

Azithromycin and the Risk of Cardiovascular Death

Wayne A. Ray, Ph.D., Katherine T. Murray, M.D., Kathi Hall, B.S., Patrick G. Arbogast, Ph.D., and C. Michael Stein, M.B., Ch.B.

N Engl J Med 2012; 366:1881-1890 [May 17, 2012](#) DOI: 10.1056/NEJMoa1003833

Share:

[Abstract](#)

[Article](#)

[References](#)

[Citing Articles \(137\)](#)

[Letters](#)

Azithromycin, a broad-spectrum macrolide antibiotic, has been reported to be relatively free of cardiotoxic effects.¹ However, the closely related drugs erythromycin and clarithromycin can increase the risk of serious ventricular arrhythmias²⁻⁷ and are associated with an increased risk of sudden cardiac death.⁸⁻¹⁰ Furthermore, accumulating evidence suggests that azithromycin also may have proarrhythmic effects. There are at least seven published reports of patients with normal baseline QT intervals in whom azithromycin had arrhythmia-related adverse cardiac effects, including pronounced QT-interval prolongation,¹¹⁻¹³ torsades de pointes,¹⁴⁻¹⁶ and polymorphic ventricular tachycardia in the absence of QT-interval prolongation.¹⁷ The Food and Drug Administration's Adverse Event Reporting System includes at least 20 reports of torsades de pointes associated with azithromycin.¹⁸

Because the ventricular arrhythmias reported in conjunction with azithromycin use are often rapidly fatal, we conducted a retrospective cohort study of mortality among patients who used this antibiotic. We hypothesized that patients who took azithromycin, as compared with persons who did not take antibiotics and with patients who took other selected antibiotics, would have an increased risk of cardiovascular death, particularly sudden cardiac death.

Methods

Study Oversight

The study was designed by the authors and approved by the local institutional review board and the Tennessee Bureau of TennCare and Department of Health, all of which waived the requirement for individual informed consent. The sponsors had no role in the study conduct or reporting.

Study Cohort

The study cohort consisted of persons enrolled in the Tennessee Medicaid program^{19,20}; all data on patients in the study were appropriately deidentified.

Computerized Medicaid data, which were linked to death certificates and to a statewide hospital-discharge database, provided information on Medicaid enrollment, medical care encounters, and dates and causes of death. Antibiotics and other medications that patients had taken were identified from Medicaid pharmacy files.[19,21-23](#)

The cohort included patients who had been prescribed azithromycin between 1992 (when azithromycin was introduced in the United States) and 2006 and met the eligibility criteria on the date on which the prescription was filled. These criteria were formulated to exclude persons at high risk for death from causes unrelated to a short-term effect of proarrhythmic medication (Tables 1 and 2 in the [Supplementary Appendix](#), available with the full text of this article at NEJM.org). Eligible cohort members were 30 to 74 years of age, had no life-threatening noncardiovascular illness, had not received a diagnosis of drug abuse or resided in a nursing home in the previous year, and had not been hospitalized in the prior 30 days. To ensure adequate data for study variables, cohort membership also required at least 365 days of Medicaid enrollment and regular use of medical care.

The study also included matched control periods (of similar length to the courses of antibiotic therapy) during which there was no use of study antibiotics. For each qualifying azithromycin prescription, we identified four such control periods, which were frequency-matched²⁴ according to a propensity score that was calculated from 153 covariates (Table 3 in the [Supplementary Appendix](#)). The persons in the control group had to satisfy the eligibility criteria on the day that the control period began and could not have used any study antibiotics during the prior 30 days.

To attempt to control for confounding by indication, we also included as additional control groups patients who took three other antibiotics: amoxicillin (including amoxicillin with clavulanate potassium), ciprofloxacin, and levofloxacin. Amoxicillin, the primary control antibiotic, has indications that are similar to those of azithromycin and has not been shown to have adverse cardiac effects.⁸ The indications for ciprofloxacin and levofloxacin overlap those of azithromycin. Ciprofloxacin is thought to have minimal adverse electrophysiological effects, although there are case reports of torsades de pointes.^{1,25} Levofloxacin, which is considered to have greater proarrhythmic potential than ciprofloxacin,^{1,25} has been implicated in numerous case reports of torsades de pointes.¹⁸

A single person could have multiple prescriptions of the study antibiotics and also could have a control period with no use of study antibiotics. However, for each person, these periods did not overlap, and the end point (death) occurred only once. Thus, assumptions of statistical independence were not violated (see the [Supplementary Appendix](#)).

