Effect of Dose and Combination of Antihypertensives on Interindividual Blood Pressure Variability

A Systematic Review

Alastair John Stewart Webb, BMBCh; Peter Malcolm Rothwell, FMedSci

Background and Purpose—Recent studies have shown that visit-to-visit blood pressure variability is a powerful risk factor for stroke, is reduced by calcium channel blockers and diuretics, and increased by β-blockers. However, it is unknown whether these effects are dose-dependent and persist in combination with other drugs.

Methods—Cochrane and Medline databases were searched for systematic reviews and randomized controlled trials of antihypertensive drugs. Eligible trials randomized all patients to a combination of drug classes or different doses of the same drug. Baseline and follow-up data for mean (SD) systolic blood pressure (SBP) and diastolic blood pressure were extracted. Differences in interindividual variance (SD²) in blood pressure were expressed as a ratio (VR). Estimates were pooled by random-effects meta-analysis.

Results—Calcium channel blockers reduced interindividual variability in SBP when added to another agent (VR, 0.75; 95% CI, 0.64 to 0.87; P = 0.0002; 12 trials; 1565 patients) with a smaller reduction with diuretics (VR, 0.85; 0.71 to 1.01; P = 0.07; 17 trials; 3217 patients). Adding other agents to calcium channel blockers did not significantly affect SBP variability (VR, 1.06; 0.83 to 1.34; P = 0.65; 12 trials; 1460 patients) despite a 5.8-mm Hg reduction in mean SBP. Randomization to a higher dose of calcium channel blockers reduced SBP variability (VR, 0.84; 0.74 to 0.94; P = 0.004; 25 trials; 2179 patients), whereas randomization to a higher dose of β-blockers increased SBP variability (VR, 1.31; 1.01 to 1.69; P = 0.034; 6 trials; 486 patients).

Conclusions—Effects of antihypertensive drugs on SBP variability are dose-dependent and persist when used in combinations. Use of a high dose of a calcium channel blocker alone or in combination with other agents is therefore likely to be particularly effective in prevention of stroke. (Stroke. 2011;42:2860-2865.)
previously described. The reference lists of all identified reviews and corresponding web tables were subsequently searched. To improve inclusion of recent trials, we also searched MEDLINE from May 1, 2007, to May 1, 2010, with the terms: (1) [Trial] AND ["blood(-)pressure lowering" OR "antihypertensive"] AND ["combination"]; and (2) [Trial] AND ["blood(-)pressure lowering" OR "antihypertensive"] AND ["low(-)dose" OR "high(-)dose" OR "dose(-)response"].

For every trial fulfilling our inclusion criteria (Supplemental Table I, http://stroke.ahajournals.org) and randomizing patients to a fixed combination or fixed doses of the same drug, the main results article was reviewed. Mean (SD) BP at baseline and at all follow-up visits were extracted.

Within-trial differences between treatment groups in interindividual variance (SD²) in BP were expressed as the ratio of the variances of group SBP at each visit (VR) as a surrogate measure of intraindividual variability (Figure 1). As previously shown in prospective cohorts, interindividual variance in SBP is dependent on both difference in mean SBP between individuals and intraindividual variability in SBP between different time points with 50% to 60% of interindividual variance in SBP at any specific time point being dependent on intraindividual variability between time points. Comparisons were pooled by random-effects meta-analysis using Mantel-Haenszel methods weighted by the inverse variance. Variance of VR was estimated from the natural logarithm of the 95% CI derived according to the F-distribution. The within-trial, between-group difference in the mean SBP or diastolic BP at follow-up was pooled by random-effects meta-analysis.

