Design and rationale of a prospective, collaborative meta-analysis of all randomized controlled trials of angiotensin receptor antagonists in Marfan syndrome, based on individual patient data: A report from the Marfan Treatment Trialists’ Collaboration

Alex Pitcher, BMBCh, Jonathan Emberson, PhD, Ronald V. Lacro, MD, Lynn A. Sleeper, Sc.D, Mario Stylianou, PhD, Lynn Mahony, MD, Gail D. Pearson, MD, ScD, Maarten Groenink, MD, PhD, Barbara J. Mulder, MD, PhD, Aeillo H. Zwinderman, PhD, Julie De Backer, MD, PhD, Anne M. De Paepe, MD, PhD, Eloisa Arbustini, MD, Guliz Erdem, MD, Xu Yu Jin, MD, Marcus D. Flather, MBBS, Michael J. Mullen, MD, Anne H. Child, MD, FRCP, Alberto Forteza, MD, PhD, Arturo Evangelista, MD, Hsin-Hui Chiu, MD, Mei-Hwan Wu, MD, PhD, George Sandor, MD, FRCPC, Ami B. Bhatt, MD, Mark A. Cregger, MD, Richard B. Devreux, MD, Bart Loeys, MD, PhD, J. Colin Forfar, MD, PhD, Stefan Neubauer, MD, Hugh Watkins, MD, PhD, Catherine Boileau, PharmD, PhD, Guillaume Jondeau, MD, PhD, Harry C. Dietz, MD, and Colin Baignent, BM, BCH, Oxford, London, Norwich, UK; Boston, Watertown, MA; Bethesda, Baltimore, MD; Dallas, TX; Amsterdam, The Netherlands; Ghent, Antwerp, Belgium; Pavia, Italy; Madrid, Barcelona, Spain; Taipei, Taiwan; British Columbia, Canada; New York, NY; and Paris, France

Rationale A number of randomized trials are underway, which will address the effects of angiotensin receptor blockers (ARBs) on aortic root enlargement and a range of other end points in patients with Marfan syndrome. If individual participant data from these trials were to be combined, a meta-analysis of the resulting data, totaling approximately 2,300 patients, would allow estimation across a number of trials of the treatment effects both of ARB therapy and of β-blockade. Such an analysis would also allow estimation of treatment effects in particular subgroups of patients on a range of end points of interest and would allow a more powerful estimate of the effects of these treatments on a composite end point of several clinical outcomes than would be available from any individual trial.

Design A prospective, collaborative meta-analysis based on individual patient data from all randomized trials in Marfan syndrome of (i) ARBs versus placebo (or open-label control) and (ii) ARBs versus β-blockers will be performed. A prospective study design, in which the principal hypotheses, trial eligibility criteria, analyses, and methods are specified in advance of the unblinding of the component trials, will help to limit bias owing to data-dependent emphasis on the results of
Background

Marfan syndrome is a heritable disorder of connective tissue, which typically produces symptoms and physical or imaging signs in several organ systems, with involvement of the cardiovascular, ocular, and musculoskeletal systems being particularly prominent.1-5 The most clinically important feature for most patients is a very high prevalence of aortic aneurysm formation (particularly, but not exclusively, in the aortic root at the sinuses of Valsalva), conferring a dramatically increased risk of potentially life-threatening aortic dissection and rupture.6

The prevalence of Marfan syndrome (based on hospital attendances) has recently been estimated at around 1 in 10,000 people,7 but the condition often goes undiagnosed, and most authorities accept a somewhat higher true prevalence of between 1 in 3,0008 and 1 in 5,000 people.9

Current medical therapy for Marfan syndrome consists mainly of β-blocker therapy. This approach, suggested by Halpern et al,10 was intended to reduce the rate of rise of aortic pressure, dP/dt, to reduce the forces imposed upon the aortic wall and so to reduce the rate of aortic dilation. The randomized evidence supporting the use of β-blockers is limited to a single, small, open-label trial.11 Many patients experience progressive aortic dilation despite such therapy,12,13 and prophylactic aortic root surgery is often required.

