

Clinical trials of angiotensin-receptor blockers for heart failure in patients already receiving ACE inhibitor

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1 angiotensin receptor blocker

Trial	Treatments	Patients	Trials design and methods
losartan vs enalapril			
Dickstein et al. , 1995 n=108/58 follow-up: 8 wk	Losartan, 25 mg, 50mg daily versus Enalapril, 10 mg twice daily	patients with moderate or severe chronic heart failure in New York Heart Association functional class III or IV and an ejection fraction \leq 35%	Parallel groups double blind
Lang et al. , 1997 n=78/38 follow-up: 12 wk	Losartan titrated to 25 mg ou 50 mg daily versus Enalapril, titrated to 10 mg twice daily	patients with congestive heart failure (New York Heart Association functional classes II to IV) and left ventricular ejection fraction \leq 45% previously treated with stable doses of ACE inhibitors and diuretic agents, with or without concurrent digitalis and other vasodilators	Parallel groups Double blind US, Canada
telmisartan vs enalapril			
REPLACE , 2001 n=301/77 follow-up: 12 wk	Telmisartan, 10 mg, 20mg, 40mg, 80mg daily versus Enalapril, 10 mg twice daily	ambulatory patients at least 21 years of age, in sinus rhythm, with chronic moderate symptomatic heart failure (New York Heart Association class III) and a left ventricular ejection fraction of 40% or lower	Parallel groups Double blind
valsartan vs enalapril			
HEAVEN , 2002 n=70/71 follow-up: 12 wk	Valsartan, 160 mg daily versus Enalapril, 10 mg twice daily	Men and women with mild/moderate heart failure stabilised on an angiotensin-converting enzyme inhibitor and left ventricular ejection fraction 0.45 or less	Parallel groups Double blind

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HEAVEN, 2002:

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2 ARBs added to ACEI

Trial	Treatments	Patients	Trials design and methods
candesartan+ACE inhibitor vs ACE inhibitor only			
CHARM-Added , 2003 n=1276/1272 follow-up: Median, 41 mo	Candesartantarget dose 32 mg once daily versus Placebo	patients with New York Heart Association functional class III/IV CHF and left-ventricular ejection fraction40% or lower, and who were being treated with ACE inhibitors.	Parallel groups double blind 26 countries
eprosartan+ACE inhibitor vs ACE inhibitor only			
ADEPT , 2001 n=18/18 follow-up: 8 wk	Eprosartan, 400 to 800 mg twice daily versus Placebo	patients with stable New York Heart Association class II-IV CHF receiving ACE inhibitor therapy	Parallel groups double blind
irbesartan+ACE inhibitor vs ACE inhibitor only			
Tonkon et al. , 2000 n=57/52 follow-up: 12 wk	Irbesartan, 150 mg daily (plus ACE inhibitor) versus Placebo (plus ACE inhibitor)	patients with heart failure (New York Heart Association functional class II and III) and left ventricular ejection fraction (LVEF) <or = 40% received stable doses of ACE inhibitors and diuretics	Parallel groups double blind
losartan+ACE inhibitor vs ACE inhibitor only			
Hamroff et al. , 1999 n=16/17 follow-up: 6 mo	Losartan, 50 mg daily (plus ACE inhibitor) versus Placebo (plus ACE inhibitor)	patients with severe congestive heart failure (NYHA III-IV) despite treatment with maximally recommended or tolerated doses of ACE inhibitors	Parallel groups double blind
valsartan+ACE inhibitor vs ACE inhibitor only			
V-HeFT , 1999 n=55/28 follow-up: 4 wk	Valsartan 80 mg and 160mg twice daily (plus ACE inhibitor) versus Placebo (plus usual ACE inhibitor)	Patients with stable symptomatic congestive heart failure (CHF) receiving long-term ACE inhibitor therapy (NYHA functional class II,III, or IV) and PCWP >or=to 15 mm Hg	Parallel groups Double blind US
Val-HeFT , 2001 n=2511/2499 follow-up: 23 mo	Valsartan, 160 mg twice daily (plus ACE inhibitor) versus Placebo (plus ACE inhibitor)	patients with heart failure of New York Heart Association (NYHA) class II, III, or IV	Parallel groups Double blind 16 countries

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3 About TrialResults-center.org

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Rigorous meta-analysis method is used to populate TrialResults-center: widespread search of published and non published trials, study selection using pre-specified criteria, data extraction using standard form.

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