The analysis of dose–response included comparisons between different groups of patients randomized to different doses of the same drug (dose comparison) and between the same group of patients randomized to receive 1 dose of a drug and then receiving treatment with a higher dose of the same drug (dose escalation). For trials with >2 doses, each group was compared with the group receiving the highest dose of the drug. These within-trial comparisons were pooled across trials for each drug class. To assess the effect of drug classes on BP variability when used in combinations, only trials in which all patients were randomized to receive the allocated drugs in a specified regimen were used taking the group allocated to the highest dose of the combination and the SD at the follow-up closest to 1 year. Sensitivity analyses were performed in trials with <26 weeks of follow-up and, for all trials, taking the SD at median follow-up.

Comparisons analyzed were: (1) combination versus placebo ("AB versus Plac"); (2) combination versus monotherapy, including combinations containing the monotherapy treatment ("A versus AB") and combinations not containing the monotherapy treatment ("A versus BC"); (3) combinations versus other combinations, including comparisons in which the 2 combinations did not share a drug class ("AB versus CD") and where 1 drug class was the same in each combination ("AB versus AC"); and (4) trials in which SD was reported for a group of patients on a monotherapy treatment and then escalation to combination treatment for all patients ("A→AB"). These types of comparisons were then pooled for each specified drug class or drug combination as: (1) each drug class in combination compared with the combined agent alone (ie, all "A versus AB" and "A→AB" comparisons in which B is the assessed drug class); (2) each drug class alone compared with that drug class in combination with another (ie, all "A versus AB" + "A→AB" comparisons in which A is the assessed drug class); (3) each drug class in combination with any other agent versus any monotherapy or combination treatment not containing the drug class (ie, in which A is the drug: "AB versus XYZ" in which XYZ="B,” “C,” “BC,” or “CD”); and (4) specific combinations of drug classes versus placebo, another combination, or a monotherapy regimen.

Monotherapy comparisons between each drug class and placebo are presented as calculated in the previous meta-analysis, including only trials in which patients were taken off all previous antihypertensives and no additional medications were allowed during the trial.

Analyses were performed in SPSS Version 14.0 or Microsoft Excel 2007.

Figure 1. Distribution of SBP measurements at 1-year follow-up in the ASCOT-BPLA trial (data from Rothwell et al). The VR is calculated from the SD of the SBP measurements at a specific time point. SDₘₐₚ indicates SD of SBP measurements in amiodipine group; SDₐₜ, SD of SBP measurements in atenolol group; SBP, systolic blood pressure; ASCOT-BPLA, Anglo Scandinavian Cardiac Outcome Trial-Blood Pressure Lowering Arm; VR, variance.
Results

We identified 255 systematic reviews and meta-analyses, of which 68 were duplicate publications or reviewed trials in excluded patient groups. The remaining 187 meta-analyses generated 1858 citations to independent trials, resulting in 1372 eligible trials as described previously.4 Of these 1372 trials, 910 Phase 2 trials (71.2%) and 73 Phase 3 trials (77.7%) did not report the mean (SD) SBP or diastolic BP at baseline and follow-up. Of the remaining 389 trials, 38 randomized all patients in at least 1 group to a combination of drug classes, whereas 31 randomized patients to different fixed doses of the same agent (21 dose comparison and 10 dose escalation studies); w1-w38 whereas 31 randomized patients to different fixed doses of the same agent (21 dose comparison and 10 dose escalation studies; w15, w23, w26, w29, w39 to w64). The additional searches for combinations or doses generated 686 and 239 abstracts, respectively, of which 108 and 22 potentially eligible articles were reviewed in full, resulting in 30 additional trials (w65 to w94) with data on SD of SBP for combination treatment and 3 dose–response trials (w95 to w97). The combined searches gave 97 comparisons of BP variability for patients receiving combination therapy compared with placebo, monotherapy, or another combination and 60 comparisons of BP variability for patients on 1 dose of a drug compared with a higher dose of the same drug (see http://stroke.ahajournals.org).

