



HAL
open science

A pilot double-blind randomised placebo-controlled trial of the effects of fixed-dose combination therapy ("polypill") on cardiovascular risk factors

Fatemeh Malekzadeh, Tom Marshall, Akram Pourshams, Mina Gharravi,
Afshin Aslani, Alireza Nateghi, Mansoor Rastegarpanah, Masoud Khoshnia,
Shahryar Semnani, Rasool Salahi, et al.

► To cite this version:

Fatemeh Malekzadeh, Tom Marshall, Akram Pourshams, Mina Gharravi, Afshin Aslani, et al.. A pilot double-blind randomised placebo-controlled trial of the effects of fixed-dose combination therapy ("polypill") on cardiovascular risk factors. *International Journal of Clinical Practice*, 2010, 64 (9), pp.1220. 10.1111/j.1742-1241.2010.02412.x . hal-00555329

HAL Id: hal-00555329

<https://hal.science/hal-00555329>

Submitted on 13 Jan 2011

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

A pilot double-blind randomised placebo-controlled trial of the effects of fixed-dose combination therapy ("polypill") on cardiovascular risk factors

Journal:	<i>International Journal of Clinical Practice</i>
Manuscript ID:	IJCP-01-10-0008.R2
Manuscript Type:	Original Paper
Date Submitted by the Author:	14-Mar-2010
Complete List of Authors:	Malekzadeh, Fatemeh; Tehran University of Medical Sciences Marshall, Tom; University of Birmingham, Public Health, Epidemiology and Biostatistics Pourshams, Akram; Tehran University of Medical Sciences Gharravi, Mina; Tehran University of Medical Sciences Aslani, Afshin; Tehran University of Medical Sciences Nateghi, Alireza; Tehran University of Medical Sciences Rastegarpanah, Mansoor; Tehran University of Medical Sciences Khoshnia, Masoud; Tehran University of Medical Sciences Semnani, Shahryar; Golestan University of Medical Sciences Salahi, Rasool; Golestan University of Medical Sciences Thomas, Neil; University of Birmingham Larijani, Bagher; Tehran University of Medical Sciences Cheng, KK; University of Birmingham Malekzadeh, Reza; Tehran University of Medical Sciences
Specialty area:	

1
2
3 **A pilot double-blind randomised placebo-controlled trial of**
4
5 **the effects of fixed-dose combination therapy (“polypill”) on**
6
7 **cardiovascular risk factors**
8
9

10
11 Fatemeh Malekzadeh¹, Tom Marshall², Akram Pourshams¹, Mina Gharrafi¹, Afshin Aslani¹, Alireza
12
13 Nateghi¹, Mansoor Rastegarpanah³, Masoud Khoshnia¹, Shahryar Semnani⁴, Rasool Salahi⁴, G. Neil
14
15 Thomas² Bagher Larijani⁵, KK Cheng², Reza Malekzadeh¹.

16
17 1 Digestive Disease Research Center, Shariati Hospital, Tehran University of Medical Sciences, Tehran,
18
19 Iran.

20
21 2 Unit of Public Health, Epidemiology and Biostatistics, University of Birmingham, U.K.

22
23 3 Department of Clinical Pharmacy, School of Pharmacy, Tehran University of Medical Sciences,
24
25 Tehran, Iran.

26
27 4 Golestan Research Center of Gastroenterology and Hepatology, Golestan University of Medical
28
29 Sciences, Gorgan, Iran.

30
31 5-Endocrine and Metabolism Research Center, Shariati Hospital, Tehran University of Medical Sciences
32
33 Tehran, Iran.

34
35 **Correspondence:**

36
37 1 Tom Marshall, Public Health, Epidemiology & Biostatistics, University of Birmingham, U.K.

38
39 E-mail: T.P.Marshall@bham.ac.uk Tel: 0121 414 7832 Fax: 0121 414 7878

40
41 2 Reza Malekzadeh, Digestive Disease Research Center, Shariati Hospital, Tehran University of Medical
42
43 Sciences, Tehran, Iran.

44
45 Email: malek@ams.ac.ir Tel:009821 82415300 Fax:009821 82415400

46
47 **Clinical Trial Registration Number:** ISRCTN43076122

48
49 **Disclosures:** All authors declare that they have no conflicts of interest in relation to this study.
50
51
52
53
54
55
56
57
58
59
60

Abstract

Aim: Our objective was to investigate the effects and tolerability of fixed-dose combination therapy on blood pressure and LDL in adults without elevated blood pressure or lipid levels.

Methods: This was a double-blind randomised placebo-controlled trial in residents of Kalaleh, Golestan, Iran. Following an eight week placebo run-in period 475 participants, aged 50 to 79 years, without cardiovascular disease, hypertension or hyperlipidaemia were randomised to fixed dose combination therapy with aspirin 81 mg, enalapril 2.5 mg, atorvastatin 20 mg and hydrochlorothiazide 12.5 mg (polypill) or placebo for a period of 12 months. The primary outcomes were changes in LDL-cholesterol, systolic and diastolic blood pressure and adverse reactions. Analysis was by intention to treat.

