Stroke Prevention: Indapamide, a Forgotten Option?

To the Editor:

We have read with interest the article by MacWalter et al.1 the comment made by Fournier et al.2 and the authors’ reply. We would like to comment.

We disagree with some of the comments made by MacWalter et al. The recommendation of the use of angiotensin-converting enzyme inhibitors (ACEIs) cannot be made on the basis of the findings of PROGRESS.3 The risk reduction observed with perindopril was a nonsignificant 5%. As has been described elsewhere, the lack of a factorial design, which must have included a group on indapamide alone, makes it impossible to know how much, if any, of the reduction observed with the combination therapy is attributable to perindopril.4,5

We agree that the use of ACEI might be beneficial, but, although members of a drug class share main actions, they may have clinically important differences in terms of efficacy and safety,6 which might explain the differences encountered with the efficacy of ramipril7 and perindopril alone.8 Comparative clinical effectiveness can be determined only by large randomized outcome trials comparing these 2 drugs head-to-head, and without that information we cannot recommend the use of perindopril. In the view of the beneficial effects of ramipril7 and indapamide,8 it will be very interesting to know if the combination therapy with ramipril and indapamide is more effective than with each drug separately.

Finally, we would like to remind that it is now clear, in opposition to MacWalter et al, that indapamide is renoprotective. Since Gambardella et al published in 1991 the renoprotective effect of long-term indapamide treatment, defined as a reduction in urinary protein loss in patients with type 2 diabetes and persistent microalbuminuria,9,10 many other authors have reported the renoprotective effect of indapamide, this drug being as effective as ACEIs.9,10

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