Title page

Title
Comparative effectiveness of 4th line anti-hypertensive agents in resistant hypertension; A systematic review and meta-analysis

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Three Figures
Four Tables
Three Appendices (two tables and one figure)
MRAs versus other 4th line agents in RH

Abstract

**Aim**
We assessed the effectiveness of 4th line mineralocorticoid receptor antagonists in comparison to other 4th line anti-hypertensive agents in resistant hypertension.

**Methods and Results**
We systematically searched Medline, EMBASE and the Cochrane library from database inception until January 2016. We included randomised and non-randomised studies that compared mineralocorticoid receptor antagonists to other 4th line anti-hypertensive agents in patients with resistant hypertension. The outcome was change in systolic blood pressure, measured in the office, at home or by ambulatory blood pressure monitoring. Secondary outcomes were changes in serum potassium and occurrence of hyperkalaemia. We used random effects models and assessed statistical heterogeneity using the I² test and corresponding 95% confidence intervals.

From 2,506 records, 5 studies met our inclusion criteria with 755 included patients. Two studies were randomised and three were non-randomised. Comparative fourth line agents included bisoprolol, doxazosin, furosemide and additional blockade of the renin angiotensin-aldosterone system. Using data from randomised studies, mineralocorticoid receptor antagonists reduced blood pressure by 7.4mmHg (95% CI 3.2 – 11.6) more than the active comparator. When limited to non-randomised studies, mineralocorticoid receptor antagonists reduced blood pressure by 11.9mmHg (95% CI 9.3 – 14.4) more than the active comparator.

**Conclusion**
On the basis of this meta-analysis, mineralocorticoid receptor antagonists reduce blood pressure more effectively than other 4th line agents in resistant hypertension. Effectiveness stratified by ethnicity and comorbidities, in addition to information on clinical outcomes such as myocardial infarction and stroke now needs to be determined.
MRAs versus other 4th line agents in RH

**Keywords**
Resistant hypertension, blood pressure, mineralocorticoid receptor antagonists, spironolactone, comparative effectiveness research, meta-analysis.
Introduction

Hypertension is a leading cause of mortality worldwide. It occurs in 1 out of 4 people and is responsible for 9.4 million deaths annually.\textsuperscript{1,2} Of those affected, approximately 14% are said to have resistant hypertension (RH)\textsuperscript{3}, defined as blood pressure (BP) that remains $\geq 140/90$mmHg despite being treated with maximum doses, or best tolerated doses, of three or more antihypertensive agents, one of which should be a diuretic.\textsuperscript{4} The prevalence of RH is equally distributed between men and women, but is more common in older people (mean age 60yrs).\textsuperscript{3} Those with diabetes and chronic kidney disease (CKD), along with those who are obese, are over-represented in the RH population.\textsuperscript{5} Patients with RH generally have a poorer prognosis than those whose hypertension is controlled, with a 50% increased risk of a cardiovascular event.\textsuperscript{6}

The pathophysiology of RH remains poorly understood. Once adherence and white coat hypertension have been ruled out, over activation of the renin-angiotension-aldosterone system (RAAS), over activation of the sympathetic nervous system, sodium retention leading to volume expansion and/or vascular stiffening have all been suggested as potential pathological mechanisms.\textsuperscript{7-10} Given the mixed pathologies and a historical dearth of evidence for the treatment of RH\textsuperscript{11}, current clinical guidance from international sources is slightly discordant. For example, NICE guidelines in the UK suggest the use of either spironolactone (a mineralocorticoid receptor antagonist (MRA) with potassium sparing diuretic activity), or increasing the dose of the thiazide diuretic in the case of high serum potassium as potential 4\textsuperscript{th} line options on top of an angiotensin-converting enzyme inhibitor (ACEI)/angiotensin receptor blocker (ARB), a calcium channel blocker, and a diuretic.\textsuperscript{4} The European Society of Hypertension/European Society of Cardiology guidelines refer to the use of fourth-line MRA, amiloride or an alpha-blocker.\textsuperscript{12} In the USA, both the American Heart Association and the Eighth Joint National Committee guidance specify adding a beta-blocker or a MRA as fourth-
line agents and/or seeking specialist advice.\textsuperscript{13,14} Despite these disparities, the general message from all is to enhance diuretic treatment.\textsuperscript{4,12-14}

Two recent systematic reviews have pointed to the effectiveness of MRAs versus placebo in lowering BP in those with RH.\textsuperscript{15,16} While this is important evidence, it would now be useful to establish how MRAs compare to other potential 4\textsuperscript{th} line agents.