The 97 trials of combination therapies or dose–response (29 020 patients) were mostly short-duration (≤26 weeks) Phase 2 studies (78%). The most common primary outcome was measured BP at follow-up (63%), whereas 18% reported a surrogate measure of cardiovascular disease (ie, arterial stiffness or proteinuria). Thirteen percent were crossover studies, and 6% of studies reported mean (SD) of SBP at >1 visit after 12 weeks.

The dose–response relationship for each drug class was assessed in 60 monotherapy comparisons. A higher versus lower dose of CCBs was associated with a significantly reduced VR and a higher dose of BB was associated with an increased VR with the pattern of increasing drug dose for each drug class being similar to that seen when adding each drug to placebo (Figure 2). All these CCB and BB comparisons were short-duration, Phase 2 trials, and exclusion of longer trials did not significantly affect comparisons with other drug classes. This pattern was also present in trials randomizing the same patients to different doses of the same agent in a forced titration schedule with a reduction in variability with increasing doses of CCBs and an increase in variability with BBs, although neither comparison was independently significant (VR for high dose versus low dose: CCBs, 0.89; 0.71 to 1.12; BB, 1.22; 0.83 to 1.77). There were no such trials using diuretics or angiotensin receptor blockers. There were insufficient dose comparisons to generate dose–response curves or determine if there is a threshold effect (ie, the minimum dose necessary to reduce VR) or identify a linear relationship between dose and BP variability. Similarly, there were insufficient trials to allow direct comparison of different drug doses when used within specific combinations.

Across 68 combination therapy trials, 15 comparison were between different specified combinations (3 “AB versus CD,” 12 “AB versus AC”), insufficient to draw conclusions about the effects of specific combinations in direct comparison. There were 22 “A versus AB” and “A→AB” comparisons in which 1 drug (B) was added to another agent compared with that agent alone (Figure 3A). There was a highly significant reduction in VR when adding a CCB to another drug class for a relatively small reduction in mean SBP and no significant reduction in VR when adding a BB despite a similar reduction in SBP. The overall pattern of drug class effects was the same in drug versus placebo comparisons in our previous meta-analysis (Figure 3B) and was unaltered when the analysis was limited to trials with <26 weeks of follow-up (CCBs: VR, 0.78; 0.68 to 0.95; P = 0.017; BB, 1.06; 0.58 to 1.93; P = 0.085). The magnitude of reduction in VR for 3 trials in which a CCB was added to a BB was similar to adding a CCB to any agent (VR, 0.76; 0.45 to 1.27; 124 patients), whereas 4 trials in which a BB was added to a CCB had no effect on VR (VR, 0.97; 0.44 to 2.11; 193 patients).

For the analysis of the difference in VR for each drug class as monotherapy compared with that class in combination with another (“A versus AB” or “A→AB” in which A is the class in question), there was no change in VR when adding another drug to a CCB, although mean SBP was reduced, whereas adding another drug to an angiotensin-converting enzyme inhibitor significantly reduced VR (CCBs: VR, 1.06; 0.83 to 1.34; P = 0.06; mean difference SBP = –0.08 mm Hg, 1460 patients, 12 comparisons; angiotensin-converting enzyme inhibitor: VR, 0.72; 0.61 to 0.86; P = 0.0003, difference SBP = –0.47 mm Hg). Adding another class to BBs, diuretics, or angiotensin receptor blockers nonsignificantly reduced VR.
For “AB versus XYZ” comparisons, there was a significant reduction in VR for combinations containing a CCB compared with treatment regimes not containing a CCB with a smaller reduction in VR for combinations containing a diuretic compared with regimens not containing a diuretic, and no significant differences with other drug classes (CCB: VR, 0.79; 0.66 to 0.95; 2564 patients; 20 comparisons; P = 0.012, mean difference SBP = -3.3 mm Hg; diuretics: VR, 0.85; 0.73 to 0.99; 5263 patients; 31 comparisons; P = 0.03, mean difference SBP = -4.4 mm Hg).

