Dear Sir,

We thank Dr. Alok Kumar and Dr. Dorchhom Khrime for their Letter to the Editor, and would like to add clarifications.

The primary aim of the study was to compare the antihypertensive efficacy of the two mentioned drugs, along with many secondary objectives. As the original study had numerous data assessment, we presented the most relevant data in the published paper.

Firstly, all patients included in this study were matched for eGFR levels. Apart from blood pressure, we performed and recorded routine investigations such as blood glucose, HbA1c, electrolytes, kidney and liver function tests, and pregnancy evaluation at each follow-up visit. Two cardiologists (GM, AS) and one physician (VKS) were responsible for analyzing the laboratory outcomes. Of 350 patients randomized in each group, Group A (azilsartan) had 92 patients with CKD Class 1 and 53 and 27 with CKD Class 2 and 3, respectively. Similarly, of 350 subjects in Group T (telmisartan), 88 had CKD Class 1, and 56 and 31 had CKD Class 2 and 3, respectively. The baseline CKD level was found to be comparable between the groups [Table 1] (not provided in the main manuscript). The Chi-square statistics is 0.42 and P value is 0.81.

Regarding another point raised, none of the participants in our study was administered SGLT2 inhibitor during the study duration. Those on previous therapy were given a washout period of 15 days prior to randomization in the study. After taking prior consent from the patients, we administered alternate hypoglycemic agents to patients with type 2 diabetes mellitus. In addition, we matched the number of diabetic patients in both groups before randomization to avoid confounding and bias. Group A and T had 178 and 182 patients, respectively, with type 2 diabetes mellitus. All patients with or without diabetes mellitus were strictly monitored during the study. As stated in the methods, if no response (reduction in systolic blood pressure below 140 mmHg) was achieved with 40 mg of drug dose, it was escalated to 80 mg at Week 2. If the patient was still not responding to single-drug therapy, dual treatment was initiated in that case, and the patient was dropped out of the study. At no time were the patients allowed to take dual therapy during the study period without informing the principal investigator. As stated above, electrolytes, including potassium, were closely followed throughout the study. No patients in our study showed any signs of hyperkalemia, and none dropped out due to the same.

Moreover, the manuscript does not state that a 100% response rate was achieved with ARB monotherapy. The results of our study state that “A significant difference was noted between the groups in terms of the number of participants who required dose titration (Group A = 99; Group T = 128; P = 0.012).” These patients were considered as non-responders, and their drug dose was escalated from 40 mg to 80 mg at Week 2 at follow-up. In addition, some patients either voluntarily dropped out of the study due to adverse drug reactions (13) or were lost to follow up (8). Upon subsequent feedback (after the study analysis was performed), most patients who withdrew from the study informed that as the test drug was unable to control their blood pressure, they opted for treatment with an alternate practitioner. All these patients were later classified as “non-responders.”

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

Megha Garg
Department of Clinical Epidemiology and Public Health, University of Bristol, United Kingdom

Address for correspondence: Dr. Megha Garg, Room 15, 2 Oakfield Place, Clifton, Bristol, UK.
E-mail: megha.723garg@gmail.com

Submitted: 25-Nov-2020  Accepted: 14-Dec-2020  Published: 26-Dec-2020

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

---

**Table 1: Chronic kidney disease classifications in both groups**

|       | CKD |       |       |
|-------|-----|-------|-------|
|       | Class 1 | Class 2 | Class 3 |
| Group A | 92 | 53   | 27   | 172 |
| Group T | 88 | 56   | 31   | 175 |
| Total   | 180| 109  | 58   | 347 |

CKD: Chronic kidney disease

---

**How to cite this article:** Garg M. Reply to the Letter to the Editor. Saudi J Med Med Sci 2021;9:83.

© 2020 Saudi Journal of Medicine & Medical Sciences | Published by Wolters Kluwer - Medknow