Study End Points

The primary study end points were cardiovascular death (see the [Supplementary Appendix](#)) and death from any cause. We hypothesized that the incidence of

cardiovascular death should be increased if azithromycin is proarrhythmic, particularly in a cohort chosen to reduce the likelihood of out-of-hospital deaths from serious illnesses. We included an analysis of death from any cause to guard against differential misclassification of deaths related to use of a study antibiotic. Given the study hypothesis, we also analyzed sudden cardiac deaths, identified with an independently validated computerized definition that is based on multiple sources of data (see the [Supplementary Appendix](#)) and that has a positive predictive value of 88% [.26](#)

Statistical Analysis

The study unit of analysis was the course of antibiotic therapy, which was defined as a fixed period, beginning with the date on which the prescription was filled, during which patients would have been advised to take the antibiotic. This should correspond to the period of greatest risk of adverse cardiac effects, given that the case reports for azithromycin suggest an acute mechanism [.11-17](#). Because the usual duration of treatment varies according to the specific study antibiotic, we analyzed two periods: the 5-day period that is generally recommended for azithromycin and the 10-day period most commonly suggested for the other study antibiotics. The 10-day analyses for azithromycin included an interval during which patients were unlikely to be taking the drug (days 6 through 10); these days were considered separately in several analyses. Although these periods usually had a fixed duration (5 or 10 days), the data were censored if the patient filled a subsequent prescription for a study antibiotic or ceased to meet the eligibility criteria.

The analysis estimated the cumulative incidence, or risk, of death during a course of antibiotic therapy. The unadjusted cumulative incidence was calculated by means of the product-limit method. The relative risk of death between the groups, defined by use of the study antibiotics, with adjustments for characteristics of the subjects, was calculated with the hazard ratio from Cox regression models (see the [Supplementary Appendix](#)).

Each study comparison was adjusted for an extensive set of covariates (reflecting status on the date on which the prescription was filled) that were possibly associated with both the use of the study antibiotic and the risk of death (Table 3 in the [Supplementary Appendix](#)). This adjustment used the propensity score [27](#) (the conditional probability of having a prescription for a study antibiotic, given the covariates). Specific propensity scores were estimated for each pairwise comparison (Tables 4 and 5 in the [Supplementary Appendix](#)). The propensity scores for comparisons between study antibiotics included the recorded antibiotic indication (see the [Supplementary Appendix](#)).

To check for misspecification of the propensity-score regression models, we evaluated whether the covariate distributions were balanced across the study groups. For the azithromycin group and the control group of persons not taking antibiotics, this distribution was unadjusted, because the propensity-score matching should ensure balance. For amoxicillin, the distribution was adjusted for the propensity score, with the use of a modified method for weighting by inverse probability of treatment [28](#) that standardized the distribution to that for

azithromycin (Table 6 in the [Supplementary Appendix](#)).²⁹ We also checked for overlap of the distribution of propensity scores (Tables 4 and 5 in the [Supplementary Appendix](#)).

To provide a summary measure of the risk of cardiovascular death, we calculated a risk score for cardiovascular disease.³⁰ This score estimated the probability of cardiovascular death (in the absence of use of a study antibiotic) as a function of the indicators of coexisting conditions (see the [Supplementary Appendix](#)).

We estimated the difference between the cumulative incidence of cardiovascular death during a 5-day course of azithromycin and the incidence during a similar period of amoxicillin use. We defined the additional risk per course of azithromycin therapy as $(HR_a - 1) \times I_0$, where HR_a was the hazard ratio for azithromycin versus amoxicillin and I_0 was the unadjusted cumulative incidence of cardiovascular death for patients taking amoxicillin. The risk difference was also calculated according to the deciles of cardiovascular risk as defined by the risk score for cardiovascular disease.

We performed alternative analyses that tested the validity of several study assumptions. These included a repeated-measures analysis testing the validity of treating the prescription periods as independent observations and an analysis stratified by propensity-score deciles. All analyses were performed with SAS software, version 9.3 (SAS Institute). All reported P values are two-sided.

