SUPPLEMENTAL MATERIAL
SUPPLEMENTAL TABLES

Table I. BP Lowering Trials for Recurrent Stroke Prevention

Trial	Subjects (Centers)	Age, y/ Female, %	Qualifying Event, %	Median Enroll Months	Mean Follow-up Years	Treatment Drug (daily dose); Control	Baseline BP, mm Hg (% HTN)	BP Reduction, mm Hg	Treatment v. Control Recurrent Event; Risk Reduction* (95% CI)
PATS 1995[1]	5,665 (44)	60/ 28	IS: 71; TIA: 12; HS: 16	14	2	Indapamide (2.5mg); placebo	154/93 (84)	5/2	9.4% v. 12.3%; RR 29% (12-42)
PROGRESS 2001[2] (Single-drug)	2,561 (172)	65/ 32	IS: 70; TIA: 23; ICH: 11	9	3.9	Perindopril (4mg); placebo	144/84 (40)	5/3	12.3% v. 12.9%; RR 5% (-19-23)
PROGRESS 2001[2] (Combination)	3,544 (172)	63/ 29	IS: 71; TIA: 22; ICH: 11	7	3.9	Perindopril (4mg) + Indapamide (2.5mg); double-placebo	149/87 (54)	12/5	8.5% v. 14.4%; RR 43% (30-54)
MOSES 2005[3]	1,405 (330)	68/ 46	IS: 61; TIA: 27; PRIND: 6; ICH: 6	12	2.5	Eprosartan (600mg); Nitrendipine (10mg)	151/87 (100) in both groups	13/3 Eprosartan; 16/7 Nitrendipine	6.6 ID Eprosartan v. 8.8 ID Nitrendipine; RR 25% (3-42)
PRoFESS 2008[4]	20,332 (695)	66/ 36	IS: 100	0.5	2.5	Telmisartan (80mg); placebo	144/84 (74)	3.8/2.0	8.7% v. 9.2% RR 5% (-4-14)

IS, ischemic stroke; TIA, transient ischemic attack; HS, hemorrhagic stroke; ICH, intracerebral hemorrhage; PRIND, prolonged reversible ischemic neurological disorder; BP, blood pressure, given as systolic/diastolic; HTN, prior hypertension, RR, risk reductions; ID, incidence density per 100 person-years; CI, confidence interval.

* Recurrent stroke relative risk reduction estimates for treatment versus placebo were based on proportional hazards regression for all studies except for MOSES where risk reduction was estimated from the incidence density ratio (ID ratio: 0.75 (0.58-0.97)) between two treatment groups.

Table II. ASA/AHA Guideline Recommendations for BP Management for Recurrent Stroke Prevention

Ischemic Stroke and Transient Ischemic Attack[5]

1. Initiation of BP therapy is indicated for previously untreated patients with ischemic stroke or TIA who, after the first several days, have an established BP ≥140 mm Hg systolic or ≥90 diastolic *(Class I; LOV B).* Initiation of therapy for patients with BP <140 mm Hg systolic and <90 mm Hg diastolic is of uncertain benefit *(Class IIb; LOV C).**
2. Resumption of BP therapy is indicated for previously treated patients with known hypertension for both prevention of recurrent stroke and prevention of other vascular events in those who have had an ischemic stroke or TIA and are beyond the first several days *(Class I; LOV A).**
3. Goals for target BP level or reduction from pretreatment baseline are uncertain and should be individualized, but it is reasonable to achieve a systolic pressure <140 mm Hg and a diastolic pressure <90 mm Hg *(Class IIa; LOV B).* For patients with a recent lacunar stroke, it might be reasonable to target an SBP <130 mm Hg *(Class IIb; LOV B).**
4. Several lifestyle modifications have been associated with BP reduction and are a reasonable part of a comprehensive antihypertensive therapy. These modifications include salt restriction; weight loss; consumption of a diet rich in fruits, vegetables, and low-fat dairy products; regular aerobic physical activity; and limited alcohol consumption. *(Class IIa; LOV C)*
5. The optimal drug regimen to achieve the recommended level of reductions is uncertain because direct comparisons between regimens are limited. The available data indicate that diuretics or the combination of diuretics and an ACEI is useful. *(Class I; LOV A)*
6. The choice of specific drugs and targets should be individualized on the basis of pharmacological properties, mechanism of action, and consideration of specific patient characteristics for which specific agents are probably indicated (eg, extracranial cerebrovascular occlusive disease, renal impairment, cardiac disease, and diabetes). *(Class IIa; LOV B)*

Intracerebral Hemorrhage[6]

1. After the acute ICH period, absent medical contraindications, BP should be well controlled, particularly for patients with ICH location typical of hypertensive vasculopathy. *(Class I; LOV A)**
2. After the acute ICH period, a goal target of a normal BP of <140/90 (<130/80 if diabetes or chronic kidney disease) is reasonable. *(Class IIa; LOV B)**

Class, class of recommendation; LOV, level of evidence; BP, blood pressure, given as systolic/diastolic mm Hg; TIA, transient ischemic attack; ICH, intracerebral hemorrhage; ACEI, angiotensin-converting enzyme inhibitor.

* New or revised recommendation from previously published guidelines

SUPPLEMENTAL REFERENCES

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