Hence, we assessed the effectiveness, in terms of systolic BP reductions, of MRAs in comparison to alternative 4\textsuperscript{th} line anti-hypertensive agents in patients with RH.
Methods

Data sources and searches

We searched Medline, Embase and the Cochrane Library from inception up to January 2016 with no language restriction. The search terms used in Medline were ‘resistant hypertension’ AND "Hypertension/drug therapy"[Mesh] AND "Antihypertensive Agents" [Pharmacological Action]; we constructed analogous searches in the other databases. We searched Clinicaltrials.gov for ongoing or completed trials of anti-hypertensive agents in RH.

We also searched the reference lists of included articles and recent clinical guidelines. Where relevant abstracts were found without corresponding full papers, we contacted study authors for full text papers. If a full text paper did not exist at that time, the record was excluded. We also contacted study authors to clarify any questions on their reported results.

Study selection

**Definition of RH**

We included studies that defined RH as systolic BP ≥140mmHg despite being on ≥3 anti-hypertensive agents.

**Study types**

Full texts of both randomised studies and non-randomised studies were eligible for inclusion. Letters, editorials and opinion pieces were excluded.

**Intervention and comparator**

The intervention was the addition of an MRA. The comparator was the addition of an alternative fourth-line anti-hypertensive agent. There was no restriction on agent, dose, duration of treatment or length of follow up. Studies that examined drugs that are not available on the market or not currently being tested in phase 2 or phase 3 trials were excluded.
Outcome

The outcome was change in systolic BP in the intervention group relative to the comparator group. We used systolic BP, as opposed to both systolic and diastolic BP for two reasons. First, because systolic hypertension is much more common in populations aged >50yrs than diastolic BP. Second, because systolic hypertension contributes more to the global cardiovascular disease burden than diastolic hypertension. There were no restrictions on how BP was measured; office, home or ambulatory blood pressure monitoring (ABPM) measurements were all included. In studies where more than one type of measurement was reported, ABPM was the preferred outcome for inclusion in the meta-analysis. Secondary outcomes included mean changes in serum potassium and the number of cases of hyperkalaemia in each treatment group.

Data extraction and quality assessment
SJS carried out the searches. After exclusion of duplicates and irrelevant titles and abstracts, four study authors (SJS, AR, RM and KM) independently assessed full texts for eligibility, and carried out data extraction and quality assessment in duplicate. Any differences of opinion were discussed and a third reviewer was available to arbitrate any issues that remained unresolved. We used a standardised data extraction form to collect information for each study on: the definition of RH used, including whether due consideration was given to white coat hypertension, adherence and secondary causes of hypertension; the type of study design and analysis used; and details on population characteristics for example, number of people included, mean age, proportion of females, mean body mass index (BMI), proportion of diabetic patients and mean estimated Glomerular Filtration Rate (eGFR). We extracted detailed data on baseline systolic BP, systolic BP at the end of follow up and change in systolic BP between the treatment arms for each study along with information on how BP
was measured. We collected adverse event data specifically for mean changes in serum potassium and hyperkalaemia.

We assessed the quality of included studies using a modified Downs and Black checklist, which can be used for randomised studies and non-randomised studies. This checklist assesses quality across four domains: internal validity (bias and confounding), external validity and general quality of study reporting. Included studies were scored out of a potential 21 points across these four domains.

**Data synthesis and statistical analysis**

We used the difference in mean reductions in systolic BP between treatment arms and the standard error in DerSimonian-Laird random effects models. Statistical heterogeneity was assessed using the I² test and corresponding 95% confidence intervals estimated using the formula proposed by Higgins and Thompson. An I² threshold of >60% indicated substantial heterogeneity. We analysed randomised and non-randomised studies separately. We did not formally test for the presence of publication bias due to the small number of included studies. Rather, we visually inspected the funnel plot. Secondary outcomes were qualitatively assessed.