There were 12 comparisons of specific combinations with placebo; however, there were only sufficient trials to assess the addition of a CCB or a diuretic to an angiotensin-converting enzyme inhibitor. These demonstrated a reduction in VR (Figure 4) for the addition of either drug to an angiotensin-converting enzyme inhibitor. Although the pooled reduction in VR with CCB+angiotensin-converting enzyme inhibitor versus placebo was less than CCB versus placebo, this difference resulted from 1 trial that used only 2.5 mg amlodipine in combination with 10 mg benazepril. Excluding this low-dose trial, the reduction in VR is equivalent to that seen with CCB versus placebo (VR, 0.70; 0.58 to 0.86; P = 0.0003; n = 769).

**Discussion**

We recently showed that increased visit-to-visit variability in SBP is associated with an increased risk of stroke, independently of mean BP, that visit-to-visit variability in SBP is reduced by CCBs and increased by BBs, and that these effects correlate with class differences in effectiveness in preventing stroke in randomized controlled trials. However, a previous meta-analysis suggested that low-dose combinations of anti-
hypertensive drugs had an equivalent impact on mean BP compared with higher doses of monotherapies and would therefore result in an equal reduction in the risk of stroke. Another meta-analysis from the same group suggested only minimal differences between antihypertensive drug classes. The majority of hypertensive patients currently escalate to combination treatment, but these studies have led to proposals to initiate antihypertensive treatment with low-dose combinations. Therefore, we determined how combining drug classes affects visit-to-visit variability in SBP and whether effects on variability are diminished with low-dose treatment.

This meta-analysis showed that higher doses of CCBs reduce BP variability more than lower doses, and higher doses of BBs increase BP variability. Thus, combinations containing a low dose of BB will have less adverse effects on variability in SBP and the associated risk of stroke, but low doses of CCBs will be less effective in reducing variability in BP and hence their use would be anticipated to lead to less reduction in the risk of stroke.

We also showed that drug class effects on variability in SBP persisted when drugs were used in combination. In particular, adding a CCB or diuretic to another antihypertensive drug reduced variability in SBP to the same extent as when seen with monotherapy versus placebo. In contrast, adding an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker to another class had no significant impact on variability in SBP. Addition of a CCB to a BB had an equivalent effect compared with addition of a CCB to any other agent, whereas addition of a BB to a CCB did not increase VR, although there were few trials to draw definitive conclusions about BBs. This suggests that the use of CCBs may partly nullify the detrimental impact of BBs on variability in SBP. For other classes, the effect of each class in combination was the same as when used as monotherapy, suggesting the mechanism of action of CCBs on variability in SBP is either dominant or independent of the mechanism of action of diuretics, angiotensin-converting enzyme inhibitors, or angiotensin receptor blockers.

The main limitations of this review result from the small number of trials randomizing patients to specific drug combinations and reporting measures of BP variability relative to the large number of possible comparisons. First, by pooling different combinations of classes, the results could be confounded by the frequency with which each class is combined with or compared with another. However, this could not result in bias in the main analysis of “A versus AB” in which the combination drug is balanced between groups. Second, there were insufficient trials to measure the dose–response of agents when used as part of a combination. However, given the equivalent effect of each class when used in combination compared with monotherapy, extrapolating the effect of dose in monotherapy comparisons to the effect of dose in combinations is valid. Third, the small number of trials means that we were unable to directly assess the impact of combinations of classes in use for specific indications. For example, there are no trials using the theoretically ideal combination (in terms of reducing variability in SBP) of a CCB and a diuretic, and so we were unable to assess whether reduction in BP variability with these 2 classes is additive, synergistic, or redundant. Felodipine Event Reduction (FEVER) randomized patients to hydrochlorothiazide versus hydrochlorothiazide plus felodipine, but there was only a small additional reduction in BP variation in the CCB group (VR, 0.90; 0.85 to 0.96) due to the low dose of felodipine (5 mg) used in FEVER. In addition, higher doses of hydrochlorothiazide were used in the monotherapy arm than the combination arm, reducing any differences in variability in SBP between the groups. Fourth, these results are not explicable by more patients responding to regimens with a lower variability: the magnitude of difference in VR (a 25% reduction with CCBs) would require a greater proportion of responders to CCBs compared with other classes than is usually seen, including in ASCOT-BPLA; large differences in the proportion of patients responding would result in a greater reduction in mean SBP. We would not expect a greater variability with a higher dose of BBs versus reduced variability with a higher dose of CCBs, especially given the similar reductions in mean SBP. Finally, this analysis is by necessity a post hoc analysis because no randomized controlled trials prospectively assessed the effect of regimens on SBP variability or cardiovascular outcomes.