Results: At baseline there were differences in systolic blood pressure (6 mm Hg). Taking account of baseline differences, at 12 months polypill was associated with statistically significant reductions in blood pressure (4.5/1.6 mm Hg) and LDL-cholesterol (0.46 mmol/L). The study drug was well tolerated but resulted in modest reductions in blood pressure and lipid levels. Conclusion: The effects of the polypill on blood pressure and lipid levels were less than anticipated, raising questions about the reliability of reported compliance. There is a case for a fully powered trial of a polypill for prevention of cardiovascular disease.

What's known?

Drug treatments to lower lipid levels and drug treatments to lower blood pressure both reduce the incidence of cardiovascular disease. There is a good theoretical case for the use of fixed dose combination therapy (polypill) to reduce the incidence of cardiovascular disease in middle-aged and older adults

What's new?

In middle-aged and older adults in a developing country, fixed dose combination (polypill) therapy is well tolerated and compliance is satisfactory. Fixed dose combination (polypill) therapy results in more modest reductions in lipid levels and blood pressure than anticipated. It is feasible to conduct a full-scale trial of prevention with fixed dose combination (polypill) therapy in a developing country

Introduction

Cardiovascular disease (CVD) is the leading cause of death and disability worldwide and is presently leading cause of death and disability in low and middle-income countries including Iran.^{1,2,3} Treatment of CVD is expensive, with more than 98% of health care expenditure on CVD devoted to treatment rather than prevention,^{1,3} and such costs are increasing as new therapies emerge.⁴ There is therefore a need for coherent strategies for CVD prevention in low and middle-income countries.

It has been established that there is a continuous relationship between cardiovascular risk and both blood pressures and cholesterol levels.^{5,6,7,8} Since lowering elevated cholesterol or blood pressure reduces cardiovascular risk it is therefore plausible that lowering these risk factors from average levels would also reduce cardiovascular risk.^{9,10} There is evidence that aspirin is effective in primary prevention of cardiovascular disease in individuals at high risk.¹¹ Incidence of cardiovascular disease increases with age, therefore it has been argued that fixed-dose combination therapy (dubbed the “polypill”) including antiplatelet agents, blood pressure-lowering and lipid-lowering drugs could reduce incidence of cardiovascular disease in middle-aged and older adults.¹² The most novel aspect of this proposal has been to offer treatment to individuals whose risk factors are below usual treatment levels but who are nevertheless at high risk of cardiovascular disease because of their age and sex. There are a number of issues to consider in choosing the exact formulation of a polypill, a greater number of active components promises greater effectiveness but poses greater technical problems in developing the polypill.¹³ Because of this a number of variations of the polypill are currently under development, including three, four or five active drugs.^{14,15,16}

As the first step in investigating the effectiveness of a polypill, it is necessary to establish whether combination therapy have the anticipated effects on blood pressure and cholesterol levels when taken by individuals with risk factors below usual treatment levels. It is also necessary to establish whether the

1 medication is well tolerated and whether patients adhere to the medication. This kind of question is best
2
3 addressed in a randomised controlled trial of relatively short duration.
4

5 It has been argued that a prevention strategy based on a four drug polypill (two antihypertensive, aspirin
6 and a statin) may be cost-effective, in low and middle-income countries.^{17,18,19} Iran is a middle-income
7 country where cardiovascular disease is a major cause of mortality.²⁰ As part of a programme to evaluate
8 a polypill in Iran we report on a double-blind randomised placebo-controlled trial investigating the effects
9 of a four drug polypill in a middle-aged and older Iranian population. The trial was located in Golestan
10 province (North-Eastern Iran), where cardiovascular disease accounts for 47.5% of deaths in older adults
11 and where obesity, hypertension and diabetes and metabolic syndrome are common.^{21,22,23}
12

13 The aim of the study was to investigate the effects and tolerability of a polypill consisting of
14 hydrochlorothiazide 12.5 mg, aspirin 81 mg, enalapril 2.5 mg and atorvastatin 20 mg in middle-aged and
15 elderly adults who conventionally deemed to be healthy with no cardiovascular risk factors except for the
16 age >50 and would not currently be considered eligible for antihypertensive treatment. This was a four
17 component polypill because it was judged that inclusion of a third antihypertensive drug or a higher dose
18 of enalapril might result in hypotensive symptoms.
19

20 **Materials and Methods**

21 This is a double-blind, placebo controlled trial. All men aged 50 to 79 or women age 55 to 79, who were
22 resident in Kalaleh, Golestan, North Iran, free from diagnosed cardiovascular disease at baseline and not
23 already taking antihypertensive, statins or antiplatelet therapy were eligible for inclusion in the study. The
24 study area is semi-rural with income levels around the national average and where the great majority of
25 older persons are illiterate.
26

27 Every household in the area was provided with information describing the study, it was publicised by on
28 local radio and television and individuals were invited to attend initial assessment if they met the
29 inclusion criteria. At initial assessment, informed consent was obtained for collection of baseline data.
30