Results

Characteristics of the Study Cohort

The study cohort included persons with 347,795 prescriptions for azithromycin, 1,391,180 matched control periods with no study antibiotic treatment, 1,348,672 prescriptions for amoxicillin, 264,626 prescriptions for ciprofloxacin, and 193,906 prescriptions for levofloxacin. Azithromycin users were primarily women (77.5%), had a mean age of 49 years, and had frequent use of cardiovascular or respiratory medications, visits to the emergency department,

Characteristic	Azithromycin	Amoxicillin	Ciprofloxacin	Levofloxacin	No Antibiotic Treatment
Age (years)	49.0	49.0	49.0	49.0	49.0
Female (%)	77.5	77.5	77.5	77.5	77.5
White (%)	77.5	77.5	77.5	77.5	77.5
Black (%)	77.5	77.5	77.5	77.5	77.5
Hispanic (%)	77.5	77.5	77.5	77.5	77.5
Other (%)	77.5	77.5	77.5	77.5	77.5
Married (%)	77.5	77.5	77.5	77.5	77.5
Unmarried (%)	77.5	77.5	77.5	77.5	77.5
Employed (%)	77.5	77.5	77.5	77.5	77.5
Unemployed (%)	77.5	77.5	77.5	77.5	77.5
Medicaid (%)	77.5	77.5	77.5	77.5	77.5
Medicare (%)	77.5	77.5	77.5	77.5	77.5
Other (%)	77.5	77.5	77.5	77.5	77.5
Diabetes (%)	77.5	77.5	77.5	77.5	77.5
Cholesterol (%)	77.5	77.5	77.5	77.5	77.5
High blood pressure (%)	77.5	77.5	77.5	77.5	77.5
Heart disease (%)	77.5	77.5	77.5	77.5	77.5
Stroke (%)	77.5	77.5	77.5	77.5	77.5
Chronic kidney disease (%)	77.5	77.5	77.5	77.5	77.5
Chronic liver disease (%)	77.5	77.5	77.5	77.5	77.5
Chronic lung disease (%)	77.5	77.5	77.5	77.5	77.5
Chronic pain (%)	77.5	77.5	77.5	77.5	77.5
Chronic mental illness (%)	77.5	77.5	77.5	77.5	77.5
Chronic substance use (%)	77.5	77.5	77.5	77.5	77.5
Chronic alcohol use (%)	77.5	77.5	77.5	77.5	77.5
Chronic tobacco use (%)	77.5	77.5	77.5	77.5	77.5
Chronic marijuana use (%)	77.5	77.5	77.5	77.5	77.5
Chronic drug use (%)	77.5	77.5	77.5	77.5	77.5
Chronic injection drug use (%)	77.5	77.5	77.5	77.5	77.5
Chronic opioid use (%)	77.5	77.5	77.5	77.5	77.5
Chronic benzodiazepine use (%)	77.5	77.5	77.5	77.5	77.5
Chronic antipsychotic use (%)	77.5	77.5	77.5	77.5	77.5
Chronic mood stabilizer use (%)	77.5	77.5	77.5	77.5	77.5
Chronic antidepressant use (%)	77.5	77.5	77.5	77.5	77.5
Chronic anxiolytic use (%)	77.5	77.5	77.5	77.5	77.5
Chronic sedative use (%)	77.5	77.5	77.5	77.5	77.5
Chronic stimulant use (%)	77.5	77.5	77.5	77.5	77.5
Chronic anticholinergic use (%)	77.5	77.5	77.5	77.5	77.5
Chronic beta-blocker use (%)	77.5	77.5	77.5	77.5	77.5
Chronic calcium channel blocker use (%)	77.5	77.5	77.5	77.5	77.5
Chronic diuretic use (%)	77.5	77.5	77.5	77.5	77.5
Chronic ACE inhibitor use (%)	77.5	77.5	77.5	77.5	77.5
Chronic statin use (%)	77.5	77.5	77.5	77.5	77.5
Chronic aspirin use (%)	77.5	77.5	77.5	77.5	77.5
Chronic nitroglycerin use (%)	77.5	77.5	77.5	77.5	77.5
Chronic beta-agonist use (%)	77.5	77.5	77.5	77.5	77.5
Chronic corticosteroid use (%)	77.5	77.5	77.5	77.5	77.5
Chronic insulin use (%)	77.5	77.5	77.5	77.5	77.5
Chronic thyroid medication use (%)	77.5	77.5	77.5	77.5	77.5
Chronic hormone therapy use (%)	77.5	77.5	77.5	77.5	77.5
Chronic birth control use (%)	77.5	77.5	77.5	77.5	77.5
Chronic contraceptive use (%)	77.5	77.5	77.5	77.5	77.5
Chronic fertility treatment use (%)	77.5	77.5	77.5	77.5	77.5
Chronic immunosuppressant use (%)	77.5	77.5	77.5	77.5	77.5
Chronic chemotherapy use (%)	77.5	77.5	77.5	77.5	77.5
Chronic radiation therapy use (%)	77.5	77.5	77.5	77.5	77.5
Chronic surgery use (%)	77.5	77.5	77.5	77.5	77.5
Chronic hospitalization use (%)	77.5	77.5	77.5	77.5	77.5
Chronic intensive care use (%)	77.5	77.5	77.5	77.5	77.5
Chronic long-term care use (%)	77.5	77.5	77.5	77.5	77.5
Chronic nursing home use (%)	77.5	77.5	77.5	77.5	77.5
Chronic hospice use (%)	77.5	77.5	77.5	77.5	77.5
Chronic palliative care use (%)	77.5	77.5	77.5	77.5	77.5
Chronic end-of-life care use (%)	77.5	77.5	77.5	77.5	77.5
Chronic death use (%)	77.5	77.5	77.5	77.5	77.5