**Sensitivity analyses**

Three methods of measuring BP were reported in the included studies; 1) office BP, 2) home BP and 3) ABPM. We conducted sensitivity analyses to assess whether combining different types of BP measurements in a meta-analysis gave substantially different result. We ran all analyses in Revman Version 5.3. We referred to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for reporting (Supplementary Information 1).
Results
From 2506 citations, after exclusion of duplicates and irrelevant titles, 22 full texts were assessed for eligibility. Seventeen of these were excluded (Figure 1). Thus, five articles were included in the review.8,23–26

This included 755 patients with a mean age of 62 years and 30% female. Diabetes was highly prevalent at 45.6%, while eGFR was 83.9 ml/min, likely due to exclusion of patients with chronic kidney disease in some studies.8,23,25,26 Mean BMI was 30.7 kg/m² (Table 1).
Of the included studies, two were randomised controlled trials\textsuperscript{26} \textsuperscript{23} and three were non-randomised\textsuperscript{24} \textsuperscript{25} \textsuperscript{8} The intervention was spironolactone in all studies. The comparator drugs included doxazosin, bisoprolol, furosemide and additional RAAS blockade (Table 2).

*Insert Table 2*

There was substantial heterogeneity across the included studies in terms of how RH was defined and identified. Four studies referred to adherence to medication regimen before including patients as RH cases, but the reported detail on how this was examined was variable.\textsuperscript{8} \textsuperscript{24} \textsuperscript{26} Bobrie \textit{et al.} referred to adherence measurement during the study by pill count, but the threshold for adherence was not reported.\textsuperscript{23} The results of on treatment adherence assessment by urinalysis in the PATHWAY-2 trial is yet to be published.\textsuperscript{26} One study did not clearly define the BP thresholds used to define RH\textsuperscript{8} and two studies did not define how long a patient should be on 3 or more anti-hypertensive agents before being defined as having RH.\textsuperscript{8} \textsuperscript{25}

Two studies measured the outcome, systolic BP, both in the office and with ABPM monitoring \textsuperscript{8} \textsuperscript{23}, one study each used office and ABPM monitoring respectively\textsuperscript{24} \textsuperscript{25} and one study used home monitoring and office measurements.\textsuperscript{26} Follow up ranged from eight weeks to six months.

Non-randomised studies were of much lower quality than randomised studies (Table 3). They achieved lower scorings on internal validity due to baseline characteristics being non-comparable, statistical tests that did not account for confounding, not accounting for losses to follow up, not being adequately powered and not tracking adherence to the intervention or comparator drug.

*Insert Table 3*
Results of meta-analysis

We included two studies, including a total of 502 patients, in a meta-analysis of randomised studies. Using a random effects model, the overall pooled estimate for reduction of systolic BP by MRAs was 7.4mmHg (95% CI 3.2 – 11.6) more than the active comparator (Figure 2a). Heterogeneity was measured as $I^2 = 76\%$ (95% CI 0 – 95.5). There was one ABPM measurement in this analysis and one home measurement.

We included three studies, including a total of 253 patients, in a meta-analysis of non-randomised studies. Using a random effects model, the overall reduction in systolic BP was 11.9mmHg (95% CI 9.3 – 14.4) more in spironolactone users than the active comparator (Figure 2b). Heterogeneity was measured as $I^2 = 0\%$ (95% CI 0 - 40). There were two ABPM measurements in this analysis and one office measurement.

Sensitivity analyses

Office measurements in non-randomised studies

In the main analysis using randomised and non-randomised studies, ABPM measurements were included where reported. In a sensitivity analysis, we included office BP, where reported, to assess the influence of measurement types on pooled results. For randomised studies, this analysis included two office BP measurements as opposed to one ABPM measurement and one home measurement in main analysis. Using a random effects model, the overall effect measure estimated that spironolactone reduced systolic BP by 7.3mmHg (95% CI 0.9 – 13.8) more than the active comparator (Figure 3a). Heterogeneity was measured as $I^2 = 87\%$ (95% CI 24.8 - 97.8). For non-randomised studies, the sensitivity analysis included two office BP measures and one ABPM measurement. Using a
random effects model, the overall effect measure estimated that spironolactone reduced systolic BP by -13.4mmHg (95% CI 8.4 – 18.3) more than the active comparator (Figure 3b). Heterogeneity was measured as $I^2 = 66\%$ (95% CI 0 – 94).