In relation to the place of combination therapy with CCBs for stroke prevention in current clinical practice, the combination of perindopril and indapamide is widely used in secondary stroke prevention and in the elderly following the results of the Perindopril Protection Against Recurrent Stroke Study (PROGRESS) and Hypertension in the Very Elderly (HYVET) trials. Our analyses suggest that addition of a CCB to this combination will further reduce the risk of future stroke, but there were no eligible trials directly addressing this possibility. In addition, angiotensin-converting enzyme inhibitors and angiotensin receptor blockers are recommended in patients with renal impairment or diabetic nephropathy. Variability in SBP and stroke risk were both increased by randomization to an angiotensin-converting enzyme inhibitor compared with other antihypertensive drug classes in our previous meta-analysis, but this meta-analysis suggests that the possible detrimental effect of these drugs on variability in SBP may be offset by combination use with CCBs, allowing their use for these indications without causing harm. This may provide a potential explanation for the improved renal outcomes in the angiotensin-converting enzyme inhibitor + CCB group in the Avoiding Cardiovascular events through COMbination therapy in Patients Living with Systolic Hypertension (ACCOMPLISH) trial. More research is required to identify ideal combinations and doses of drugs for the prevention of stroke in specific patient groups with particular reference to effects on variability in BP.

Conclusions

The reduction in variability in SBP seen with calcium channel blockers and diuretics when used as monotherapy is maintained when the drugs are used in combination with other classes. However, the effects of CCBs and BBs on variability in BP depend on dose with important implications for the effectiveness of low-dose combination treatment in preventing stroke. Use of a high-dose of a CCB alone or in
combination with other agents is likely to be particularly effective in prevention of stroke.

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**Disclosures**
None.

**References**
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SUPPLEMENTAL DATA

EFFECT OF DOSE AND COMBINATION OF ANTIHYPERTENSIVES ON INTER-
INDIVIDUAL BLOOD PRESSURE VARIABILITY: A SYSTEMATIC REVIEW

Webb AJS, Rothwell PM

Stroke Prevention Research Unit, Department of Clinical Neurology,
University of Oxford

 Correspondence to:
Prof P M Rothwell
Stroke Prevention Research Unit,
Department of Clinical Neurology
John Radcliffe Hospital
Headington
Oxford OX3 9DU
United Kingdom

TEL: (44) 1865 231610
FAX: (44) 1865 234639
E-mail: peter.rothwell@clinero.ox.ac.uk
Inclusion Criteria

- Controlled trials, group allocation by randomisation, minimisation or similar
- Reported in peer-reviewed journal available in the British Library.
- >2 weeks of follow-up.
- Any language.
- Reports number of patients and mean and standard deviation at both baseline and follow-up of either systolic or diastolic blood pressure.
- Trials must contain either: one group wherein all patients are randomised to a combination of drug classes or two groups randomised to different doses of the same drug.

Exclusion Criteria

- Trials requiring a recent acute cardiovascular event (within 3 months of a stroke, myocardial infarction or chest pain requiring intervention)
- Trials requiring patients with: active left ventricular failure (symptomatic or ejection fraction <40%), portal hypertension, severe liver disease, pulmonary hypertension, dialysis dependent renal failure, major life-limiting disease or disease causing significant functional impairment (excluding stroke more than 3 months prior to randomisation).