and prior use of antibiotics ([Table 1](#) Table 1 Demographic and Clinical Characteristics of Patients at the Time That the Prescriptions for the Study Antibiotics Were Filled and at the Beginning of the Control Period for Persons Who Received No Antibiotic Treatment., and [Table 7](#) in the [Supplementary Appendix](#)). The characteristics of patients receiving azithromycin prescriptions and the propensity-score matched controls were very similar. In contrast, patients who were prescribed ciprofloxacin or levofloxacin were generally more likely to have complications of diabetes, incontinence, and wheelchair or walker use. The mean summary cardiovascular risk scores for

patients taking amoxicillin (9.5), ciprofloxacin (10.3), and levofloxacin (10.6) were higher than the scores for those taking azithromycin (9.3) ([Table 1](#)).

For both azithromycin and amoxicillin, the most common indications were infections of the ear, nose, or throat and bronchitis, respectively accounting for 62% and 63% of the prescriptions for which an indication was known (43% and 40% of total prescriptions) (Tables 8 and 9 in the [Supplementary Appendix](#)). The most frequent indication for ciprofloxacin was infection of the genitourinary tract. Levofloxacin was commonly prescribed for infections of the ear, nose, or throat and for other respiratory and for genitourinary indications.

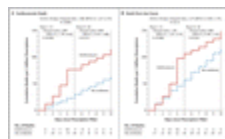
Cardiovascular Death and Total Deaths

Among patients who took azithromycin, there were 29 cardiovascular deaths during the 5-day course of treatment (85.2 per 1 million courses) ([Table 2](#)Table

Cause of Death	Azithromycin (n=1000)	No Antibiotic Treatment (n=1000)	Amoxicillin (n=1000)
Total Deaths	29	41	42
Cardiovascular Deaths	29	41	42
Sudden Cardiac Deaths	22	33	29
Other Cardiovascular Deaths	7	8	13
Noncardiovascular Deaths	0	0	0
Death from Any Cause	29	41	42

2 Cumulative Incidence of Death among Patients during a 5-Day Course of Azithromycin, as Compared with Persons Who Received No Antibiotic Treatment and Patients Who Took Amoxicillin, According to Cause of Death.). Of these, 22 (64.6 per 1 million courses) were sudden cardiac deaths. During matched 5-day intervals among persons who did not take antibiotics, there were 41 cardiovascular deaths (29.8 per 1 million periods) and 33 sudden cardiac deaths (24.0 per 1 million periods). During the first 5 days of a course of amoxicillin therapy, there were 42 cardiovascular deaths (31.5 per 1 million courses) and 29 sudden cardiac deaths (21.8 per 1 million courses).

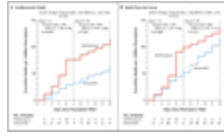
When a 5-day course of azithromycin therapy was compared with a matched period of no antibiotic treatment, azithromycin was associated with an increased risk of both cardiovascular death and death from any cause during that 5-day



