Prediction of Cardiovascular Events and All-Cause Mortality With Brachial-Ankle Elasticity Index
A Systematic Review and Meta-Analysis

Charalambos Vlachopoulos, Konstantinos Aznauridis, Dimitrios Terentes-Printzios, Nikolaos Ioakeimidis, Christodoulos Stefanidis

Abstract—Brachial-ankle elasticity index (baEI; also known as brachial-ankle pulse wave velocity) has been proposed as a surrogate end point for cardiovascular disease. We performed a meta-analysis of longitudinal cohort studies for determining the ability of baEI to predict risk of cardiovascular events and all-cause mortality and dissecting factors influencing this predictive ability. Multiple online databases, reference lists from retrieved articles, and abstracts from international cardiovascular conventions were searched until April 2012. Longitudinal cohort studies that reported associations of baEI with clinical risk were included. Of the 18 studies included (8169 participants; mean follow-up, 3.6 years), 15 reported results on total cardiovascular events (5544 individuals), 7 on cardiovascular mortality (2274 individuals), and 9 on all-cause mortality (5097 individuals). The pooled relative risks for total cardiovascular events, cardiovascular mortality, and all-cause mortality were 2.95 (95% CI, 1.63–5.33), 5.36 (95% CI, 2.17–13.27), and 2.45 (95% CI, 1.56–3.86), respectively, for subjects with high versus low baEI (all P<0.001). An increase in baEI by 1 m/s corresponded with an increase of 12%, 13%, and 6% in total cardiovascular events, cardiovascular mortality, and all-cause mortality, respectively. We conclude that baEI is associated with increased risk of total cardiovascular events and all-cause mortality. Issues such as expansion of data to non-Asian populations, validation of path length estimation, determination of reference values, and prospective comparison with carotid-femoral pulse wave velocity remain to be resolved. (Hypertension. 2012;60:00-00.) ● Online Data Supplement

Key Words: brachial-ankle pulse wave velocity ■ cardiovascular risk ■ cardiovascular disease ■ mortality ■ prediction ■ meta-analysis ■ arterial stiffness

Arterial stiffness is increasingly recognized as a surrogate end point for cardiovascular (CV) disease and is associated with presence of CV risk factors and atherosclerotic disease.1 Arterial stiffness can be measured with noninvasive, reproducible, and relatively inexpensive techniques, and, thus, it is suitable for large-scale studies. Carotid-femoral pulse wave velocity (PWV; cfPWV) is considered the gold-standard method for assessing aortic stiffness2 and predicts future CV events and all-cause mortality in a strong and independent manner.3 Brachial-ankle PWV, calculated as the ratio of the distance between the brachial and the tibial artery divided by the transit time between these 2 arteries, has been proposed as an additional arterial biomarker of CV risk. PWV is classically referred to “segmental stiffness.” Because of the complexity of the anatomic course of the brachial-ankle arterial system, it is unclear whether the term brachial-ankle PWV is appropriate to define any particular segmental stiffness or whether it is just the ratio of a virtual brachial-ankle distance and the measurement of the brachial-ankle transit time. For this reason, this index will be referred to as the brachial ankle elasticity index (baEI) in the current article. Use of this index has been popularized primarily in East Asian countries over the past 13 years and has been shown in cross-sectional comparisons to be associated with CV risk factors and function, as well as CV disease (CVD), in a similar to cfPWV fashion.3–8 A number of studies examined the ability of baEI to predict the risk of future CV events and total mortality. In addition, the Japanese guidelines for the management of hypertension suggested the measurement of cfPWV or baEI as a tool for assessment of subclinical target organ damage.9

Although baEI has been generally shown to have a predictive role based on the results of individual studies,10–27 no overall quantitative estimate of this role exists. Furthermore, the studies that investigated the predictive role of baEI involved different populations. Moreover, the sizes of the
populations studied were highly diverse and, thus, gave rise to dissimilar risk estimates. In addition, because most published studies yielded positive results, publication bias may have been involved. Finally, an important issue is whether the predictive ability of baEI extends beyond CV events. Accordingly, we conducted the present systematic review and meta-analysis with the primary aim to provide an overview of relevant cohort studies and to calculate robust quantitative estimates of the predictive value of baEI for different outcomes. Second, we investigated whether publication bias or quality of studies could have affected the true predictive ability of baEI. Third, we evaluated the effect of different baseline CV risk factors on the predictive ability of baEI.