*Insert Figure 3*

**Changes in serum potassium and hyperkalaemia**

All five included studies reported changes in serum potassium or cases of hyperkalaemia.\(^8,23^\)\(^-26\) From **Table 4**, there were 12 cases of hyperkalaemia in 424 patients treated with MRAs, in comparison to 0 events in 471 patients treated with another fourth-line agent. Mean serum potassium values increased to a greater extent in patients treated with MRAs than patients treated with another fourth-line agent (**Table 4**).

*Insert Table 4*

**Publication bias**

There was some visual evidence of asymmetry in the funnel plot, suggesting a small study bias (**Supplementary Information 3**).
Conclusions

This meta-analysis, encompassing five separate studies and 755 patients, found that when MRAs were compared with another fourth-line agent or strategy in the treatment of RH, MRAs achieved larger reductions in systolic BP, in the order of 7 to 12mmHg.

Three previous reviews have indicated the effectiveness of MRAs versus placebo, in addition to its’ safety. The reduction in systolic BP achieved by MRAs in previous reviews averaged at approximately 20mmHg. This is roughly double the reduction in BP shown in our review. This difference was not unexpected considering we included studies with an active comparator only, whereas previous reviews included studies where placebo was the comparator group. Whether this magnitude of reduction in systolic BP will translate to a decrease in cardiovascular outcomes in patients with RH remains to be examined. It might be reasonably expected that clinical relevance is likely given recent evidence that, in a general hypertensive population, a 10mmHg reduction in systolic BP was associated with an approximate 20% reduction in risk of cardiovascular and coronary heart disease events, and an approximate 30% reduction in risk of stroke and heart failure.

Our sensitivity analysis for randomised studies demonstrated little difference in the magnitude of reductions gained in systolic BP when measured using office measurements versus home or ABPM measurements. The randomised nature of these studies likely preserved the relative difference between treatment arms. In contrast, when the majority of non-randomised studies reported office BP rather than the majority reporting ABPM measurements larger reductions in systolic BP were found (-13.8mmHg versus -11.9mmHg). Although the difference in these findings was not significant, the trend towards greater reductions via office measurements is in line with current knowledge on the contribution of white coat hypertension in RH, and indeed in hypertension more broadly. This finding
also points to the importance of home BP or ABPM monitoring in detecting BP levels that
are ultimately predictive of clinical events and mortality.\(^\text{48}\)

In all studies, where reported, the average increase in serum potassium was larger in the
MRA group compared with other 4\(^\text{th}\) line agents. The magnitude of mean changes appeared
to be larger in non-randomised studies than randomised studies. Similar findings were
reported in a recent systematic review whereby the increase in serum potassium, found in
non-randomised studies, was 0.46mmol/L higher than in placebo treated patients.\(^\text{16}\) However,
in randomised studies, the mean change between the groups was 0.15mmol/L, and this was
non-significant.\(^\text{16}\) A second review, encompassing a meta-analysis of mixed randomised and
non-randomised studies, showed an increase of 0.33mmol/L (95% CI, 0.27-0.39) in serum
potassium in users of MRAs.\(^\text{15}\)

Our review also points to an increased number of hyperkalaemia-related events in patients
treated with MRAs in comparison to patients treated with other 4\(^\text{th}\) line agents. The
systematic review authored by Dahal et al. reports an event rate of 46/1000 for hyperkalaemia
in patients treated with MRAs in comparison to placebo, but this was solely in non-
randomised studies and the same finding of increased risk was not found in randomised
studies.\(^\text{16}\) The difference in biochemical parameters reported by randomised and non-
randomised studies may reflect differences in how patients are monitored in different study
settings. For example, in clinical trials frequent follow up visits allow opportunity to identify
changes in serum potassium before advancement to hyperkalaemia. In contrast, non-
randomised studies are often conducted in routine care and reflect the true
frequency/infrequency of laboratory testing, and thus the real world safety implications of
treatments for patients.\(^\text{49}\) Discordant findings between randomised and non-randomised
studies aside, the risk of hyperkalaemia related events, especially in people using both and
ACEI/ARB and spironolactone, remains a worry and frequent lab monitoring is recommended.50