Remarkable progress has been made in recent years in understanding the pathophysiological basis of Marfan syndrome.14 Mutations in the FBN-1 gene, which encodes the extracellular matrix protein, fibrillin-1, were identified as the cause of Marfan syndrome in a number of families,15 and modern DNA sequencing techniques can now identify FBN-1 mutations in up to 92% of patients.16

Data from mouse models suggest that many of the manifestations of Marfan syndrome arise as a consequence of dysregulated Transforming Growth Factor β (TGFβ) signaling. The angiotensin receptor blocker (ARB) losartan (which down-regulates TGFβ signaling) rescued the aortic phenotype in a mouse model of Marfan syndrome,17 suggesting that targeted manipulation of TGFβ or its downstream pathways and regulators could prove to be productive strategies for the prevention of aortic disease in Marfan syndrome in patients.18-29

Several observational studies of ARBs in patients with Marfan syndrome have shown promising reductions in the rate of aortic dilation, both in combination with β-blockers12,30 and as monotherapy.31 Furthermore, 2 relatively small, randomized studies found reduced rates of aortic dilation in patients with Marfan syndrome (already taking β-blockers in most or all cases), randomly allocated to losartan, compared to patients who were randomly allocated to open-label control.25,27

Rationale for a meta-analysis of ARB trials in Marfan syndrome

Ten randomized controlled trials of ARBs in patients with Marfan syndrome were in progress at the time of protocol writing, each designed to evaluate the effects of ARBs, compared to either β-blockade or placebo/open-label control, on aortic root size (and other aspects of cardiovascular and noncardiovascular structure and function).18,29 These studies plan to answer a number of important questions regarding the efficacy, safety, and tolerability of ARB therapy in different circumstances. Individually, however, some of these studies may not be large enough to answer reliably a number of important outstanding questions regarding the effects of ARB therapy in Marfan syndrome.

Meta-analyses of randomized trials can, by reducing random errors and tending to minimize biases, provide more reliable estimates of the effects of a particular treatment strategy than any individual study.32 If individual participant data from these trials of ARBs in Marfan syndrome were to be combined, a meta-analysis of the resulting data (from approximately 2,300 patients) would provide more precise estimates across a number of trials of the treatment effects both of ARB therapy and β-blockade. In particular, it will increase statistical power to address the question of whether the treatments studied influence a clinically important composite end point of several clinical outcomes.

A meta-analysis of all trials will—because of its large size—allow sources of variation in the effect of treatment (eg, by age, baseline aortic root dimensions, or genotype) to be explored. Finally, a meta-analysis may be able to explore subsidiary hypotheses about the effects of treatments on a range of outcomes of interest beyond aortic root dimensions.
The principal investigators of these trials were contacted in 2012 and were asked if they might be willing to join a collaborative group—the Marfan Treatment Trialists’ Collaboration (MTTC)—in which it would be prospectively agreed that individual patient data from each trial would, after the completion of each trial, be provided to a central repository to allow for an individual patient data meta-analysis to be performed.

A prospective study design, in which the principal hypotheses, trial eligibility criteria, analyses, and methods are specified in advance of the unblinding of the component trials, will help to limit bias owing to data-dependent emphasis on the results of particular trials.

Members of the MTTC attended a series of meetings in Chicago in July 2012 and in Munich in August 2012 and subsequently agreed a protocol for such a meta-analysis in late 2012. Since the protocol was finalized, the results from 2 open-label trials have been published, and the results of the remaining trials are awaited.

This report summarizes the protocol and statistical analysis plan, which together define the rationale, trial eligibility criteria, analyses to be performed, and statistical methods that were agreed upon by members of the MTTC, without foreknowledge of the results of the component trials. The full protocol and detailed statistical analysis plan will be made available online (http://www.ctsu.ox.ac.uk/research/meta-trials).