Materials and Methods
The meta-analysis was conducted according to the checklist of the Meta-Analysis of Observational Studies in Epidemiology. The outcomes of interest were as follows: (1) total CV events (CV deaths and nonfatal CV events); (2) CV mortality; and (3) all-cause mortality. We refer to the online-only Data Supplement for an expanded version of this section.

Data Sources and Searches
Studies evaluating relationships of baEI with the risk of future clinical events were drawn from a systematic review of the English and non-English literature in the PubMed, Cochrane, and Embase databases until April 2012. Reference lists from retrieved articles and abstracts from international CV conventions were also sought.

Study Selection
Studies were deemed eligible if they were full-length publications in peer-reviewed journals or abstracts in CV international conventions; evaluated baEI; and reported a combined CV outcome or CV mortality or all-cause mortality. Otherwise, no restriction criteria were imposed with regard to the type or the size of the population studied.

Data Extraction
The literature search, selection of studies, and extraction of data were done independently by 2 reviewers. Disagreements were resolved by consensus. For each study, we recorded a risk estimate for baEI. Numeric data appearing in the articles were used.

Quality Assessment
We evaluated the quality of the included studies by assessing selection bias, detection bias, and attrition bias.

Data Synthesis and Analysis
The risk estimates of each study were reported as a hazard ratio, relative risk (RR), odds ratio, or dichotomous frequency data. We treated hazard ratios as RRs. Because no uniform cutoff values are available for baEI, patients were allocated to the high baEI or low baEI group according to cutoffs provided by each study. When available, we used the adjusted risk estimates from multivariate models.

We performed meta-analyses of studies investigating baEI to obtain the pooled RRs separately for total CV events, CV mortality, and all-cause mortality. The proportion of inconsistency across studies not explained by chance was quantified with the I² statistic.

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Heterogeneity between subgroups was calculated with the Cochran Q test. When significant heterogeneity (P<0.05) existed among studies, the random-effects model was used to obtain the pooled RRs. We also calculated adjusted RRs per absolute baEI difference (1 m/s) for all of the clinical end points in addition to the calculation of RR of high versus low stiffness groups in each study. Risk estimates between subgroups were compared with a test of interaction. The RRs and CIs of individual studies were illustrated with forest plots. To estimate the contribution of continuous study moderators to the overall heterogeneity, we ran a metaregression analysis with fixed-effect estimates. The presence of publication bias was investigated graphically by funnel plots of precision, the Duval and Tweedie trim-and-fill method, and the classic fail-safe N method. All of the analyses were performed with Comprehensive Meta Analysis version 2 (Biostat, Englewood, NJ).

Results

Literature Search
The results of the literature search are shown in Figure 1. We retrieved 930 articles from our preliminary search. Of these, 24 articles were identified for full review. After full review, 6 studies were excluded (Figure 1).

Study Characteristics
Our meta-analysis included 16 original articles and 2 abstracts assessing relationships of baEI with total CV events, CV mortality, and all-cause mortality. In total, the included studies analyzed 8169 subjects. Details of the individual studies are shown in Table S1, available in the online-only Data Supplement. Of the 18 studies included (8169 participants; mean follow-up, 3.6 years), 15 reported results on total CV events (5544 individuals), 7 on CV mortality (2274 individuals), and 9 on all-cause mortality (5097 individuals).

Shape of the Association Between baEI and Clinical Events
Analysis of the 4 studies reporting tertiles for all-cause mortality showed that the pooled RRs increase in a stepwise, linear-like fashion from the first to the third tertile (please see Figure S1).

Meta-Analysis
baEI and Total CV Events
The magnitude of risk for total CV events in individuals who had high baEI was significantly higher compared with the
risk of individuals with low baEI (RR, 2.89 [95% CI, 1.99–4.20]; Figure 2A). By applying a sensitivity analysis, we excluded low-quality studies based on our quality assessment, without significant changes in our final results for total CV events (RR, 2.95 [95% CI, 1.63–5.33]; P<0.001).