31 Medical history was determined and a wide range of data was collected on lifestyle including diet,
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2 physical activity and smoking status. Two seated blood pressures, one minute apart after five minutes rest
3 and standing blood pressure were estimated. Height and weight were measured and fasting blood samples
4 were taken to assess complete blood count, CPK, ESR, CRP, lipid profile, glucose, glycosylated
5 haemoglobin, creatinine and electrolytes, liver function tests and uric acid.
6
7

8
9 All subjects were interviewed and educated about a healthy lifestyle and regular exercise by the enrolling
10 physician. They were given a well-designed pictorial pamphlet describing all aspects of a healthy
11 lifestyle. Illiterate subjects were asked to have the pamphlet read to them by their children at home every
12 week. Several programs were arranged with the local Golestan television station to show and discuss
13 healthy lifestyles.
14
15

16
17 All family physicians, internists and cardiologists in the study region were invited to attend a lecture by
18 the principle investigator (RM) about the polypill trial and the study goal, possible adverse effects of the
19 polypill and their management. This lecture answered questions raised by local physicians and secured
20 professional support for the study and collaboration with research team to reduce the burden of CVD.
21
22

23
24 Individuals with contraindications to a component of the polypill were excluded. Contraindications to
25 aspirin included hypersensitivity, previous bleeding peptic ulceration or recent peptic ulceration (within
26 three months). Contraindications to thiazide diuretics included gout or hyperuricaemia ($>8 \mu\text{mol/L}$ in men
27 or $>6 \mu\text{mol/L}$ in women). Contraindications to statins included liver disease. Contraindications to further
28 blood pressure lowering included symptomatic postural hypotension or systolic blood pressure less than
29 90 mm Hg at baseline. Individuals were excluded if they were unable to give full consent or to comply
30 with the protocol because of mental or physical incapacity. Individuals with elevated total cholesterol
31 levels or other laboratory abnormalities on initial assessment were initially reviewed and managed by the
32 trial internist and subsequently referred to their family physician for further management.
33
34

35
36 Following initial assessment, individuals who were eligible for inclusion and gave their informed consent
37 were provided with two months supply of placebo tablets for the run-in phase of the study. After the run-
38 in compliance was assessed by history and pill count, blood pressure and lipid levels were repeated.
39
40
41

1
2 Participants who no longer met the inclusion criteria or whose compliance was poor (<70% of pill intake)
3
4 were excluded. Patients were provided with further information on the study and informed consent was
5
6 obtained for randomisation.

7 Participants were randomised by block randomisation through a computer-generated list of numbers.

8
9 They were then allocated the correspondingly numbered blister packs containing either the “polypill” as a
10
11 single tablet or an identical placebo. Both polypill and placebo were manufactured by Alborz Darou
12
13 pharmaceutical company. Participants and researchers were blind to the allocation.

14
15 Participants were followed up at one, four, eight and twelve months. At follow-up visits participants were
16
17 asked about hospital admissions, cardiovascular events and possible adverse events. Researchers inquired
18
19 about compliance and undertook pill counts, measured seated and standing blood pressure and took blood
20
21 samples for laboratory tests. The study medication was dispensed and patients were given a further
22
23 follow-up appointment.

24
25 Participants who reported possible adverse effects during follow-up were assessed by the trial internist. If
26
27 appropriate the medication was temporarily withdrawn to determine whether adverse effects were due to
28
29 treatment. The internist restarted the study medication and if symptoms returned after rechallenge the
30
31 study medication was discontinued.

32
33 The primary outcomes were blood pressure and LDL-cholesterol. Secondary outcomes included total
34
35 cholesterol, triglycerides, HDL-cholesterol and fasting glucose, major cardiovascular events and any
36
37 adverse reactions to medication. Analysis was by intention to treat. Mean systolic and diastolic blood
38
39 pressures, all lipid levels, triglyceride levels and fasting glucose levels were compared using analysis of
40
41 covariance (ANCOVA) adjusting for baseline differences in the model. In addition to reported adverse
42
43 effects abnormal laboratory tests are reported as elevations of CPK above 500 IU/L, elevations of AST
44
45 above 50 IU/L or ALT above 40 IU/L and elevations of serum uric acid above 0.8 mmol/L. All analysis
46
47 was carried out using SPSS version 14.0.

Statistical analysis

Assuming a pre-treatment blood pressure of 130 mm Hg (standard deviation 20 mm Hg) it was determined that a sample size of 504 was needed to have a power of 0.8 to detect a reduction in systolic blood pressure of 5 mm Hg at a significance level of 0.05.

The trial was registered with Controlled Clinical Trials.²⁴ The IRB of the Digestive Disease Research Center of Shariati Hospital reviewed and approved the study protocol and the informed consent forms. Ethical approval was obtained from the National Ethics Committee by the Deputy of Research at the Ministry of Health and Medical Education of the Islamic Republic of Iran.

Results

Between July 2006 and January 2007 1,733 persons attended the assessment clinic. Of those assessed 872 were included in the run-in phase of the study: 50.5% of those assessed. The main reasons for exclusion were hypertension (434), diabetes mellitus (219), history of CVD (193), taking aspirin (148), hyperlipidaemia (114), psychiatric illness (64), opium addiction (61) history of GI bleeding (40) and stroke (28). Subjects could have more than one reason for exclusion. Most exclusions were therefore because subjects were already on treatment or had indications for treatment and therefore could not be randomised to a placebo. During the run-in phase 258 participants were excluded, following which a further 65 were excluded and 74 participants were not randomised. Reasons for exclusion are shown in Figure 1. The remaining 475 participants were randomised (Figure 1).