Our review provides evidence that on average, MRAs are more efficient in lowering systolic BP than other potential fourth-line agents such as bisoprolol, doxazosin and additional RAAS blockade. This may be explained by the main pathophysiology associated with RH; volume expansion secondary to salt sensitivity/retention.10

MRAs’ antagonism of aldosterone at the distal tubule, resulting in the removal of sodium in exchange for potassium thus increasing diuresis, reduces the problem of volume expansion.51 While the use of an ACEI or an ARB should block the production of aldosterone at an earlier stage in the RAAS, a phenomenon referred to as “aldosterone synthesis escape” requires direct blockade of aldosterone at the mineralocorticoid receptor to ensure lowering of blood pressure, thus providing a functional and productive role for spironolactone on top of other anti-hypertensive agents.52

While other pathophysologies can be implicated in RH, such as over-activation of the sympathetic nervous system10, the success of MRAs in RH may be due to volume expansion being the most prevalent mechanism underpinning the disease. A second reason for the benefit of MRAs above other 4th line agents is that, in addition to its’ action at the distal tubule, there is evidence to suggest that MRAs also work on the vasculature reducing BP by other mechanisms. For example, spironolactone has been found to increase vascular compliance in rats52, inhibit vasoconstriction in the arterioles 53 and eplerenone has been found to improve endothelial function and inhibit Rho-associated kinases, which are involved in the contracture of vascular smooth muscle cells.54

We observed several important sources of heterogeneity between the studies included in the review, for example; study authors rarely discussed how long their included populations
were on ≥3 anti-hypertensive agents before being classified as RH. Not all studies sought to exclude white coat hypertension, nor did all studies examine insufficient adherence to anti-hypertensive medication regimens during the study. This points to a requirement for a more stringent application of a standardised definition of resistant hypertension to avoid mixed samples of patients, leading to results that do not apply to the actual RH population. We noted some evidence of publication bias in the funnel plots. This was likely associated with poor methodological quality in the included non-randomised studies.55

Our review has multiple strengths. First, we used a comprehensive search strategy yielding more than 2,500 records that we screened for inclusion. Second, we carried out study selection and data abstraction in duplicate to enhance the reliability of our findings. Third, this review provides a quantitative estimate of the effectiveness of MRA in comparison to other antihypertensive agents that could be used as fourth-line agents in RH, improving on other reviews that examined placebo as the comparison group.15 16 44 Information on comparative effectiveness is constructive in that MRAs will not suit every patient with RH, for example in patients where a drug-drug interaction is expected or adverse events such as hyperkalaemia could reasonably occur.56 In such cases, information on the effectiveness of alternative pharmacologic options is required.

Our review is limited in that it we did not assess individual level patient data. This would have allowed comprehensive subgroup analyses according to sex, age, diabetes status and renal function. The number of included studies in each meta-analysis was low. While more studies would have been preferable, it was still appropriate to carry out a meta-analysis. This was for reasons of transparency in the processes employed to reach a summary conclusion, and also because combining the results of studies added information beyond what was held in each individual study.57 A small number of included studies meant it was also challenging to accurately assess between-study heterogeneity. We attempted to ameliorate this limitation by
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presenting 95% confidence intervals around the point estimate for $I^2$ value.\textsuperscript{58,19} A further limitation is that the included studies were of varying quality. Non-randomised studies, in particular, often include an amount of confounding by indication, and the studies included in this review mostly used methodology not designed to address this, for example simple statistical analyses such as t-tests or Wilcoxon tests. Nonetheless, a meta-analysis of these studies was useful for the reasons of transparency and combining information as mentioned above.\textsuperscript{57} In addition, for a topic area where not many trials exist, it seems efficient to use all available evidence, with due appreciation for its’ limitations. The non-randomised studies we included found a similar overall effect to the randomised studies in this review suggesting confounding may not have been strong in this instance. This is likely to arise if the choice between different drugs is not driven by strong evidence and could indicate a perception of equipoise in many cases. It therefore appears that observational data may be of further use for investigating the comparative effects of different drug choices for RH. However, our nuanced summary of deficits noted in the literature should be addressed in future studies.