Because we observed significant heterogeneity (I²=66.0%; P<0.001) between the included studies, we conducted between-study subgroup analyses and found that the RR for high baEI varied between different populations (please see Figure S2). The pooled RR of total CV events for an increase in baEI over and beyond baseline conventional risk factors, we performed a sensitivity analysis in which we included studies that had adjusted for most (≥5 of 6) conventional risk factors, namely, age, sex, smoking, diabetes mellitus, dyslipidemia, or cholesterol levels and hypertension or blood pressure (as opposed to the remainder of the studies10,12–15,17,19,25,27 that had adjusted for ≤4). RR in studies that adjusted for most CV risk factors11,16,20,24,26 (RR, 2.01 [95% CI, 1.34–3.01]) for studies that adjusted for most CV risk factors versus RR, 3.43 [95% CI, 2.02–5.81] for studies that adjusted for <5 CV risk factors) was lower to the overall combined estimated risk but still remained statistically significant and did not differ from the overall combined risk of studies that adjusted for <5 CV risk factors (P=0.29).

**baEI and CV Mortality**

The magnitude of risk in individuals who had high baEI was significantly higher compared with the risk of individuals
with low baEI. The pooled RRs for baEI were 7.68 (95% CI, 3.91–15.07) for CV mortality (Figure 2B). By applying a sensitivity analysis, we excluded the low-quality studies based on our quality assessment, with the overall estimate for total CV events (RR, 5.36 [95% CI, 2.17–13.27]; P<0.001) becoming lower but still a significant one. The pooled RR of CV mortality for an increase in baEI by 1 m/s was 1.13 (95% CI, 1.06–1.20), corresponding with a risk increase of 13% (Z=3.96, P<0.001; I²=0.0%, P=0.941).12,14,17

In a sensitivity analysis similar to the one for total CV events, RR in studies that adjusted for most CV risk factors11,16,20 (RR, 5.55 [95% CI, 2.17–14.22] for studies that adjusted for most CV risk factors versus RR, 10.82 [95% CI, 4.11–28.50] for studies12–14,17 that adjusted for <5 CV risk factors) was lower to the overall combined estimated risk but still remained statistically significant and did not differ from the overall combined risk of studies that adjusted for <5 CV risk factors (P=0.33).

**baEI and All-Cause Mortality**

The magnitude of risk in individuals who had high baEI was significantly higher compared with the risk of individuals with low baEI. The pooled RRs were 2.48 (95% CI, 1.82–3.37) for all-cause mortality (Figure 2C). By applying a sensitivity analysis, we excluded low-quality studies based on our quality assessment, without significant changes in our final results for all-cause mortality (RR, 2.45 [95% CI, 1.56–3.86]; P<0.001). There was no significant difference in RR between different populations.

The pooled RR of all-cause mortality for an increase in baEI by 1 m/s was 1.06 (95% CI, 1.02–1.10), corresponding with a risk increase of 6% (Z=2.81, P=0.005; I²=0.0%, P=0.732).14,17,21

For additional sensitivity analyses regarding clinical end points please see the online-only Data Supplement.

**Publication Bias**

The funnel plot was asymmetrical at the bottom (please see Figure S3) for all of the clinical end points, suggesting an absence of small studies with small or negative risk estimates in our meta-analysis, either because of publication bias or because of a true inexistence of negative studies (absence of publication bias). The trim-and-fill method imputed missing studies and recalculated our pooled risk estimate. The imputed RRs were 2.42 (95% CI, 1.67–3.51), 5.93 (95% CI, 3.23–10.90), and 2.26 (95% CI, 1.68–3.05) for total CV events, CV mortality, and all-cause mortality, respectively, which are lower than our original risk estimates but are still remaining statistically significant and did not differ from the overall combined risk of studies that adjusted for <5 CV risk factors (P=0.33).

**Metaregression Analysis**

Age at enrollment was not a predictor of the magnitude of the log RR for total CV events (P=0.128) in the whole population.10–17,19,20,25,26 However, there were differences according to the group of patients studied. Specifically, age was inversely significantly related to the predictive role of high baEI for total CV events in end-stage renal disease (ESRD) patients11,14,16,20,25 and CVD patients,10,13,15,19 indicating that baEI is a stronger determinant of prognosis in younger ESRD and CVD patients (P=0.029 and P=0.005, respectively; please see Figure S4) The percentage of diabetics in 9 studies10,11,13,14,16,17,19,20,27 showed a significant inverse association with the predictive value of high baEI (P<0.001; please see Figure S4). In particular, diabetes mellitus percentage was inversely significantly related to the predictive role of high baEI for total CV events in CVD patients,10,13,19 indicating that baEI is a stronger determinant of prognosis in nondiabetics with CVD (P=0.002). In accordance, both hemoglobin A1c14,17,19 and blood glucose10,17,19,26 were inversely significantly related to the predictive role of high baEI for total CV events (P=0.012 and P=0.004, respectively).