interval ([Figure 1](#)Figure 1 Cumulative Incidence of Cardiovascular Death and Death from Any Cause among Patients Who Took Azithromycin and Persons Who Did Not Take Study Antibiotics during a 10-Day Period. and [Table 2](#)). For cardiovascular death, the hazard ratio was 2.88 (95% confidence interval [CI], 1.79 to 4.63; $P < 0.001$); the risk was increased for both sudden cardiac death and other cardiovascular deaths. Although there was no increased risk of death from noncardiovascular causes, the risk of death from any cause was increased (hazard ratio, 1.85; 95% CI, 1.25 to 2.75; $P = 0.002$). For the 10-day period after the prescription was filled, azithromycin use was associated with an increased risk of cardiovascular death (hazard ratio, 1.86; 95% CI, 1.27 to 2.73; $P = 0.002$), but the risk of death from any cause was not significantly increased (hazard ratio, 1.27; 95% CI, 0.92 to 1.75; $P = 0.20$). In contrast, amoxicillin use was not associated with a significantly increased risk of death from cardiovascular or noncardiovascular causes or of death from any

cause during either the first 5 or all 10 days of therapy ([Table 2](#), and Fig. 1 in the [Supplementary Appendix](#)).

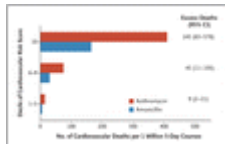
A 5-day course of azithromycin therapy, as compared with the first 5 days of a course of amoxicillin therapy, was associated with significant increases in the risk of both cardiovascular death (hazard ratio, 2.49; 95% CI, 1.38 to 4.50; $P=0.002$) and death from any cause (hazard ratio, 2.02; 95% CI, 1.24 to 3.30;



$P=0.005$) ([Figure 2](#) [Figure 2](#) Cumulative Incidence of Cardiovascular Death and Death from Any Cause for Patients Who Took Azithromycin or Amoxicillin during a 10-Day Period., and Table 10 in the [Supplementary Appendix](#)). Thus, patients who took azithromycin had an estimated 47 additional cardiovascular deaths per 1 million 5-day courses of therapy. Alternative analyses, including a repeated-measures analysis, an analysis stratified by propensity score, and an analysis with a model that included terms for other proarrhythmic drugs, had similar results (Table 11 in the [Supplementary Appendix](#)). The risk of cardiovascular death was significantly higher for a 10-day period (hazard ratio, 1.87; 95% CI, 1.16 to 3.01; $P=0.01$) ([Figure 2](#)), although the risk was not increased for days 6 through 10. The risk of death from any cause was not significantly increased during the 10-day period.

As compared with patients who took amoxicillin, those who took ciprofloxacin did not have an increased risk of either cardiovascular death or death from any cause during a 10-day course of therapy, whereas there was a nonsignificant trend toward an increased risk of cardiovascular death with the use of levofloxacin (hazard ratio, 1.50; 95% CI, 0.82 to 2.72; $P=0.18$) (Fig. 2 in the [Supplementary Appendix](#)). A 5-day course of azithromycin therapy, as compared with the first 5 days of a course of ciprofloxacin therapy, was associated with an increased risk of cardiovascular death (hazard ratio, 3.49; 95% CI, 1.32 to 9.26; $P=0.01$) and a nonsignificant trend toward an increase in death from any cause (hazard ratio, 1.75; 95% CI, 0.91 to 3.37; $P=0.09$). However, mortality with azithromycin did not differ significantly from that with levofloxacin (hazard ratio for cardiovascular death, 1.27; 95% CI, 0.66 to 2.47; $P=0.48$; hazard ratio for death from any cause, 1.07; 95% CI, 0.61 to 1.85; $P=0.82$).

The absolute excess risk of cardiovascular death for patients who took azithromycin, as compared with those who took amoxicillin, varied according to the baseline risk score for cardiovascular disease ([Figure 3](#) [Figure 3](#)



[Figure 3](#) Excess Risk of Cardiovascular Death with Azithromycin as Compared with Amoxicillin, According to Decile of Cardiovascular Risk Score., and Table 12 in the [Supplementary Appendix](#)). For patients in the highest decile of risk scores, who accounted for 59% of the cardiovascular deaths during

azithromycin therapy, there were an estimated 245 additional cardiovascular deaths per 1 million 5-day courses of azithromycin therapy.

Discussion

We found that a 5-day course of azithromycin was associated with a small absolute increase in the risk of cardiovascular death, which was most pronounced for patients in the highest decile of the baseline risk of cardiovascular disease. There was no increased risk of death from noncardiovascular causes among patients who took azithromycin, but there was an increase in the risk of death from any cause. The risk of cardiovascular death was significantly greater with azithromycin than with either amoxicillin or ciprofloxacin but did not differ significantly from the risk with levofloxacin.