While quantitative estimates of the benefits of MRAs in reducing BP in RH are now available, it would be helpful to stratify these changes in BP by patient characteristics such as ethnicity, and co-morbidities such as diabetes and renal function.\textsuperscript{15,59} Future meta-analyses might endeavour to stratify by different classes of comparator agents, e.g., beta-blockers, diuretics and alpha-blockers to enable a more nuanced understanding of the comparative effectiveness of MRA. It is now important that an assessment of effects on clinical outcomes such as stroke and myocardial infarction is conducted. A rough calculation using information on outcome parameters from the SPRINT trial indicates that an RCT of approximately 15,000 patients with 2 years follow up would be required to detect a 20% difference in cardiovascular outcomes for RH patients on spironolactone versus other 4th line agents.\textsuperscript{60} The practical challenges of recruiting this number could be sidestepped by conducting a well-
designed and appropriately powered observational study. From the data presented in this study, it appears that observational studies can detect similar effect sizes to randomised trials in studies of RH, and thus, if designed appropriately offer a useful and practical way forward.

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Conflicts of Interest
There are no conflicts of interest to report.

Authorship
SJS contributed to the conception or design of the work. SJS, ID, LT, RM, KM, AR and LS contributed to the acquisition, analysis, or interpretation of data for the work. SJS drafted the manuscript. ID, LT, RM, KM, AR and LS critically revised the manuscript. All gave final approval and agree to be accountable for all aspects of work ensuring integrity and accuracy.
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50. MHRA. Drug Safety Notice. Spironolactone and renin angiotensin system drugs in heart failure: risk of potentially fatal hyperkalaemia. Available at https://www.gov.uk/drug-safety-

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Figures

**Figure 1:** Flowchart of results

**Figure 2A (upper panel):** Meta-analysis of changes in systolic BP for randomised studies.

**Figure 2B (lower panel):** Meta-analysis of changes in systolic BP for non-randomised studies
Figure 3: Meta-analysis of changes in systolic BP for non-randomised studies, using office BP measurements where reported.
Tables

**Table 1: Description of participants in included studies**

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<th>Mean Age</th>
<th>% Female</th>
<th>% Diabetes</th>
<th>Mean eGFR</th>
<th>% Smoking</th>
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<th>Mean no. of drugs</th>
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<th>Outcome measurement 2</th>
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eGFR – estimated Glomerular Filtration Rate, ABPM – Ambulatory Blood Pressure Monitoring, BMI – Body Mass Index, BP – Blood Pressure

^GFR calculated with MDRD equation, #GFR calculated with unknown method, *GFR calculated with CKD EPI equation, ~Creatinine Clearance given

NR- not reported
## Table 2: Description of included studies

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<th>Assessment of adherence prior to inclusion</th>
<th>Assessment of adherence during trial</th>
<th>Follow up</th>
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<td>France</td>
<td>165</td>
<td>Nephron blockade: spironolactone 25mg, followed by furosemide 20mg/day, titrated to 40mg/day, followed by addition of amiloride.</td>
<td>Block of RAS: ramipril 5mg/day, titrated to 10mg/day, followed by bisoprolol 5mg/day titrated to bisoprolol 10mg/day</td>
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<td>Yes - pill counts</td>
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<td><strong>Non-randomised studies</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alvarez-Alvarez 2010&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Prospective crossover</td>
<td>Spain</td>
<td>39</td>
<td>Spironolactone 25mg increased to 50mg</td>
<td>Addition of ACEI/ARB</td>
<td>Yes</td>
<td>No details</td>
<td>No details</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Rodilla 2009&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Cohort study</td>
<td>Spain</td>
<td>181</td>
<td>Spironolactone 14mg (average)</td>
<td>Doxazosin 4mg (average)</td>
<td>Yes</td>
<td>Yes, but no details how</td>
<td>No details</td>
<td>3 months for spironolactone and 6 months for doxazosin</td>
</tr>
<tr>
<td>Verdalles 2015&lt;sup&gt;25&lt;/sup&gt;</td>
<td>Cohort study</td>
<td>Spain</td>
<td>30</td>
<td>Spironolactone 25mg</td>
<td>Furosemide 40mg</td>
<td>Yes</td>
<td>Yes, but no details how</td>
<td>No details</td>
<td>6 months</td>
</tr>
</tbody>
</table>