**Discussion**

In this systematic review and meta-analysis, we pooled baEI data for 8169 subjects from 18 studies, who were followed up for a mean of 3.6 years. Our study is the first meta-analysis to investigate in a thorough manner the predictive role of baEI and to assess factors influencing this predictive ability. Our principal finding is that subjects with high baEI compared with patients with low baEI have 3-fold higher risk for total CV events, 5-fold higher risk for CV mortality, and 2.5-fold higher risk for all-cause mortality, respectively. An increase in baEI by 1 m/s corresponds with an increase of 12%, 13%, and 6% in total CV events, CV mortality, and all-cause mortality. Finally, the predictive ability of subjects with high baEI is higher in younger patients with ESRD and CVD and lower in diabetics.

**Strengths and Limitations of the Present Meta-Analysis**

Few narrative reviews38 and editorials,39 including the Japanese guidelines for management of hypertension, have commented on the possible predictive role of baEI. However, the present study is the first meta-analysis to provide robust pooled estimates of this role. An important strength of our study is the exhaustive search strategy that likely enabled us to capture most, if not all, relevant studies. Furthermore, as a meta-analysis, the present study overcomes the potentially biased inclusion and weighing of results that may appear in reviews when interpreting the available evidence. In addition, we dealt with the heterogeneous quality of studies, as well as with potential publication bias.

In the majority of studies, patients with high baEI were in most cases older, had higher blood pressure, and were more often diabetic or dyslipidemic. Thus, it is reasonable to assume that patients with high baEI were a priori at higher
baseline risk than patients with low baEI patients. However, most prospective studies have dealt with this potential limitation by adjusting for the potential confounders between patients with low baEI and high baEI. Furthermore, as it was shown in our relevant sensitivity analysis, RR in studies that adjusted for most conventional risk factors was lower but not substantially different from the overall combined risk.

In this analysis, we used aggregate data as reported in published articles (or calculated from other data provided in the articles) rather than data for individual patients. Accordingly, we did not deal with potential methodologic problems of the original studies. Furthermore, the ability of baEI to discriminate, calibrate, and reclassify risk could not be assessed. None of the included studies provided robust estimates of the discriminatory and reclassification power of baEI beyond classic risk factors or Framingham risk score. Second, although CV mortality and all-cause mortality were uniformly defined, the definition of total CV events differed among the studies included in analysis. Third, it must be stressed that all but one of the studies were conducted on Asian subjects, thus the application of our findings cannot be extrapolated to non-Asian subjects.

**baEI: Clinical Implications**

Our results support the potential of baEI as a biomarker of risk that can amalgamate the effect of CV factors on the arterial tree. Improvement of baEI either by pharmacological or lifestyle interventions, per se, might be beneficial in terms of prognosis in high-risk groups; however, such data are limited. Mechanisms explaining its predictive value can be inferred by its associations with arterial and overall CV performance. baEI is associated with left ventricular function, left ventricular hypertrophy, and impaired coronary perfusion. Furthermore, baEI is an independent predictor of longitudinal increases in BP, as well as of new onset of hypertension and microalbuminuria. An interesting finding of our analysis is that baEI is a predictor of all-cause mortality in addition to CV outcomes. Although pathophysiological explanations are not readily identifiable, this could reflect the existence of common pathogenetic mechanisms, such as inflammation, aging, and oxidative stress, over a wide range of conditions.

Further dissection of our findings provided interesting information. The predictive ability of baEI for clinical events is higher in younger patients with ESRD or CVD. Explanations may include a “selection” phenomenon, with ESRD and CVD survivors who reach an older age being less vulnerable to the harmful effects of arterial stiffening, as shown previously for cfPWV as well. Nevertheless, identification of high baEI in younger patients may suggest the existence of an aggressive arterial disease.

**baEI: Theoretical and Methodologic Considerations**

Ease of use of the technique for measurement of baEI has assisted popularization of the technique. However, both theoretical and technical considerations exist.

