration website for studies published before November, 2009, that included any of the seven currently available ARBs. Randomised controlled trials with an ARB given in at least one group, with a follow-up of at least 1 year, and that enrolled at least 100 patients were included. New-cancer data were available for 61 590 patients from five trials. Data on common types of solid organ cancers were available for 68 402 patients from five trials, and data on cancer deaths were available for 93 515 patients from eight trials.

Interpretation

This meta-analysis of randomised controlled trials suggests that ARBs are associated with a modestly increased risk of new cancer diagnosis. Given the limited data, it is not possible to draw conclusions about the exact risk of cancer associated with each particular drug. These findings warrant further investigation.

The Lancet Oncology, Volume 11, Issue 7, Pages 627 - 636, July 2010

FDA Drug Safety Communication: Ongoing safety review of the angiotensin receptor blockers and cancer

Additional Information for Healthcare Professionals

- Know that FDA's meta-analysis of 31 randomized controlled trials comparing ARBs to other treatment found no evidence of an increased risk of incident (new) cancer, cancer-related death, breast cancer, lung cancer, or prostate cancer in patients receiving ARBs.
- Report adverse events involving ARB medications to the FDA MedWatch program, using the information in the "Contact Us" box at the bottom of the page.

Additional Information for Patients

- Do not stop taking your ARB medication without talking to your healthcare professional.
- Discuss any questions or concerns about ARB medications with your healthcare professional.
- Report any side effects you may experience to the FDA MedWatch program using the information in the "Contact Us" box at the bottom of the page.

Применение валсартана у больных с ИБС, постинфарктным кардиосклерозом через 12 мес после операции АКШ +АЭ

осле операции АКШ + Аневризмэктомия блюдались в течение 12 мес

Клінічна характеристика	Показник
Вік, роки	56,38 ± 9,28
Чоловіки	133 (89,6%)
Жінки	15 (10.1%)
Курці	101 (68%)
Гіпертонічна хвороба	86 (58.1%)
Цукровий діабет тип 2	14 (9,4%)
Стенокардія напруги	112 (75,67%)

Локалізація ІМ:	
передньо-перетинково-верхівковий	69 (46,6%)
передньо-перетинково-верхівково-боковий	31 (20,9%)
циркулярне ураження	29 (19,6%)
ураження ЗСЛШ та верхівки ЛШ	19 (12,8%)

Лечение пациентов до и после операции АКШ+АЭ

	До операції АКШ+АЕ n=148	Через 1 рік після операціїАКШ+АЕ n=137
β-блокатори	142 (95,9%)	101 (73,7%)
Інгібітори АПФ	145 (97,9%)	90 (66,5%)
БРА (ВАЛЬСАКОР)	0	18 (20%)
спіронолактон	67 (45,3%)	37 (27%)
діуретики	63 (45,9%)	56 (37,8%)
статини	148 (100%)	72 (52,5%)
нітрати	131 (88,5%)	38 (27%)
НМГ	148 (100%)	0 (0%)
аспірин	0 (0%)	98 (67,2%)
клопідогрель	0 (0%)	21 (15,3%)
непрямі антикоагулянти	0 (0%)	12 (8,8%)
аміодарон	6 (4,1%)	38 (27,7)

...остояние больных, которые получали ...ез 12 мес после операции АКШ+АЭ

Клінічна характеристика	ІАПФ n=90	БРА n=18
Стенокардія напруги I-II ф.к.	32%	30%
II	40%	39%
III	17%	19%
IV	0%	0%

При непереносимости ИАПФ пациенты с ИБС, постинфарктным кардиосклерозом после операции АКШ+АЭ могут получать валсартан, что не ухудшает их клинического состояния

P>0.05