**Aims**

**Primary aim**

The primary aim of this meta-analysis is to estimate the effect of (i) ARB therapy and (ii) β-blocker therapy, on change in aortic root size across a number of trials conducted in patients with Marfan syndrome and no prior aortic root surgery.

**Secondary aims**

The secondary aims of this meta-analysis are to assess the effects of these 2 treatment modalities on:

1. change in aortic root size at the sinuses of Valsalva among different patient subgroups, defined on the basis of baseline characteristics (Table II);
2. cardiovascular outcomes, including a composite of aortic dissection, aortic root surgery, or death, and on individual components of this end point (Table III); and
3. clinically or biologically important secondary outcomes of interest (Table III).

**Methods**

**Study eligibility and identification**

Randomized trials in patients with Marfan syndrome (defined according to the 1996 Ghent criteria or the updated 2010 Ghent criteria) are eligible for inclusion in the meta-analysis if they include a properly randomized comparison of one or both of (i) ARB versus placebo (or open-label control) or (ii) ARB versus β-blockers.

The inclusion of trials that have allocated patients to ARB versus placebo (or open-label control) and those that have allocated patients to ARB versus β-blockers allows not only for unbiased assessments of treatment effects of ARBs but also, indirectly, for an assessment of the effect of β-blockers versus placebo or open-label control.

Relevant trials were identified by searching online trial registries (eg, clinicaltrials.gov, ISRCTN, PUBMED); computer-aided and manual searches of journals; scrutiny of published trial protocols, abstracts and meeting proceedings, and the reference lists of review articles; and inquiry among colleagues, collaborating trialists, and manufacturers of ARBs. These sources will be rechecked periodically to identify trials that may be relevant but were not registered at the time of protocol drafting. The list of the trials currently identified as being eligible is shown in Table 1.

**Analytic approach**

The primary analytic approach for the meta-analysis will be according to the intention-to-treat principle, classifying each randomized subject according to their assigned treatment. Where participants discontinue allocated treatment strategies after randomization, data from such participants will continue to be included where available.

**Primary analysis**

**Primary outcome.** The primary outcome will be the annual rate of change of body surface area (BSA)-adjusted aortic root dimension z-score, measured at the aortic sinuses of Valsalva. The z-score is a dimensionless quantity, representing the signed number of standard deviations (SDs) away from the mean where an observation lies.

For the primary analysis, data from subjects with prior aortic root surgery at enrollment (enrolled in only a minority of trials) will be excluded. For subjects who underwent aortic root surgery or who died during the follow-up period, measurements of aortic root dimensions obtained before aortic surgery or death will be included in the analysis. Measurements of aortic root dimensions obtained after aortic root surgery will not be included.

For each trial, the imaging method of estimating aortic root dimension used for that trial’s primary analysis will be used as the primary outcome measure in this meta-analysis. Aortic root dimensions will be scaled for body size and normalized to appropriate reference populations. For each patient, linear slopes of rate of change of BSA-adjusted aortic root dimension z-score will be calculated.