Although baEI may predominantly be determined by central (elastic) artery stiffness, its values that are higher than cfPWV or PWV of the arteries of the upper and lower limbs indicate that it may be determined by stiffness of distal peripheral arteries. Among parameters of arterial stiffness, aortic PWV was the primary independent correlate of baEI, explaining 58% of the total variance in baEI, and an additional 23% of the variance was explained by femoral-ankle PWV. Accordingly, the pertinent question is whether addition of segments of the arterial tree that differ markedly in terms of geometry, structure, and function, as well as the influence of age and sex, adds to the predictive value of aortic stiffness or rather “dilutes” its predictive ability. Importantly, whereas aortic PWV has a proven predictive ability, this is not the case for the stiffness of upper or lower limb arteries. Scarce data that compare baEI with cfPWV exist. Two cross-sectional studies showed that both predict prevalent CVD and CV complications. Only 1 abstract investigated the prospective predictive role of both indices demonstrating a superiority of cfPWV. It cannot be overemphasized that the 2 indices should not be used interchangeably, and large prospective studies should be conducted comparing the prognostic role of each.

Path length is calculated using anthropometric data (height-based formulas) rather than the actual "above the body” distances, and this may introduce error in terms of actual stiffness of an individual subject. Furthermore, anthropometric data are derived from a Japanese population, rendering the applicability to other populations questionable. Inherent to this consideration is the need for the determination of reference values as has been done for cfPWV.

Predictive ability may differ and applicability may be limited in specific conditions where arteries of smaller caliber are affected, such as in diabetes mellitus or in peripheral arterial disease, where the pressure wave may be delayed and distorted when traveling toward the periphery. In line with this, predictive value is lower in diabetics, as we showed in our analysis. Furthermore, in patients with low ankle-brachial index, baEI has shown inconsistent results, and for this reason several studies have excluded such patients.

**Perspectives**

Our findings showing that baEI predicts risk of total CV events and all-cause mortality are potentially applicable to clinical practice and call for extension to other disease states and population groups. Indeed, potential for a universal clinical applicability awaits prospective studies and standardized assessment of path length in non-Asian populations, as well as determination of reference values. Furthermore, it should be stressed that baEI cannot be used interchangeably with cfPWV, and prospective studies that compare these 2 indices are warranted.

**Acknowledgment**

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**Disclosures**

None.
References


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PARIS WORKSHOP

Title: Prediction of cardiovascular events and all-cause mortality with brachial-ankle elasticity index: a systematic review and meta-analysis

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Materials and Methods

The meta-analysis was conducted according to the checklist of the Meta-analysis of Observational Studies in Epidemiology. The outcomes of interest were: 1) total cardiovascular (CV) events (CV deaths and nonfatal CV events); 2) CV mortality; and 3) all-cause mortality. Non fatal CV events were defined as myocardial infarction, revascularization, cerebrovascular events, peripheral vascular disease, angina and heart failure.

Data sources and searches
Studies evaluating relationships of baEI with the risk of future clinical events were drawn from a systematic review of the English and non-English literature in the PubMed, Cochrane and Embase databases until January 2012. The search terms were “brachial-ankle”, “pulse wave velocity” “stiffness” or “arterial stiffness” and “prediction”, “cardiovascular disease”, “risk”, “death”, “mortality”, “outcome”, “myocardial infarction”, “stroke”, “transient ischemic attacks”, “intracranial hemorrhage” or “events”. Data sources were also identified through manually searching the references of articles. All abstracts from large international cardiovascular conventions were also sought.

Study selection
Studies were deemed eligible if they: 1) were full-length publications in peer-reviewed journals or abstracts in large cardiovascular international conventions; 2) evaluated baEI; 3) reported a combined CV outcome or CV mortality or all-cause mortality. Otherwise, no restriction criteria were imposed with regard to the type of the population studied (general population or populations with risk factors or disease) or the size of the population. One study used a composite endpoint of all-cause mortality and initiation of hemodialysis. We included this study in the meta-analysis for all-cause mortality but also performed a sensitivity analysis that did not include this study. Moreover, studies by Inoue et al. and Amemiya et al. have a part of their population in common. The Inoue et al. study was selected for estimation of risk for total CV events per 1 m/s increase in baEI. Hence, in the total population of the meta-analysis and total CV events the population of Amemiya et al. was not added. The Amemiya et al. data were used for estimation of all-cause mortality in this meta-analysis and the study’s population was added in the total population of the analysis for all-cause mortality. Studies by Kato et al. and had a part of their population in common. The Kato et al. study was selected for estimation of risk for all clinical endpoints, despite its smaller population size. because it had longer follow-up and more clinical events than Kato et al. study.

