journals were compared using descriptive and comparative chi-squared statistics.

RESULTS: 4,036 advertisements were identified from all issues in three General and three MC journals with 194 unique advertisements evaluated for potential outcomes messages. General and MC journals had QoL messages included in 36.0% and 41.7% of advertisements (p < 0.005) and pharmacoeconomic messages in 7.3% and 9.0% of advertisements (p = 0.08), respectively. MC journals had more advertisements detailing pharmaceutical expenditure savings (p = 0.01) and listing specific costs (p = 0.001). Trends for increased implicit QoL (p = 0.07) and QoL references (p = 0.08) in advertisements were found in MC journals.

CONCLUSIONS: Leading journals contain large numbers of QoL advertisements, with MC having significantly more than General journals. MC journals are also more specific as to the details of the cost data, however very few advertisements contain these messages. Increased detail in both QoL and pharmacoeconomic advertisements will help improve communication of this timely data.

CARDIOVASCULAR DISEASES/DISORDERS—Clinical Outcomes Presentations

Efficacy of Amlodipine in Reducing Systolic Blood Pressure: A Systematic Review of the Literature
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OBJECTIVE: To perform a systematic review of the literature pertaining to the efficacy of amlodipine monotherapy in reducing systolic blood pressure (SBP) in a variety of patient subgroups. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI) recommends diuretics or long-acting dihydropyridine calcium channel blockers (CCBs) for the treatment of isolated systolic hypertension (ISH). Amlodipine is the most commonly prescribed CCB worldwide; therefore, a systematic review was performed to capture the impact of amlodipine monotherapy on SBP.

METHODS: Following a protocol that had been developed a priori, published literature in five languages was searched from 1980 to 2001, using three electronic databases and manual bibliography checks of recent review articles and all accepted studies. Randomized controlled trials with at least 10 patients, one treatment arm of amlodipine monotherapy, minimum treatment duration of 8 weeks, reporting baseline and endpoint BP, and presence of baseline hypertension (defined as SBP ≥140 mm Hg, diastolic blood pressure (DBP) ≥90 mm Hg, or both) were accepted for this systematic review.

RESULTS: A total of 696 citations were reviewed, of which 85 met all inclusion criteria. Comparable treatment arms were pooled, and weighted means of efficacy results were calculated. In the amlodipine monotherapy arms, representing over 5,000 patients treated with the drug, amlodipine reduced SBP by an average of 17.5 mm Hg from baseline (an estimated 13.3 mm Hg more than placebo). The effect of amlodipine in reducing SBP was even more marked in elderly patients (24.1 mm Hg mean reduction), black patients (23.9 mm Hg mean reduction), and patients with ISH (25.9 mm Hg mean reduction), although the number of studies investigating these special populations was small.

CONCLUSION: Amlodipine is effective for reducing SBP. Long-term trials are needed to correlate SBP reduction with clinical outcomes.

ADVERSE EVENTS IN CABG TRIALS: A SYSTEMATIC REVIEW AND ANALYSIS
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OBJECTIVES: To quantify the incidence of major adverse events (AE) occurring in hospital or within 30 days after surgery in patients undergoing coronary artery bypass grafting (CABG), and identify risk factors for these AEs.

METHODS: A systematic review and analysis of studies published in English since 1990. Studies of isolated standard CABG reporting post-operative incidence of myocardial infarction (MI), stroke, GI bleeding, renal failure, or death in hospital or within 30 days, were eligible. The incidence of these events was calculated overall, and for selected patient groups defined by: all elective CABG vs. mixed (elective and urgent/emergency CABG); mean ejection fraction (EF) <50% vs. >50%; mean age <60 years vs. >60 years; primary CABG only vs. some patients with reoperations; RCTs vs. cohort studies; single center vs. multicenter studies. Odds ratios of selected AEs were computed according to group risk factors.

RESULTS: 176 studies (205,717 patients) met all inclusion criteria. The average incidence of major AEs occurring in-hospital was: death −1.7% (range 0%–6.6%), non-fatal MI—2.4% (range 0%–13.9%), non-fatal stroke—1.3% (range 0%–3.2%), GI bleeding—1.5% (range 0.7%–2.7%), and renal failure requiring dialysis—0.8% (range 0%–6.2%). Thirty-day mortality was 2.1% (range 0%–7.7%). Subset analyses revealed interesting differences in overall mortality and MI incidence by groups with all elective vs. mixed CABG, by study design, mean age, primary CABG vs. some patients with reoperation, and by number of study sites. Meta-analyses of odds ratios suggest that old age (>70 years); female gender; low EF; history of stroke, MI, or heart surgery;