Sources of variation in the method of aortic root measurement (including, for example, leading-edge to leading-edge method, compared to inner-edge to inner-edge method; systolic compared to diastolic measures) and in the methods used for body size indexation and reference population normalization will be explored and reported (see **Secondary outcomes** below).
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample size</th>
<th>Diagnostic criteria</th>
<th>Aortic size criteria</th>
<th>Age (y)</th>
<th>Treatment</th>
<th>Comparator</th>
<th>Follow-up duration (mo)</th>
<th>Primary end point</th>
<th>Timing of follow-up visits (mo)</th>
<th>Imaging methods</th>
<th>Study end date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARB vs β-blocker</td>
<td>608</td>
<td>Ghent</td>
<td>z-score &gt;3.0 and aortic root ≤5.0 cm</td>
<td>0.5-25</td>
<td>Losartan 0.4-1.4 mg/kg daily</td>
<td>Atenolol</td>
<td>36</td>
<td>Rate of change in aortic root (sinus of Valsalva) BSA-adjusted z-score</td>
<td>6, 12, 24, 36</td>
<td>Echo</td>
<td>Nov 14</td>
</tr>
<tr>
<td>US (Pediatric Heart Network)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy (ARB vs β-blocker arms)</td>
<td>156</td>
<td>Ghent and mutation in FBN1</td>
<td>z-score ≥2 or aortic root &gt;3.8 cm (F)/&gt;4.0 cm (M) and ≤5.0 cm</td>
<td>1-55</td>
<td>Losartan target dose 100 mg daily</td>
<td>Nebivolol</td>
<td>48</td>
<td>Aortic root growth rate</td>
<td>12, 24, 36, 48</td>
<td>Echo</td>
<td>Sept 15</td>
</tr>
<tr>
<td>Spain</td>
<td>150</td>
<td>Ghent</td>
<td>No minimum, aortic root ≤4.5 cm</td>
<td>5-60</td>
<td>Losartan 12.5-100 mg daily</td>
<td>Atenolol</td>
<td>36</td>
<td>Progression of aortic dilation</td>
<td>6, 12, 24, 36</td>
<td>CMR</td>
<td>Sept 14</td>
</tr>
<tr>
<td>US (Boston)</td>
<td>50</td>
<td>Ghent</td>
<td>Unrestricted</td>
<td>25+</td>
<td>Losartan</td>
<td>Atenolol</td>
<td>6</td>
<td>Arterial stiffness measures</td>
<td>6</td>
<td>Echo</td>
<td>Sept 14, 15</td>
</tr>
<tr>
<td>Canada</td>
<td>17</td>
<td>Ghent</td>
<td>Unrestricted</td>
<td>12-25</td>
<td>Losartan</td>
<td>Losartan</td>
<td>12</td>
<td>Pulse wave velocity</td>
<td>12</td>
<td>Echo</td>
<td>Sept 14</td>
</tr>
<tr>
<td>ARB vs placebo (or open-label control)</td>
<td>490</td>
<td>Revised Ghent</td>
<td>z-score &gt;0, aortic root &lt;4.5 cm</td>
<td>≥6-40</td>
<td>Irbesartan 150-300 mg daily*</td>
<td>Placebo*</td>
<td>48-60</td>
<td>Absolute change in aortic root diameter per year</td>
<td>12, 24, 36, 48, 60</td>
<td>Echo</td>
<td>Sept 18</td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Netherlands</td>
<td>233</td>
<td>Ghent</td>
<td>No minimum size, but aortic root ≤5 cm</td>
<td>≥18</td>
<td>Losartan 50-100 mg daily*</td>
<td>Open-label control*</td>
<td>36</td>
<td>Largest change at any aortic level by MRI from baseline to end of study</td>
<td>12, 24, 36</td>
<td>CMR (0 and 36)</td>
<td>Nov 13</td>
</tr>
<tr>
<td>France</td>
<td>300</td>
<td>Ghent</td>
<td>Unrestricted</td>
<td>≥10</td>
<td>Losartan 50-100 mg daily*</td>
<td>Placebo*</td>
<td>36</td>
<td>Rate of change of normalized aortic root diameter expressed as z-score</td>
<td>6, 12, 18, 24, 30, 36</td>
<td>Echo</td>
<td>Sept 14</td>
</tr>
<tr>
<td>Italy (ARB + β-blocker vs β-blocker arms)</td>
<td>156</td>
<td>Ghent and mutation in FBN1</td>
<td>z-score ≥2 or aortic root &gt;3.8 cm (F)/&gt;4.0 cm (M) and ≤5.0 cm</td>
<td>1-55</td>
<td>Losartan 100 mg and nebivolol</td>
<td>Nebivolol</td>
<td>48</td>
<td>Aortic root growth rate</td>
<td>12, 24, 36, 48</td>
<td>Echo</td>
<td>Sept 15</td>
</tr>
<tr>
<td>Belgium</td>
<td>39</td>
<td>Revised Ghent</td>
<td>Recognized aortic dilation</td>
<td>≥10</td>
<td>Losartan 25-100 mg daily*</td>
<td>Losartan and either atenolol or propranolol</td>
<td>Placebo*</td>
<td>36</td>
<td>Rate of change in the aortic root by linear regression of the z-score</td>
<td>6, 12, 24, 36</td>
<td>Echo (primary) and CMR (0 and 36)</td>
</tr>
<tr>
<td>Taiwan</td>
<td>29</td>
<td>Ghent</td>
<td>Recognized aortic dilation</td>
<td>1+</td>
<td>Losartan and either atenolol or propranolol</td>
<td>Atenol or propranolol</td>
<td>35</td>
<td>Aortic root growth rate</td>
<td>6, 12, 24, 36</td>
<td>Echo</td>
<td></td>
</tr>
</tbody>
</table>

