Hepatitis: The total number of subjects in clinical studies of ATACAND, 21,983 (9362) were 65 and older, while 3,700 (1688) were 75 and older. The most common adverse events leading to drug discontinuation were digestive disorders; dyspepsia, abdominal pain, nausea, vomiting, increased liver enzymes, hyperbilirubinemia; and hepatitis. In patients treated with placebo, the most common adverse events leading to drug discontinuation were hypoten- sion, edema, and blurred vision.

Adverse Effects Associated with Higher Incidence in Elderly Patients

The following events had a higher incidence in elderly patients treated with ATACAND compared with placebo (at least 1.5 fold greater): cough (5.9% vs. 3.1%), ankle edema (1.4% vs. 0%); and hypotension (4.3% vs. 1.5%).

The following events had a higher incidence in elderly patients treated with placebo compared with ATACAND (at least 1.5 fold greater): anemia (2.5% vs. 1.7%), and postural hypotension (2.4% vs. 0%).

ADVERSE REACTIONS

Hyponatremia

Hyponatremia was associated with ATACAND and was significantly more frequent in patients treated with ATACAND compared with those treated with placebo. Despite an increased incidence of the event in the ATACAND group, the event was not associated with any adverse clinical consequences or hemodynamic effects.

Lactation

It is not known whether ATACAND is excreted in human milk. However, in animal studies (rats, mice, and rabbits), ATACAND was excreted in the milk. In nursing mothers, ATACAND has been excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from ATACAND, women should be advised not to breastfeed if they are taking ATACAND.

Pregnancy

It is not known whether ATACAND crosses the placenta. ATACAND should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. ATACAND is not indicated for use in women during pregnancy. The safety and efficacy of ATACAND have not been established in female patients of childbearing potential.

Statins Protective in Carotid Endarterectomy

By Miriam E. Tucker
Senior Writer

WASHINGTON—Perioperative statin use may significantly reduce the incidence of cerebrovascular events and mortality in patients undergoing carotid endarterectomy, Bruce A. Perler, M.D., reported at a conference for science reporters sponsored by the American Medical Association.

Dr. Perler and his associates conducted a retrospective analysis of 1,566 patients who underwent carotid endarterectomy (CEA) between 1994 and 2004 at Johns Hopkins Hospital. Those who had been taking a statin for at least 1 week prior to surgery had a shorter duration of stroke and fivefold reduction in death in the subsequent 30 days, compared with those not on a perioperative statin. The ef- fects were independent of other risk factors, and both were highly significant. “The results were quite remarkable to us, really eye-opening,” Dr. Perler, professor and chief of vascular surgery at Johns Hopkins University, Baltimore.

“Because this was a retrospective study and not designed to establish clinical prac- tice, we have only to do is to let it go,” Dr. Perler noted.

Results of the study, which was not in- dustially funded, were published in Novem- ber (J. Vasc. Surg. 2005;42:829-36).

Of the 1,566 patients, 92% underwent solitary CEA; the other 8% had simulta- neous coronary artery bypass grafting (CABG). Mean age was 72 years, and 63% were male. CEA was symptomatic in 42% (14% with a history of stroke and 28% with transient ischemic attacks) and asymptomatic steno- sis in 58%.

Forty-two percent of the patients had been using statins for at least 1 week prior to the procedure. The most common- ly used statins were atorvastatin (51%) and simvastatin (29%), both at a mean dose of 20 mg/day. Although the duration of statin therapy was unknown, most of the patients had been taking them for quite a bit longer, Dr. Perler noted.

At 30 days after CEA, the incidence of stroke among the 675 statin patients was 1.2%, compared with 4.9% of the 909 non-takers. Indications for CEA among patients on statins was 0.3% versus 2.1% in patients not taking the agent. Perioperative MIs were also less frequent among the statin users (1.2%) than among non-takers (2.6%) at 30 days.

Although overall statin use increased with time over the 10-year period, differ- ences between statin users and nonusers re- mained significant throughout, he said. After adjustment for all other variables found to be associated with stroke (symp- tomatic carotid disease, chronic atrial fi- brillation, hyperlipidemia, use of intralumi- nal shunts, and history of smoking), no main effect of CEA (CABG), statin use remained associ- ated with a threefold reduction in the 30 day risk for stroke (odds ratio 0.28).

Although this study is the first ever to in- vestigate the impact of statin use on CEA outcome, there have been several previous clinical trials supporting the use of statin therapy to reduce complications after oth- er vascular procedures, including CABG (Circulation 2000;110[suppl. 2]:II45-9 and Am. J. Cardiol. 2000;86:1128-30).

The fact that statins reduce the risk of stroke in individuals with both normal and elevated cholesterol levels—and that no similar effect has been seen with non-statin cholesterol-lowering agents—sug- gests the mechanism is related to the statins’ non-lipid-mediated actions. These include stabilization of atherosclerotic plaques and improvement of endothelial function, along with antiinflammatory and antioxidant effects.

Given their plaque-stabilizing potential, it would be reasonable to assume statins would have a similar protective effect as adjunctive therapy for patients undergoing carotid angioplasty and stenting, as well. “It certainly ought to be considered—al- though that’s pure speculation, because our study didn’t address this,” Dr. Perler said in response to a reporter’s question.

But what this study does point to, he not- ed, is a potential way to enhance the safety of CEA, the most commonly performed of all vascular procedures, including CABG. Although still considered the “gold standard” for treating occlusive carotid disease, that status is now being challenged by data suggesting that a statin might be an alterna- tive of carotid stenting is not inferior with regard to outcomes (N. Engl. J. Med. 2004;351:1493-501).