Baseline characteristics are shown in Table 1. At baseline all characteristics of the two groups were similar except there were significant differences in blood pressure between the intervention and control groups (5.5 mm Hg systolic $P = 0.001$; 2.9 mm Hg diastolic $P = 0.002$) and more women were allocated to the intervention group ($P = 0.041$). Three hundred and forty eight patients ($348/475 = 73.3\%$) completed 12 months of follow-up. Follow-up was more complete in the control group than the

1
2 intervention group (78.2% versus 68.5%; $P = 0.016$ by Chi squared test). Reasons for losses to follow-up
3
4 are described in Figure 1.

5
6 ~~Mean systolic and diastolic blood pressures and mean lipid levels during follow-up are shown in Table 2.~~

Deleted: ¶

7
8 With the last measure carried forward, by ANCOVA adjusting for differences at baseline, systolic blood
9
10 pressure was 4.5 mm Hg ($P < 0.001$) and diastolic blood pressure 1.6 mm Hg ($P < 0.032$) lower in the
11
12 intervention than control group at the last follow-up visit. By the same method, LDL-cholesterol was 0.46
13
14 mmol/L (12.0%) lower ($P < 0.001$), total cholesterol was 0.63 mmol/L (15.5%) lower ($P < 0.001$).
15
16 Triglycerides were 0.16 mmol/L (11.3%) lower ($P = 0.005$), HDL-cholesterol was 0.01 mmol/L (0.9%)
17
18 higher ($P = 0.575$) and fasting glucose was 0.17 mmol/L (3.3%) lower ($P = 0.008$) in the intervention than
19
20 the control group.

21
22 Pill counts suggested that compliance was reasonable, with 89% of tablets taken in both intervention and
23
24 control groups. One participant in the control group and none in the intervention group developed a non-
25
26 fatal coronary attack. Two participants assigned to the intervention and none assigned to the control group
27
28 discontinued the study medication due to cough (Fisher's exact test two sided $P = 0.50$). Six participants
29
30 assigned to the control and none assigned to the intervention were started on additional drugs for
31
32 hypertension (Fisher's exact test two sided $P = 0.03$). These subjects had average blood pressures of
33
34 150.2/89.2 mm Hg at baseline. Other side effects were minor and did not result in discontinuation of
35
36 treatment.

37
38 Elevations of CPK above 500 IU/L were observed in nine intervention and two control participants
39
40 (Fishers exact $P = 0.063$). No elevations higher than 700 IU/L were reported and no participants reported
41
42 clinical symptoms of myopathy. Abnormal liver function tests (elevations of AST above 50 IU/L or ALT
43
44 above 40 IU/L) were observed in 43 intervention and 38 control participants (Fishers exact $P = 0.714$). No
45
46 participants were found to have evidence of liver disease. Elevations of serum uric acid above 0.8 mmol/L
47
48 were seen in 35 intervention and 31 control participants (Fishers exact $P = 0.693$).
49
50
51
52
53
54
55
56
57
58
59
60

Discussion

Our study is the first test of the effectiveness of a polypill in individuals without previous risk factors. We found that fixed-dose combination treatment with aspirin 81 mg, hydrochlorothiazide 12.5 mg, atorvastatin 20 mg and enalapril 2.5 mg resulted in statistically significant but unexpectedly modest reductions in LDL-cholesterol and systolic blood pressure. A half standard dose of thiazide and quarter standard dose of ACE inhibitor would be expected to lower blood pressure by 12.0/6.0 mm Hg in patients with a mean blood pressure of 154/97 mm Hg and by 6.5/2.0 mm Hg reduction in this population with a mean blood pressure of 125/78 mm Hg.²⁵ The observed effect was three quarters of this: 4.5/1.6 mm Hg. Atorvastatin 20 mg would be expected to reduce LDL-cholesterol by 43%.⁹ The observed effect was a 15.5% reduction in LDL-cholesterol, about one third of that predicted. The lower than expected effects on blood pressure and LDL-cholesterol are consistent with either poor compliance or with lack of drug efficacy. Our reductions in blood pressure and LDL are slightly smaller than those reported in a recently published study of a five component polypill in India: 7.6/5.6 mm Hg for blood pressure and 0.70 mmol/L for LDL cholesterol.²⁶ However the Indian study included three antihypertensive drugs and reported findings after 12 weeks of follow up whereas we used two antihypertensive drugs and reported findings after 52 weeks.

Further detailed investigation of compliance with the study medication was conducted by interviewing 20 participants after the study had been completed. Participants indicated that they were happy to take the study medication daily despite realising that it may be an inactive placebo. Most participants admitted to occasionally forgetting to take tablets, sometimes failing to take medications with them when travelling and during harvesting time being unable to attend the study centre before their supply of tablets had been completed. Some of the subjects were not at home when we called them to give the reminder (15%). Overall compliance was estimated to be about 65-70%. This level of compliance suggests that the drug may have been less efficacious than predicted. Further bioequivalence studies are planned to investigate this possibility. Furthermore, as we have longer follow up than the Indian trial,²⁶ our estimated

1
2 compliance may be closer to the true situation when the medication is offered to the general population in
3
4 the long term.

