were accepted for this systematic review.

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.
Current data are limited regarding the effects of statins in the naturalistic setting of clinical practice.

OBJECTIVES: This study sought to determine the effects of statins on the lipid profile and target LDL-cholesterol (LDL-C) attainment in this setting.

METHODS: Patients newly initiated on atorvastatin, fluvastatin, pravastatin, or simvastatin from 1/99 to 6/99 were retrospectively identified from a southeastern U.S. health plan database. A parallel design incorporated four study arms based on the statin prescribed. Exclusion criteria included statin therapy in the prior 6 months, less than 90 days of statin therapy, switching of statin, use of combination dyslipidemia therapy, or non-continuous enrollment in the health plan. Changes in lipid subfractions and attainment of LDL-C goal based on NCEP ATP II guidelines were evaluated with OLS and logistic regression techniques utilizing clinically relevant covariates.

RESULTS: A total of 2,429 patients (age = 62 ± 13 years, 47.8% male) were identified. Comorbidities included 73% hypertension, 24% diabetes, and 34% atherosclerotic vascular disease. Median duration of statin therapy was 19.4 months. Patients receiving atorvastatin had significantly greater mean absolute (and percentage) reductions in LDL-C and triglycerides compared to the other statins in both the unadjusted and adjusted results (all p < 0.05 vs. atorvastatin). Differences in HDL-cholesterol (HDL-C) were small, however, a statistically significant increase was observed with simvastatin compared to atorvastatin (p < 0.05). Also, a significantly greater percentage (unadjusted, adjusted) of patients reached their NCEP LDL-C goal on atorvastatin (74.0%, 73.0%) compared with fluvastatin (52.0%, 51.0%), pravastatin (58.3%, 56.4%) and simvastatin (69.0%, 69.4%), and atorvastatin patients reached goal faster than the other statins (median: 184 days vs. 215–357 days, all p < 0.05 vs. atorvastatin).

CONCLUSION: Patients prescribed atorvastatin had statistically significant improvements in LDL-C and triglycerides, though not in HDL-C, compared to those prescribed other statins. In addition, atorvastatin patients attained LDL-C goal more often and in a shorter timeframe.