Imaging methods: where >1 imaging method is listed (primary) indicates the method used for the primary outcome. Abbreviations: MRI, magnetic resonance imaging; CMR, cardiovascular magnetic resonance

* Trials based in the UK, France, Belgium, and the Netherlands allow enrolled patients to remain on their baseline therapy (usually, but not always β-blockers). The Italian and Taiwanese trials mandate β-blocker in the comparator arm(s). The Italian trial is randomizing 235 subjects in a 3-way, 1:1:1 randomization, to losartan alone, nebivolol alone, or losartan + nebivolol. Sample per arm is estimated as 78 (235/3) and 156 per comparison (78 × 2).
Effect of ARB versus placebo and of ARB versus \(\beta\)-blocker on aortic root size.\footnote{The availability of individual patient data will allow exploration of whether the benefits or hazards of treatment with ARBs or \(\beta\)-blockers are particularly great in certain types of patient, defined on the basis of characteristics present at the time of randomization.}\footnote{The absolute effects on the primary outcome of allocation to ARBs (and, indirectly, of allocation to \(\beta\)-blockers) versus control will, therefore, be examined separately, according to a limited number of subgroups defined by prespecified baseline characteristics (Table I).} Between-trial variation in age-range, other eligibility criteria, and treatment protocol, a common analysis plan will be implemented separately within each participating trial. For each trial, the difference in mean annual rate of change of BSA-adjusted aortic root dimension z-score between patients allocated to ARBs and patients allocated to control therapy (ie, placebo/open-label control or \(\beta\)-blocker, depending on the trial) will be estimated, as will the standard error of this mean difference.

The overall estimate of the effect on aortic root dimension of allocation to ARB versus placebo (or open-label control) will also be made, from the 5 trials that only compared ARB versus \(\beta\)-blocker (in the 5 trials that provide such a comparison) and the effect of allocation to ARB versus \(\beta\)-blocker in the 5 trials that provide such a comparison).

Results will be considered to be statistically significant if the 2-sided \(P\) value is \(<.05\), but chief emphasis will always be placed on the effect size estimate and its associated confidence intervals, which are the primary results of meta-analyses.

Effect of \(\beta\)-blockers on aortic root size: combining direct and indirect evidence. Only 1 of the 10 trials identified allows for a direct randomized assessment to be made of the effect of allocation to \(\beta\)-blockers (compared with control) on aortic root dimension (the Italian trial; Table I). However, an indirect assessment of the effect of \(\beta\)-blockers on aortic root dimension (and some other outcome measures) can be made from the other 9 trials, by combining the results from the 5 trials that only compared ARB versus \(\beta\)-blockers with the results from the 4 trials that only compared ARB versus placebo (or open-label control).