Data Collection

- Trial validity: Randomisation, blinding, intention-to-treat analysis, washout of prior medications.
- Inclusion/exclusion criteria
- Demographic characteristics: Number of patients, age, gender, ethnicity and disease characteristics.
- Treatment: Dose, frequency and duration of treatment with trial agents, pre-existing and maintained medications affecting blood pressure and any add-on antihypertensives during the trial.
- Results: The baseline and follow-up measures of systolic and diastolic blood pressure and the associated standard deviation at each timepoint recorded in the trial, if reported numerically.
Web-figure 1. Standard deviation at follow-up plotted against logarithm of group size for all drug groups allocated CCBs or BBs. The distributions are symmetrical without clear reporting bias and the large trials accurately reflect the average of smaller trials.


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References


42. Sluiter HE Felodipine in hypertensive patients. A dose finding study in patients refractory to beta-blocker monotherapy. Drugs. 1987; 34 s 3: 97-106


60. Lefebvre J, Poirier L, Archambault F, Jewell D, Reed CV, Lacourcière Y. Comparative effects of felodipine ER, amlopidine and nifedipine GITS on 24 h blood pressure control and trough to peak ratios in mild to moderate ambulatory hypertension: a forced titration study. *Can J Cardiol*. 1998; 14: 682-688


64. Bojestig M, Karlberg BE, Lindström T, Nyström FH. Reduction of ACE activity is insufficient to decrease microalbuminuria in normotensive patients with type 1 diabetes. *Diab Care*. 2001; 24: 919-924


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개인 간 혈압 변동성에 대한 항고혈압제의 용량 및 조합의 효과
체계적 고찰

Effect of Dose and Combination of Antihypertensives on Interindividual Blood Pressure Variability
A Systematic Review
Alastair John Stewart Webb, BMBCh; Peter Malcolm Rothwell, FMedSci
(Stroke. 2011;42:2860-2865.)

Key Words: antihypertensive □ blood pressure variability □ dose □ stroke □ systematic review

배경과 목적
최근 연구 결과, 방문 간(visit-to-visit) 혈압 변동성이 뇌졸중의 강력한 위험 인자로, 칼슘통로차단제(calcium channel blocker) 및 이뇨제(diuretic)에 의해서는 줄어들고 베타차단제(β-blocker)에 의해서는 증가한다고 보고되었다. 그러나 이러한 효과가 용량 의존적인지 다른 약물과 함께 병용할 경우에도 지속되는지에 대해서는 알려지지 않았다.

방법
Cochrane과 Medline 데이터베이스 내에서 항고혈압제에 대한 체계적 문헌 고찰 및 무작위 배정 연구를 검색하였다. 적정한 연구들의 환자들은 다른 계열 약물의 병용 또는 동일 약물의 다른 용량으로 무작위로 배정되었다. 수측기 및 이완기 혈압 평균(SD)의 기초 및 추적값을 추출하였다. 혈압의 개인 간 분산의 차이(SD)는 분산(VR)으로 표현되었다. 무작위-효과 메타분석으로 추정값을 통합하였다.

결과
칼슘통로차단제를 다른 약제에 추가할 경우 수측기 혈압의 개인 간 변이가 감소하였고(VR, 0.75; 95% CI, 0.64~0.87; P=0.002; 12개 연구, 1,565명), 이뇨제 추가 시 감소 정도가 적었다(VR, 0.85; 95% CI, 0.71~1.01; P=0.07; 17개 연구, 3,217명). 칼슘통로차단제에 다른 약제를 추가하면 평균 수측기 혈압은 5.8 mm Hg 감소하였으나 수측기 혈압 변동성에는 영향을 미치지 않았다(VR, 1.06; 0.83~1.34; P=0.65; 12개 연구, 1,460명). 고용량의 칼슘통로차단제로 무작위 배정된 경우 수측기 혈압 변동성이 감소하였으나(VR, 0.84; 0.74~0.94; P=0.004; 25개 연구, 2,179명), 고용량의 베타차단제로 무작위 배정된 경우 오히려 수측기 혈압 변동성이 증가하였다(VR, 1.31; 1.01~1.69; P=0.034; 6개 연구, 486명).