RCT – randomised controlled study, RAS – renin-angiotensin system, RH – resistant hypertension, ABPM- ambulatory blood pressure monitoring. ACE – angiotensin converting enzyme, ACEI/ARB - angiotensin converting enzyme inhibitor/angiotensin receptor blocker
Table 3: Description of quality of included studies

<table>
<thead>
<tr>
<th></th>
<th>Internal Validity - Bias</th>
<th>Internal Validity - Confounding</th>
<th>External Validity</th>
<th>Adverse event reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Randomised studies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bobrie 2012\textsuperscript{23}</td>
<td>6.5/8</td>
<td>6/10</td>
<td>2/2</td>
<td>1/1</td>
</tr>
<tr>
<td>Williams 2015\textsuperscript{26}</td>
<td>8/8</td>
<td>8/10</td>
<td>1/2</td>
<td>1/1</td>
</tr>
<tr>
<td><strong>Non-randomised studies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alvarez-Alvarez 2010\textsuperscript{9}</td>
<td>5/8</td>
<td>4/10</td>
<td>0/2</td>
<td>1/1</td>
</tr>
<tr>
<td>Rodilla 2009\textsuperscript{24}</td>
<td>3/8</td>
<td>3/10</td>
<td>0/2</td>
<td>1/1</td>
</tr>
<tr>
<td>Verdalles 2015\textsuperscript{25}</td>
<td>5/8</td>
<td>4/10</td>
<td>0/2</td>
<td>1/1</td>
</tr>
</tbody>
</table>

Notes: A detailed scoring sheet along with description of quality assessment form is included in Supplementary Information 2.
MRAs versus other 4th line agents in RH

**Table 4:** Number of cases of hyperkalaemia and mean changes in serum potassium in patients treated with spironolactone and other 4th line agents

<table>
<thead>
<tr>
<th>Study</th>
<th>Spironolactone</th>
<th>Other 4th line agents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases of hyperkalaemia</td>
<td>Mean change in serum potassium (SE)</td>
</tr>
<tr>
<td><strong>Bobrie 2012</strong></td>
<td>3/85</td>
<td>0.30 (0.80)</td>
</tr>
<tr>
<td><strong>Williams 2015</strong></td>
<td>6/285</td>
<td>0.42*</td>
</tr>
<tr>
<td><strong>Subtotal events for randomised studies</strong></td>
<td>9/370</td>
<td>~</td>
</tr>
<tr>
<td><strong>Alvarez-Alvarez 2010</strong></td>
<td>1/39</td>
<td>0.53 (0.09)</td>
</tr>
<tr>
<td><strong>Rodilla 2009</strong></td>
<td>NR</td>
<td>0.41 (0.05)</td>
</tr>
<tr>
<td><strong>Verdalles 2015</strong></td>
<td>2/15</td>
<td>NR</td>
</tr>
<tr>
<td><strong>Subtotal events for non-randomised studies</strong></td>
<td>3/54</td>
<td>~</td>
</tr>
<tr>
<td><strong>Total events</strong></td>
<td>12/424</td>
<td>~</td>
</tr>
</tbody>
</table>

**Notes:** NR = not reported. Verdalles reported two cases of “mild” hyperkalaemia defined as serum potassium 5.0-5.5mmol/L. *

*Variance for serum potassium changes not reported. ^Bisoprolol as comparator. #Doxazosin as comparator.
### Supplementary Information 1