An important concern in this observational study was confounding by factors associated with both azithromycin use and an increased risk of cardiovascular death. These factors include cardiovascular disease and other coexisting conditions, behavioral risk factors associated with cardiovascular disease (e.g., smoking, high body-mass index, poor diet, and low physical activity), and indication for antibiotic therapy.

We included two distinct control groups in an effort to minimize confounding. One group comprised control periods that were propensity-score-matched with courses of azithromycin therapy. This balanced the prevalence of recorded cardiovascular disease and other coexisting conditions and probably provided some control for behavioral risk factors, given that their effects may be partially mediated through variables more readily identified in the database, such as diagnosed hyperlipidemia, hypertension, diabetes, heart failure, angina, or myocardial infarction. To minimize confounding by the short-term effects of infections, we included a second control group that comprised courses of amoxicillin therapy, which has indications similar to those for azithromycin. Patients who took amoxicillin had no increase in the risk of either cardiovascular death or death from any cause during the study period, which is consistent with our previous findings.⁸ When azithromycin was directly compared with amoxicillin, in an analysis that also controlled for recorded antibiotic indication, the increased risk persisted for azithromycin.

Our study was prompted by evidence that azithromycin is proarrhythmic,¹¹⁻¹⁷ which led us to hypothesize that it would increase the risk of sudden cardiac death. Patients who took azithromycin did have an increased risk of sudden cardiac death, as identified from a previously developed computer definition.²⁶ However, they also had a similarly increased risk of other, out-of-hospital cardiovascular deaths, although the numbers of these deaths were small. This finding could be due to misclassification, given that our definition of sudden cardiac death was designed to be specific; our prior study suggested that as many as 25% of patients would be misclassified as having died from other cardiovascular causes.²⁶ Alternatively, a proarrhythmic effect of azithromycin might increase the risk of other types of cardiovascular death. Thus, although our data are consistent with an adverse cardiac effect of azithromycin, they cannot establish a specific causal mechanism.

The increased risk of cardiovascular death during the usual 5-day course of azithromycin therapy did not persist after the course of therapy ended. Although concentrations of azithromycin remain elevated in tissue for several days after cessation of oral therapy, serum concentrations decline more rapidly, falling to trough levels within 24 hours.³¹ For many other drugs with proarrhythmic effects, an elevated serum concentration is a key determinant of increased risk,³² which is an important reason why rapid infusion of erythromycin is not recommended.²⁵

The cohort also included patients who had taken ciprofloxacin and levofloxacin, which provided information on the relative safety of these broad-spectrum fluoroquinolones. For ciprofloxacin, the risks of both cardiovascular death and death from any cause during the study period were similar to those for amoxicillin, a finding that is consistent with the current opinion that ciprofloxacin has limited proarrhythmic liability.^{1,25} In contrast, levofloxacin, which has recognized proarrhythmic potential,^{1,25} was associated with a trend toward an increased risk of cardiovascular death, although the point estimates were not significant. When azithromycin was compared directly with levofloxacin, there was no significant difference in the risk of either cardiovascular death or death from any cause.

In conclusion, during 5 days of azithromycin therapy, there was a small absolute increase in cardiovascular deaths. As compared with amoxicillin, there were 47 additional cardiovascular deaths per 1 million courses of azithromycin therapy; for patients in the highest decile of baseline risk of cardiovascular disease, there were 245 additional cardiovascular deaths per 1 million courses.

Supported by a grant from the National Heart, Lung, and Blood Institute (HL081707) and a cooperative agreement from the Agency for Healthcare Quality and Research Centers for Education and Research on Therapeutics (HS1-0384).

[Disclosure forms](#) provided by the authors are available with the full text of this article at NEJM.org.

We thank the Tennessee Bureau of TennCare and Department of Health for providing the study data.

Source Information

From the Division of Pharmacoepidemiology, Department of Preventive Medicine (W.A.R., K.H.), the Departments of Medicine and Pharmacology, Divisions of Cardiology (K.T.M.), Rheumatology (C.M.S.), and Clinical Pharmacology (K.T.M., C.M.S.), and the Department of Biostatistics (P.G.A.), Vanderbilt University School of Medicine; and the Geriatric Research Education and Clinical Center, Nashville Veterans Affairs Medical Center (W.A.R.) — both in Nashville.

Address reprint requests to Dr. Ray at the Department of Preventive Medicine,
Village at Vanderbilt, Suite 2600, 1501 21st Ave. S., Nashville, TN 37212, or
cindy.naron@vanderbilt.edu.