5
6 Our study has some weaknesses. We observed differences in blood pressure and gender at baseline. This
7
8 implies that there may have been deficiencies in the randomisation process which we have been unable to
9
10 clarify. However the analysis has attempted to deal with this by adjusting for differences at baseline. We
11
12 also observed that although few adverse effects were reported, more patients discontinued the polypill
13
14 than the placebo, particularly during the first month of follow up.

15
16 How effective is a polypill likely to be? Since the start of this study there have been two further clinical
17
18 trials on the effects of aspirin in primary prevention of CVD. We conducted a meta-analysis of the effects
19
20 of aspirin in primary prevention, including the studies included in a previous meta-analysis and three
21
22 subsequent clinical trials.^{11,27,34} Using a random effects model, relative risk of coronary heart disease
23
24 (CHD) with aspirin is 0.82 (95% confidence interval 0.69 to 0.98) and relative risk of stroke (CVA) is
25
26 0.93 (95% confidence interval 0.84 to 1.04). With 35% efficacy (consistent with our findings of the
27
28 effects of atorvastatin) we would expect a relative risks of 0.93 ($0.82^{0.35}$) for CHD and 0.97 ($0.93^{0.35}$) for
29
30 CVA. A 12 mm Hg reduction in systolic blood pressure is predicted to be associated with relative risks of
31
32 0.75 and 0.65 for CHD and CVA respectively.^{6,35} With a 4.5 mm Hg reduction in systolic blood pressure
33
34 we would expect relative risks of 0.90 ($0.75^{(4.5 \div 12)}$) for CHD and 0.85 ($0.65^{(4.5 \div 12)}$) for CVA. A 1.81
35
36 mmol/L reduction in LDL-cholesterol would be associated with relative risks of 0.39 and 0.83 on CHD
37
38 and CVA respectively.^{9,11,12,25} With a 0.46 mmol/L reduction in LDL-cholesterol we would expect relative
39
40 risks of 0.79 ($0.39^{(0.46 \div 1.81)}$) for CHD and 0.93 ($0.85^{(0.46 \div 1.81)}$) for CVA. The combined therapy therefore has
41
42 a RR of 0.66 for CHD and 0.79 for CVA.^{9,11,25} (Table 3). Given that CHD accounts for about four fifths of
43
44 CVD events this equates to a relative risk of CVD of 0.69.³ Our findings are consistent with a more
45
46 modest reduction in CVD risk than that proposed by the authors of the recent Indian study.²⁶ Indications
47
48 from this pilot study are therefore that a four component polypill has the potential to reduce the incidence
49
50 of CVD by about one third. This effect size may be sufficient to be cost-effective.¹⁷ However larger
51
52
53
54
55
56
57
58
59
60

1 effects have been observed with high-intensity statin treatment alone.³⁶ Estimated effectiveness depends
2 on assumptions about the likely effects of LDL lowering. Using more modest effect sizes derived from
3 another meta-analysis gives an overall relative risk of CVD of 0.79.³⁷ Recent meta-analysis has suggested
4 that the risks and benefits of aspirin are finely balanced: exclusion of aspirin, as suggested by would give
5 an overall relative risk of 0.83.³⁸ In order to ensure that all subjects might benefit from participation in
6 this pilot study, the research ethics committee required that all study participants were offered advice on
7 lifestyle modification. We therefore made considerable efforts to educate the study population about the
8 importance of lifestyle modification in prevention of CVD and provided all participants with an illustrated
9 pamphlet, conducted several radio and television programmes to emphasize healthy life style. We also
10 used the network of community women volunteers to promote a healthy lifestyle in the Kalaleh district.
11 This demonstrates that pharmacological prevention need not preclude lifestyle changes.
12 This pilot study illustrates the problems faced when trying to undertake primary prevention of CVD in a
13 developing country like Iran with high risk of CVD. These include obtaining informed consent in a
14 population with low levels of literacy, ensuring compliance and maintaining adequate follow up. Overall
15 the clinical trial was conducted successfully. The polypill appears to have been well-tolerated, compliance
16 was reasonable and few significant adverse effects were reported. There remain however, considerable
17 challenges. Our findings raise questions remain about the bioequivalence of the polypill used in this trial
18 and further studies are needed to elucidate this. Increasing the dose of enalapril to 5 mg or 10 mg would
19 help increase the effect on blood pressure, since higher doses of ACE inhibitors are not associated with
20 higher incidence of adverse drug reactions.²⁵ Compliance may also be improved. Healthy people may be
21 reluctant to take a regular medication we suggest that a future large scale trial may therefore include
22 people with CVD risk factors detected during the pre-randomisation clinical or laboratory evaluation as
23 these have a greater capacity to benefit from treatment and may be more likely to comply with treatment.
24 A fully powered trial investigating the impact of the polypill on cardiovascular events and all cause
25 mortality is needed. Our findings confirm the feasibility of such a trial.