Specifically, if \(d_1\) (with variance \(v_1\)) is the difference in mean annual rate of change in aortic root dimension estimated from the 5 trials that only compared ARB versus \(\beta\)-blockers and \(d_2\) (with variance \(v_2\)) is the difference in mean annual rate of change in aortic root dimension estimated from the 4 trials that only compared ARB versus placebo/open control, then an indirect estimate of the effect of \(\beta\)-blockers is provided by \(d_2 - d_1\) (which has variance equal to \(v_1 + v_2\)).

The overall estimate of the effect on aortic root dimension of allocation to \(\beta\)-blocker is then provided by the inverse-variance-weighted average of the direct result from the Italian trial and the indirect evidence from the 9 other trials.\footnote{Because the likelihood of a false-positive result (ie, a type I error) increases with the number of subgroup analyses performed, these tests will not be considered statistically significant unless the interaction \(P\) value is \(<.01\) (and, even then, may be considered only as “hypothesis-generating”). Secondary analyses will always be identified as such in manuscripts arising from this work.}

For the comparison of ARB versus placebo, the randomization of \(>1200\) patients should provide \(>90\%\) power (with a 2-sided \(\alpha = .05\)) to detect a 0.2 SD difference in annual rate of change of BSA-adjusted aortic root dimension z-score, whereas the randomization of \(>900\) patients to ARB versus \(\beta\)-blocker would provide \(>80\%\) power (with a 2-sided \(\alpha = .05\)) to detect a between-group difference of 0.2 SD and \(>90\%\) power to detect a 0.25 SD difference.
and other biomarkers may be available from some trials. Analyses of these biomarkers may be feasible, but such analyses will only be considered to be hypothesis generating.

**Secondary outcomes.** Analyses will be performed to estimate the effect of ARB therapy (and, indirectly, of β-blockers) versus control on certain prespecified secondary outcome measures (Table III).

Continuous measures will be analyzed by calculating the inverse-variance-weighted average result across the trials (using, when appropriate, repeated-measures methods for each trial). Time-to-event outcomes will be analyzed using log-rank methods for meta-analyses. All P values will be two-sided, with a significance level of .05 being deemed significant, but any marginally significant results will be interpreted with appropriate caution and may be considered only as hypothesis generating.

Differences in the proportional effects of allocation to ARB (and, indirectly, of allocation to β-blocker) on the prespecified secondary outcomes by baseline characteristics (Table II) will also be assessed.

A sensitivity analysis will also estimate the effects of different methods of BSA estimation, body size estimation (height, BSA, BSA0.5), and normalization on the primary outcome and on secondary outcomes where appropriate.

Exploratory analyses will be conducted to assess the sensitivity of the final results to the analysis method used. In particular, the effect size estimates for each of the outcomes will be compared to those yielded by “random-effects” models, and if these are substantially discrepant, the final report will include a discussion of possible reasons for any differences.

**Interim analyses**

The final analysis will seek to include all trials of ARBs worldwide. Interim analyses may be performed if ≥1 trials are delayed, and these analyses may be submitted for publication before the completion of all trials. A separate analysis, confined to those trials evaluating the ARB losartan, will be performed before an analysis of trials including all ARBs.

**Collaborative group structure, organization, and management**

The meta-analysis will be undertaken by the MTTC, which is a collaborative group of trialists, meta-analysts, statisticians, biological scientists, and clinicians. The group includes representatives of each collaborating trial and meets periodically to discuss the design, conduct, and reporting of this meta-analysis. The study is supported and coordinated by a secretariat based at the Clinical Trial Service Unit & Epidemiological Studies Unit, University of Oxford, UK, and at the Division of Cardiovascular Medicine, Radcliffe Department of Medicine, University of Oxford, UK.