<table>
<thead>
<tr>
<th>Section/topic</th>
<th>#</th>
<th>Checklist item</th>
<th>Reported on page #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>1</td>
<td>Identify the report as a systematic review, meta-analysis, or both.</td>
<td>Title page</td>
</tr>
<tr>
<td><strong>ABSTRACT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured summary</td>
<td>2</td>
<td>Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.</td>
<td>1</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>3</td>
<td>Describe the rationale for the review in the context of what is already known.</td>
<td>3+4</td>
</tr>
<tr>
<td>Objectives</td>
<td>4</td>
<td>Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).</td>
<td>4</td>
</tr>
<tr>
<td><strong>METHODS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol and registration</td>
<td>5</td>
<td>Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.</td>
<td>No, attempted to register at PROSPERO however, our work had begun so our protocol could not be included in PROSPERO</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>6</td>
<td>Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.</td>
<td>5+6</td>
</tr>
<tr>
<td>Information sources</td>
<td>7</td>
<td>Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.</td>
<td>5+6</td>
</tr>
<tr>
<td>Search</td>
<td>8</td>
<td>Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.</td>
<td>5</td>
</tr>
<tr>
<td>Study selection</td>
<td>9</td>
<td>State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).</td>
<td>5+6</td>
</tr>
<tr>
<td>Data collection process</td>
<td>10</td>
<td>Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.</td>
<td>5+6</td>
</tr>
<tr>
<td>Section/topic</td>
<td>#</td>
<td>Checklist item</td>
<td>Reported on page #</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Risk of bias across studies</td>
<td>15</td>
<td>Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).</td>
<td>7</td>
</tr>
<tr>
<td>Additional analyses</td>
<td>16</td>
<td>Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.</td>
<td>7</td>
</tr>
<tr>
<td><strong>RESULTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study selection</td>
<td>17</td>
<td>Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.</td>
<td>Figure 1 and page 8</td>
</tr>
<tr>
<td>Study characteristics</td>
<td>18</td>
<td>For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.</td>
<td>Table 1 and page 9</td>
</tr>
<tr>
<td>Risk of bias within studies</td>
<td>19</td>
<td>Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).</td>
<td>Table 2 and page 10</td>
</tr>
<tr>
<td>Results of individual studies</td>
<td>20</td>
<td>For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.</td>
<td>Figures 2 and 3.</td>
</tr>
<tr>
<td>Synthesis of results</td>
<td>21</td>
<td>Present results of each meta-analysis done, including confidence intervals and measures of consistency.</td>
<td>Figures 2, and 3</td>
</tr>
<tr>
<td>Risk of bias across studies</td>
<td>22</td>
<td>Present results of any assessment of risk of bias across studies (see Item 15).</td>
<td>Appendix 3 and page 14.</td>
</tr>
<tr>
<td>Additional analysis</td>
<td>23</td>
<td>Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).</td>
<td>Figure 3 and Table 3, also pages 13 and 14.</td>
</tr>
</tbody>
</table>
### Summary of evidence

| 24 | Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers). |

### Limitations

| 25 | Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias). |

### Conclusions

| 26 | Provide a general interpretation of the results in the context of other evidence, and implications for future research. |

### Funding

| 27 | Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review. |

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For more information, visit: [www.prisma-statement.org](http://www.prisma-statement.org).

Page 2 of 2
### Supplementary Information 2

#### Quality Assessment

**Table S2:** A detailed scoring across quality indicators as assessed using a modified Downs and Black quality assessment tool

<table>
<thead>
<tr>
<th>Question #</th>
<th>Internal Validity - Bias</th>
<th>Internal Validity - Confounding</th>
<th>External Validity</th>
<th>Misc - study quality</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Alvarez-Alvarez</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Bobrie</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rodilla</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Verdalles</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Williams</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Supplementary Information 3
Publication bias

![Funnel plot](image)

**Figure S1:** A funnel plot demonstrating the direction and size of effects in Randomised Studies and non-Randomised Studies.

- Largest study (Williams, n=335) is at the top of the graph, with a smaller effect size than the mean estimated effect.
- Note, all the NRS lie to the left of the mean effect estimate. This indicates that the effect of MRA is more beneficial in NRS than in RS.
- The likelihood of publication bias is small for two reasons.
  - First, the most commonly used MRA, spironolactone, is an off-patent medicine and investigators would have little financial incentive to not publish negative results. Second, the small study effects are likely due to poor methodological quality. Asymmetry in the graph is caused by the distribution of NRS. The methodological quality of all the NRS was quite low, as recorded in quality assessment forms.