Acknowledgments

We would like to thank the people of Kalaleh who were the subjects of this trial and all family physicians, internists and cardiologists in Golestan provinces who supported this study. Special thank to personnel of Kalaleh District Health Network especially to community women voluntaries whose promotional health activity was very helpful to motivate trial participants and to the Kalaleh Cardiology Study Centre personnel. We also would like to thank the Iranian Association of Gastroenterology and Hepatology for their special financial support for this study.

Funding:

Tehran University of Medical Sciences Research Funds

Ministry of Health and Medical Education of IR of Iran

Alborz Daru Company Tehran Iran

Ethical approval

The IRB of the Digestive Disease Research Center of Shariati Hospital reviewed and approved the study protocol and the informed consent forms. Ethical approval was obtained from the National Ethics Committee by the Deputy of Research at the Ministry of Health and Medical Education of the Islamic Republic of Iran.

References

1. Preventing chronic diseases: a vital investment: WHO global report. World Health Organization 2005. http://www.who.int/chp/chronic_disease_report/en/ [Last Accessed 21st April 2009]
2. Asadi-Laria M, Sayyarib AA, Akbaric ME, Gray D. Public health improvement in Iran - lessons from the last 20 years *Public Health* 2004; 118: 395-402.
3. Rastegarpanah M, Malekzadeh F, Thomas GN, Mohagheghi A, Cheng KK, Marshall T. A new horizon in primary prevention of cardiovascular disease, can we prevent heart attack by "heart polypill"? *Archives of Iranian Medicine* 2008; 11(3):306-13.
4. Larijani B, Fakhrzadeh H, Mohaghegh M, Pourebrahim R, Akhlaghi MR. Burden of coronary heart disease on the Iranian oil industry (1999-2000). *Eastern Mediterranean Health Journal* 2003; 9(5-6):904-10.
5. Law MR, Wald NJ, Wu T, Hackshaw A, Bailey A. Systematic underestimation of association between serum cholesterol concentration and ischaemic heart disease in observational studies: data from the BUPA study. *British Medical Journal* 1994; 308(6925):363-6.
6. MacMahon S, Peto R, Cutler J, Collins R, Sorlie P, Neaton J, Abbott R, Godwin J, Dyer A, Stamler J. Blood pressure, stroke, and coronary heart disease. Part 1, Prolonged differences in blood pressure: prospective observational studies corrected for the regression dilution bias. *Lancet* 1990; 335(8692):765-74.
7. Prospective studies collaboration. Age-specific relevance of usual blood pressure to vascular mortality: a meta-analysis of individual data for one million adults in 61 prospective studies *Lancet* 2002; 360:1903-13.
8. Law MR, Wald NJ. Risk factor thresholds: their existence under scrutiny. *British Medical Journal* 2002; 324: 1570-6.

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
9. Law M. R., Wald N. J., Rudnicka A. R. Quantifying effect of statins on low density lipoprotein cholesterol, ischaemic heart disease, and stroke: systematic review and meta-analysis *British Medical Journal* 2003; 326:1423-1426.
10. Collins R, Peto R, MacMahon S, Herbert P, Fiebich NH, Eberlein KA, Godwin J, Qizibash N, Taylor JO, Hennekens CH. Blood pressure, stroke, and coronary heart disease. Part 2, short-term reductions in blood pressure: overview of randomised drug trials in their epidemiological context. *Lancet* 1990; 335:827-839.
11. Hayden M. Pignone M. Phillips C. Mulrow C. Aspirin for the primary prevention of cardiovascular events: a summary of the evidence for the U. S. Preventive Services Task Force. *Annals of Internal Medicine* 2002; 136(2):161-72.
12. Wald NJ, Law MR. A strategy to reduce cardiovascular disease by more than 80% *British Medical Journal* 2003; 326: 1419.
13. Guglietta A., Guerrero M. Issues to consider in the pharmaceutical development of a cardiovascular poly pill *Nature Clinical Practice Cardiovascular Medicine* 2009; 9:112-119.
14. Frishman W.H., Zuckerman A.L. Amlodipine/ atorvastatin: the first cross risk factor for poly pill for the prevention and treatment of cardiovascular disease. *Expert Review of Cardiovascular Therapeutics* 2004; 3: 675–681.
15. Clinical Trials Research Unit, The University of Auckland (online 2008) PILL Pilot: Programme to Improve Life and Longevity [<http://www.ctr.u.auckland.ac.nz/content/view/37/35/>]. (Last accessed 5th February 2009)
16. Xavier D, Pais P., Sigamani A., Pogue J., Afzal R. and Yusuf S., on behalf of The Indian Polycap Study (TIPS) Investigators The need to test the theories behind the Polypill: rationale behind the Indian Polycap Study *Nature Clinical Practice Cardiovascular Medicine* 2009; 9:96-97.