**Protocol preparation and publication policy**

Draft versions of the protocol and statistical analysis plan were prepared by the secretariat in spring 2012 and were reviewed at the meetings of the MTTC in Chicago in July 2012 and in Munich in August 2012. Drafts were circulated to all members of the collaboration throughout the process, and the documents were finalized after a series of teleconferences in late 2012.
Manuscripts arising from the meta-analysis will be prepared by the secretariat and reviewed by the collaborative group. The main findings of the meta-analysis will be submitted for publication in a peer-reviewed journal irrespective of the outcome of the overview. All publications will be submitted in the name of the MTTC, listing all collaboration members. Further information regarding the approach to analysis is available on request from the corresponding author, and inquiries from those wishing to perform similar types of analyses would be particularly welcome.

Disclosures
The study is supported by funding from The Marfan Foundation; the Medical Research Council; and the British Heart Foundation Centre for Research Excellence, Oxford. Alex Pitcher acknowledges funding support from the Marfan Foundation; the Gibson fund; the NIHR Biomedical Research Centre, Oxford; and the British Heart Foundation Centre for Research Excellence (grant code RE/13/1/30181). Alex Pitcher is supported by the Academy of Medical Sciences Clinical Lecturer Starter Grant scheme, which is administered by the Academy on behalf of the the Academy, the Wellcome Trust, the Medical Research Council, the British Heart Foundation, Arthritis Research UK, Prostate Cancer UK and the Royal College of Physicians. Eloisa Arbustini acknowledges Telethon grant number GGP08238.

Table III. Secondary endpoints and outcome measures

- The composite end point of aortic dissection, aortic root surgery, or death
- Annual rate of change in absolute aortic dimensions at the sinuses of Valsalva
- Annual rate of change in absolute aortic dimensions at the ascending aorta
- Annual rate of change in absolute aortic dimensions at other aortic sites
- Annual rate of change in BSA-adjusted, normalized aortic dimensions, expressed as a z-score
- Annual rate of change in proportional aortic root size
- Annual rate of change in absolute and BSA-adjusted dimensions of the pulmonary artery
- The incidence of moderate to severe aortic valve regurgitation
- The incidence of moderate to severe mitral valve regurgitation
- The incidence of aortic valve-sparing aortic root surgery and combined aortic valve and aortic root replacement
- Annual rate of change of measures of left ventricular cavity size, wall thickness, and systolic function
- Annual rate of change of brachial systolic, diastolic, and mean arterial pressure and pulse pressure
- Rate of change of age-adjusted measures of arterial stiffness/elasticity
- Rate of change of levels of circulating biomarkers of vascular function (including TGFβ whenever available)
- Annual rate of change of markers of somatic growth and disproportion
- Tolerability and side effects of therapy, frequency, and nature of adverse drug reactions and quality of life indices and the proportion of treatment failures, discontinuations, and/or patient drop-outs.

* And of each of these components separately.
† Sensitivity analysis will also estimate the effects of different imaging methods (systole vs diastole, inner-edge to inner-edge vs leading-edge to leading-edge method, echo versus magnetic resonance imaging).
‡ At the aortic annulus, sinuses of Valsalva, sinusotubular junction, ascending aorta, aortic arch, and descending aorta.
§ End-diastolic dimension, end-diastolic volume, end-systolic dimension, end-systolic volume, left ventricular wall thickness (septum), left ventricular wall thickness (posterior wall), left ventricular mass, left ventricular mass/volume ratio, fractional shortening, and ejection fraction, each indexed to body size and normalized where appropriate.
¶ Height, weight, body surface area, body mass index z-scores indexed to age, and markers of skeletal disproportion (arm span-to-height ratio and upper segment-to-lower segment ratio) with age at enrollment and height at enrollment as covariates.

Declaration
The authors declare that they have no conflicts of interest. All authors contributed to the design of the meta-analysis described in this work and have reviewed and approved the final manuscript.

Acknowledgements
We gratefully acknowledge Mary Roman, Steve Colan, Dan Roden, Christie Ingram, Sara Van Driest, Catherine Klersy, and Lut Van Laer for advice in preparing the protocol; Sylvia De Nobile, Valentina Favalli, Carolyn Levering, Josephine Grima, and The Marfan Foundation for supporting the collaboration; and Thomas Cassar for assistance in manuscript preparation.