결론
수측기 혈압 변동성에 대한 항고혈압제의 효과는 용량의 의존적 이며 병용으로 사용할 경우에도 지속적으로 나타났다. 따라서 고용량의 칼슘통로차단제 단독 혹은 타 약물과의 병용 요법은 뇌졸중의 예방에 있어 특히 효과적인 수 있다.
Figure 2. Pooled estimates of the effect of within-trial comparisons of higher versus lower doses of the same drug on variability in systolic blood pressure at follow-up according to drug class. Estimates of variability in SBP are expressed as the ratio of variance (VR), VR and difference in mean SBP are pooled by random-effects meta-analysis with 95% CIs. CCB indicates calcium channel blockers; DD, diuretics; ARB, angiotensin receptor blockers; ACEI, angiotensin-converting enzyme inhibitors; BB, \( \beta \)-blockers; Het, heterogeneity; SBP, difference in mean SBP; Comp, comparison; SBP, systolic blood pressure.

A

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</tbody>
</table>

B

<table>
<thead>
<tr>
<th>VR</th>
<th>95%CI</th>
<th>N</th>
<th>Comp</th>
<th>pPool</th>
<th>pHet</th>
<th>SBP</th>
<th>95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCB</td>
<td>0.71 (0.61, 0.83)</td>
<td>2108</td>
<td>27</td>
<td>0.0001</td>
<td>0.36</td>
<td>-13.3</td>
<td>(-17.2, -9.4)</td>
</tr>
<tr>
<td>DD</td>
<td>0.87 (0.81, 0.93)</td>
<td>6646</td>
<td>17</td>
<td>0.0002</td>
<td>0.49</td>
<td>-9.23</td>
<td>(-12.1, -6.3)</td>
</tr>
<tr>
<td>ARB</td>
<td>0.91 (0.79, 1.06)</td>
<td>1499</td>
<td>9</td>
<td>0.39</td>
<td>0.55</td>
<td>-9.72</td>
<td>(-13.0, -6.5)</td>
</tr>
<tr>
<td>ACEI</td>
<td>0.93 (0.79, 1.09)</td>
<td>3589</td>
<td>33</td>
<td>0.52</td>
<td>0.004</td>
<td>-8.58</td>
<td>(-11.3, -5.9)</td>
</tr>
<tr>
<td>BB</td>
<td>1.11 (0.94, 1.32)</td>
<td>1055</td>
<td>15</td>
<td>0.38</td>
<td>0.97</td>
<td>-9.81</td>
<td>(-12.6, -7.0)</td>
</tr>
</tbody>
</table>

Figure 3. Pooled estimates of within-trial comparisons of the effect of each drug class on variability in systolic blood pressure at follow-up. A, Comparison of each class of drug in combination with another drug class versus the combination drug alone. B, Comparison of each class of drug as monotherapy versus placebo. B are data from our previous meta-analysis for trials in which no other antihypertensive drugs were allowed during the trial. Estimates are pooled by random-effects meta-analysis with 95% CIs. CCB indicates calcium channel blockers; DD, diuretics; ARB, angiotensin receptor blockers; ACEI, angiotensin-converting enzyme inhibitors; BB, \( \beta \)-blockers; Het, heterogeneity; SBP, difference in mean SBP; Comp, comparison; SBP, systolic blood pressure.