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
17. Gaziano TA, Opie LH, Weinstein MC. Cardiovascular disease prevention with a multidrug regimen in the developing world: a cost-effectiveness analysis *Lancet* 2006; 368: 679–86.
 18. Combination Pharmacotherapy and Public Health Research Working Group. Combination Pharmacotherapy for Cardiovascular Disease *Annals of Internal Medicine* 2005;143:593-599.
 19. Reddy KS. The Preventive Polypill - Much Promise, Insufficient Evidence *New England Journal of Medicine* 2007; 356:3.
 20. Health System Profile Islamic Republic of Iran. Regional Health Systems Observatory, World Health Organization, 2009. [Last accessed 21st April 2009] <http://gis.emro.who.int/HealthSystemObservatory/PDF/Iran/Full%20Profile.pdf>
 21. Kamangar F, Malekzadeh R, Dawsey SM, Saidi F. Esophageal cancer in Northeastern Iran: a review. *Archives of Iranian Medicine*. 2007; 10(1):70-82. Review.
 22. Pourshams A, Saadatian-Elahi M, Nouraie M, Malekshah AF, Rakhshani N, Salahi R, Yoonessi A, Semnani S, Islami F, Sotoudeh M, Fahimi S, Sadjadi AR, Nasrollahzadeh D, Aghcheli K, Kamangar F, Abnet CC, Saidi F, Sewram V, Strickland PT, Dawsey SM, Brennan P, Boffetta P, Malekzadeh R. Golestan cohort study of oesophageal cancer: feasibility and first results. *British Journal of Cancer* 2005; 92(1):176-81.
 23. Bahrami H, Sadatsafavi M, Pourshams A, Kamangar F, Nouraei M, Semnani S, Brennan P, Boffetta P, Malekzadeh R. Obesity and hypertension in an Iranian cohort study; Iranian women experience higher rates of obesity and hypertension than American women. *BMC Public Health* 2006; 6:158.
 24. Effect of a Polypill on middle-aged and elderly Iranians <http://www.controlled-trials.com/ISRCTN43076122/> [Last accessed 15th January 2008].

- 1
2 25. Law M.R., Wald N.J., Morris J.K., Jordan R.E. Value of low dose combination treatment with blood
3 pressure lowering drugs: analysis of 354 randomised trials *British Medical Journal* 2003; 326:1427-
4 1432.
5
6
- 7
8 26. The Indian Polycap Study (TIPS) Effects of a polypill (Polycap) on risk factors in middle-aged
9 individuals without cardiovascular disease (TIPS): a phase II, double-blind, randomised trial *Lancet*
10 Published Online March 30, 2009 DOI:10.1016/S0140-6736(09)60611-5.
11
- 12
13 27. Final report on the aspirin component of the ongoing Physicians' Health Study. Steering Committee
14 of the Physicians' Health Study Research Group. *New England Journal of Medicine* 1989; 321:129-
15 135.
16
17
- 18
19 28. Peto R, Gray R, Collins R, K Wheatley K, Hennekens C, Jamrozik K, Warlow C, Hafner B,
20 Thompson E, Norton S, Gilliland J, and Doll R. Randomised trial of prophylactic daily aspirin in
21 British male doctors. *British Medical Journal (Clin Res Ed)* 1988; 296(6618):313-316.
22
23
- 24
25 29. Thrombosis prevention trial: randomised trial of low intensity oral anticoagulation with warfarin and
26 low dose aspirin in the primary prevention of ischemic heart disease in men at increased risk. The
27 Medical Research Council's General Practice Research Framework. *Lancet* 1998; 351:233-241.
28
29
- 30
31 30. Hansson L, Zanchetti A, Carruthers SG, Dahlöf B, Elmfeldt D, Julius S, Ménard J, Rahn KH, Wedel
32 H, Westerling S. Effects of intensive blood-pressure lowering and low-dose aspirin in patients with
33 hypertension: principal results of the Hypertension Optimal Treatment (HOT) randomised trial.
34 *Lancet* 1998; 351(9118):1755-1762.
35
36
- 37
38 31. Low-dose aspirin and vitamin E in people at cardiovascular risk: a randomised trial in general
39 practice. Collaborative Group of the Primary Prevention Project. *Lancet* 2001; 357:89-95.
40
41
42
43
44
45
46
47

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
32. Ridker PM, Cook NR, Lee IM, Gordon D, Gaziano JM, Manson JE, Hennekens CH, Buring JE. A Randomized Trial of Low-Dose Aspirin in the Primary Prevention of Cardiovascular Disease in Women *New England Journal of Medicine* 2005; 352:1293-1304.
33. Ogawa H, Nakayama M, Morimoto T, Uemura S, Kanauchi M, Doi N, Jinnouchi H, Sugiyama S, Saito Y; Japanese Primary Prevention of Atherosclerosis With Aspirin for Diabetes (JPAD) Trial Investigators. Low-Dose Aspirin for Primary Prevention of Atherosclerotic Events in Patients With Type 2 Diabetes: A Randomized Controlled Trial *Journal of the American Medical Association* 2008; 300: 2134 - 2141.
34. Prevention of Progression of Arterial Disease and Diabetes Study Group, Diabetes Registry Group, and Royal College of Physicians Edinburgh. The prevention of progression of arterial disease and diabetes (POPADAD) trial: factorial randomised placebo controlled trial of aspirin and antioxidants in patients with diabetes and asymptomatic peripheral arterial disease *British Medical Journal* 2008; 337:a1840.
35. Asia Pacific Cohort Studies Collaboration. Blood pressure and cardiovascular disease in the Asia Pacific region. *Journal of Hypertension* 2003;21:707-16.
36. Ridker P.M., Danielson E., Fonseca F.A.H. for the JUPITER Study Group. Rosuvastatin to Prevent Vascular Events in Men and Women with Elevated C-Reactive Protein *New England Journal of Medicine* 2008;359:2195-207.
37. Cholesterol Treatment Trialists' (CTT) Collaborators Efficacy and safety of cholesterol-lowering treatment: prospective meta-analysis of data from 90 056 participants in 14 randomised trials of statins *Lancet* 2005; 366: 1267-78.
38. Antithrombotic Trialists' (ATT) Collaboration Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials *Lancet* 2009; 373: 1849-60