References

syndrome in a general population: a national database study. Mayo

card for: Marfan syndrome type 1 and related phenotypes [FBN1]. Eur
J Hum Genet 2010;18(9), http://dx.doi.org/10.1038/ejhg.2010.42.
[Epub 2010 Apr 7].


of aortic rupture in the Marfan syndrome with data on survivorship

and the benefit of long-term beta-adrenergic blockade in Marfan’s

2008;358(26):2787-95.


14. Lindsay ME, Dietz HC. Lessons on the pathogenesis of aneurysm from

15. Dietz HC, Cutting GR, Pyeritz RE, et al. Marfan syndrome caused by a
recurrent de novo missense mutation in the fibrillin gene. Nature

sequencing to molecular diagnosis of Marfan and Loeys-Dietz

17. Habashi JP, Judge DP, Holm TM, et al. Losartan, an AT1 antagonist,
prevents aortic aneurysm in a mouse model of Marfan syndrome.
Science 2006;312(5770):117-21.

18. Lacro RV, Dietz HC, Wruck LM, et al. Rationale and design of a
randomized clinical trial of beta-blocker therapy (atenolol) versus
angiotensin II receptor blocker therapy (losartan) in individuals with

methods, quality review, and measurement accuracy in a randomized
multicenter clinical trial of Marfan syndrome. J Am Soc Echocardiogr

20. Lacro RV, Guey LT, Dietz HC, et al. Characteristics of children and
young adults with Marfan syndrome and aortic root dilation in a
randomized trial comparing atenolol and losartan therapy. Am Heart

placebo-controlled, double-blind, multicenter study of the effects of
irbesartan on aortic dilation in Marfan syndrome (AIMS trial): study
protocol. Trials 2013;14. [408-6215-14-408].

22. Detaint D, Aegeert P, Tubach F, et al. Rationale and design of a
randomized clinical trial (Marfan Sartan) of angiotensin II receptor
blocker therapy versus placebo in individuals with Marfan syndrome.

aortic dilation rate in adults with Marfan syndrome: a randomized

24. Fortezza A, Evangelista A, Sanchez V, et al. Study of the efficacy and
safety of losartan versus atenolol for aortic dilation in patients with

randomized, double-blind placebo controlled trial with losartan
in Marfan patients treated with beta-blockers. Int J Cardiol
2011;14:354-8.

evaluating the effects of losartan vs. nebivolol vs. the association of
both on the progression of aortic root dilation in Marfan syndrome
with FBN1 gene mutations. J Cardiovasc Med (Hagerstown)

therapy for aortic root dilation in Marfan syndrome: a randomized,

05/22, 2011].

NCT00593710?term=marfan+vancouver&rank=1.

of angiotensin II receptor blocker versus beta-blocker on aortic root
growth in paediatric patients with Marfan syndrome. Heart

31. Pees C, Iaccone F, Hagl M, et al. Usefulness of losartan on the size of
the ascending aorta in an unselected cohort of children, adolescents, and
young adults with Marfan syndrome. Am J Cardiol 2013;112(9):1477-83.

32. Emberson J, Baigent C. Clinical trials and meta-analysis. In: Yusuf S,
Cairns JA, Camm AJ, Fallen EL, Gersh BJ, eds. Evidence based

33. De Paepe A, Devereux RB, Dietz HC, et al. Revised diagnostic criteria

34. Loeys BL, Dietz HC, Braverman AC, et al. The revised Ghent nosology

35. Coxib and traditional NSAID Trialists’ (CNT) CollaborationBhala N,
Cribb PR, Emberson J, et al. Vascular and upper gastrointestinal effects of
non-steroidal anti-inflammatory drugs: meta-analyses of individual
participant data from randomised trials. Lancet 2013;382(9894):
769-79.