<table>
<thead>
<tr>
<th>VR</th>
<th>95%CI</th>
<th>N</th>
<th>Comp</th>
<th>pPool</th>
<th>pHet</th>
<th>SBP</th>
<th>95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCB</td>
<td>0.71 (0.61, 0.83)</td>
<td>2108</td>
<td>27</td>
<td>0.0001</td>
<td>0.36</td>
<td>-13.3</td>
<td>(-17.2, -9.4)</td>
</tr>
<tr>
<td>CCB+ACEI</td>
<td>0.82 (0.57, 1.17)</td>
<td>817</td>
<td>4</td>
<td>0.37</td>
<td>0.13</td>
<td>-14.0</td>
<td>(-26.8, -1.2)</td>
</tr>
<tr>
<td>DD</td>
<td>0.87 (0.81, 0.93)</td>
<td>6646</td>
<td>17</td>
<td>0.0002</td>
<td>0.49</td>
<td>-9.2</td>
<td>(-12.1, -6.3)</td>
</tr>
<tr>
<td>DD+ACEI</td>
<td>0.90 (0.53, 1.51)</td>
<td>457</td>
<td>3</td>
<td>0.54</td>
<td>0.17</td>
<td>-7.8</td>
<td>(-15.4, -0.2)</td>
</tr>
<tr>
<td>ACEI</td>
<td>0.93 (0.79, 1.09)</td>
<td>3589</td>
<td>33</td>
<td>0.52</td>
<td>0.004</td>
<td>-8.6</td>
<td>(-11.2, -5.9)</td>
</tr>
</tbody>
</table>

Figure 4. Pooled estimates of within-trial comparisons of the effect on variability in systolic blood pressure at follow-up of calcium channel blockers or diuretics as monotherapy or in combination with an ACEI compared with placebo. Monotherapy comparisons are data from our previous meta-analysis for trials in which no other antihypertensive drugs were allowed during the trial. Estimates are pooled by random-effects meta-analysis with 95% CIs. CCB indicates calcium channel blockers; DD, diuretics; ACEI, angiotensin-converting enzyme inhibitor; Het, heterogeneity; SBP, difference in mean SBP; Comp, comparison; SBP, systolic blood pressure.
降圧薬の用量および併用が個体間血圧変動へ及ぼす影響
——系統的レビュー——

Effect of Dose and Combination of Antihypertensives on Interindividual Blood Pressure Variability — A Systematic Review

Alastair John Stewart Webb, BMBCh; Peter Malcolm Rothwell, FMedSci
Stroke Prevention Research Unit, Department of Clinical Neurology, University of Oxford, Oxford, UK.

Stroke 2011; 42: 2860-2865

背景および目的：最近の研究において、降圧薬が個体間血圧変動へ及ぼす影響は、重要な視点となり、カルシウムチャネル遮断薬および利尿薬の影響が注目されている。しかし、これらの薬を併用した場合、特に降圧薬の用量が変化すると、個体間血圧変動が変化する可能性がある。そこで、本研究では、カルシウムチャネル遮断薬や利尿薬の用量を変化させた場合、個体間血圧変動の変化を調査した。

方法：CochraneおよびMedlineデータベースにおいて、降圧薬の用量変化および併用による影響を検討した。全薬の用量を変化させた群と用量を固定した群を比較し、個体間血圧変動の変化を調査した。

結果：カルシウムチャネル遮断薬の用量を増加させた群では、個体間血圧変動の変化が見られなかった（p = 0.05）。利尿薬の用量を増加させた群では、個体間血圧変動の変化が見られなかった（p = 0.03）。薬の併用での用量変化が見られなかった。なお、カルシウムチャネル遮断薬の用量を増加させた群では、個体間血圧変動の変化が見られた（p = 0.01）。

結論：降圧薬の用量変化および併用による影響を調査した結果、個体間血圧変動の変化が見られた。特に、カルシウムチャネル遮断薬の用量変化が見られなかった。なお、利尿薬の用量変化が見られた。