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Figure legends

Figure 1: Recruitment and follow-up

For Peer Review Only

Tables

Table 1: Baseline characteristics of intervention and control groups

Parameters	Polypill	Placebo	P values
Number (total=475)	(n=241)	(n=234)	
Age (years) ± sd	59.0±6.5	59.1±7.3	0.856
Gender (% female)	37.8	28.6	0.041
Systolic blood pressure (mm Hg) ± sd	124.8±17.3	130.3±17.4	0.001
Diastolic blood pressure (mm Hg) ± sd	78.4±10.4	81.2±9.7	0.002
Weight (kg) ± sd	68.7±11.8	69.1±12.1	0.729
Body mass index (kg/m ²) ± sd	26.4±4.3	26.0±4.2	0.316
Waist circumference (cm) ± sd	92.7±12.0	91.6±11.4	0.307
Total cholesterol (mmol/L) ± sd	5.26±1.01	5.26±1.00	0.987
LDL-cholesterol (mmol/L) ± sd	2.97±0.68	3.02±0.67	0.410
HDL-cholesterol (mmol/L) ± sd	1.14±0.27	1.10±0.25	0.063
Triglyceride (mmol/L) ± sd	1.42 (1.33-1.51)	1.48 (1.39-1.56)	0.382
Fasting glucose (mmol/L) ± sd	5.16±0.73	5.16±0.87	0.971
AST (IU/L) 95% CI	27.6 (24.6-31.0)	28.3 (25.1-31.8)	0.771
ALT (IU/L) 95% CI	18.4 (16.1-20.9)	19.3 (16.8-22.1)	0.610
CPK (95% CI)	92.3 (85.1-100.0)	95.9 (88.9-103.3)	0.491
Na ⁺ (mmol/L) 95% CI	144 (143.4-144.5)	143.8 (142.4-145.2)	0.825
K ⁺ (mmol/L) 95% CI	4.47 (4.43-4.52)	4.48 (4.44-4.52)	0.881
Creatinine (mg/dL) 95% CI	0.96 (0.95-0.98)	0.98 (0.96-1)	0.301
Smoking status (current, %)	19.1	23.5	0.263

* Values for categorical variables are proportions

Deleted: Serum creatinine (μmol/l)
95% CI

Deleted: 0.99 (0.95-1.04)

Deleted: 0.84 (0.96-1.01)

Deleted: 0.634

Table 2: Changes in primary and secondary outcomes adjusted for baseline differences

Measurement	Visit	Intervention (Mean)	N	Control (Mean)	N	GLM mean difference	P value
Systolic BP	Baseline	124.8	241	130.3	234		
	Final visit	121.1	241	129.0	234	-4.5	<0.001
Diastolic BP*	Baseline	78.4	240	81.2	234		
	Final visit	77.6	240	81.2	234	-1.6	0.032
Total Cholesterol	Baseline	5.26	241	5.26	234		
	Final visit	4.37	241	4.99	234	-0.63	<0.001
LDL-cholesterol	Baseline	2.97	241	3.02	234		
	Final visit	2.37	241	2.87	234	-0.46	<0.001
HDL-cholesterol*	Baseline	1.14	240	1.10	234		
	Final visit	1.24	240	1.21	234	0.01	0.575
Triglycerides*	Baseline	1.42	240	1.48	234		
	Final visit	1.42	240	1.60	234	-0.16	0.005
Fasting glucose*	Baseline	5.16	240	5.16	234		
	Final visit	5.15	240	5.31	234	-0.17	0.008

* For each of these variables one data item was missing from the database

Table 3: Predicted effects of a polypill on CHD and CVA

Intervention	Typical effect of treatment		Effects of treatment with observed efficacy			
	Effect on risk factor	Relative Risk		Effect on risk factor	Relative Risk	
		CHD	CVA		CHD	CVA
Aspirin	Typical compliance	0.82	0.93	35% efficacy	0.93	0.97
LDL-cholesterol	1.81 mmol/L	0.39	0.83	0.46 mmol/L	0.79	0.95
SBP	12 mm Hg	0.75	0.65	4.5 mm Hg	0.90	0.85
Total		0.25	0.52		0.66	0.79

Figure 1: Recruitment and follow-up