Data extraction
The literature search, selection of studies and extraction of data were done independently by 2 reviewers. Disagreements were resolved by consensus. For each study, we recorded a risk estimate for baEI. Numeric data appearing in the articles were used.

Quality Assessment
We evaluated the quality of the included studies by assessing selection bias, detection bias, and attrition bias. For control of selection bias, we assessed whether each study’s
risk estimates from multivariate analysis included age, CV risk factors, and previous CV disease when necessary in analysis. For control of detection bias, we recorded whether the investigators who were assessing outcomes were aware of the patient’s status of baEI. Finally, for control of attrition bias, we evaluated the extent of loss to follow-up by calculating the ratio of the number of individuals lost to follow-up to the number of clinical events in the study. This ratio comprises a measure of how loss to follow-up influenced the study’s risk estimate. We considered a loss-events ratio <15% as satisfactory control of attrition bias.

Data synthesis and analysis
The risk estimates of each study were reported as a hazard ratio, relative risk (RR), odds ratio, or dichotomous frequency data. We treated hazard ratios as RRs. Because no uniform cutoff values are available for baEI, patients were allocated to high baEI or low baEI group according to cutoffs provided by each study (median, upper tertile, optimal cutoff derived by receiver-operator characteristic curve analysis or by an individually specified level of increase) (Table 1). When available, we used the adjusted risk estimates from multivariate models.

We performed meta-analyses of studies investigating baEI to obtain the pooled RRs separately for: 1) total CV events; 2) CV mortality; and 3) all-cause mortality. The proportion of inconsistency across studies not explained by chance was quantified with the I^2 statistic. Heterogeneity between subgroups was calculated with Cochran’s Q test. When significant heterogeneity (p<0.05) existed among studies, the random effects model was used to obtain the pooled RRs. We also calculated adjusted RRs per absolute baEI difference (1 m/s) for total CV events, CV mortality and all-cause mortality in addition to the calculation of RR of high versus low stiffness groups in each study. We performed a between-study subgroup analysis to evaluate whether the strength of risk estimates differs between different populations (general population, end-stage renal disease [ESRD] patients, diabetics and patients with CVD). For the comparison between different populations, the study by Nakamura et al. that reported data on diabetics with CVD was used both in the pooled estimate of the diabetics groups as well as the CVD group. Risk estimates between subgroups were compared with a test of interaction. The RRs and confidence intervals (CIs) of individual studies were illustrated with forest plots. To estimate the contribution of continuous study moderators to the overall heterogeneity, we ran a meta-regression analysis with fixed effect estimates. The presence of publication bias was investigated graphically by funnel plots of precision, and its implications for our results were assessed by the Duval and Tweedie trim-and-fill method and the classic fail-safe N method. All analyses were performed with Comprehensive Meta Analysis Version 2 (Biostat, Englewood, New Jersey).

Results

Study characteristics
All studies were published since 2005, and the mean/median follow-up ranged from 14 months to 6.5 years. The sample sizes ranged from 725 to 2,480 individuals. Age and other risk factors for CV disease were controlled for in most of the studies (Table S1).

Shape of the association between baEI and clinical events
Seven studies provided data on the risk according to strata of baEI and allowed estimation of the shape of the association between baEI and the risk of clinical events. A total of 5 studies reported risk according to tertiles, 7,10,12,15,19 1 study reported risk according to quartiles, 3 and 1 study reported risk according to quintiles 20 (Table S1). Analysis of the 4 studies 10,12,15,19 reporting tertiles for a common clinical endpoint (all-cause mortality) showed that the pooled RRs increase in a stepwise, linear-like fashion from the first to the third tertile (Figure S1).

**Meta-analysis**

**baEI and total CV events (sensitivity analysis):** By applying a sensitivity analysis in the analysis for high vs low baEI, we excluded the 2 studies from abstracts, 16,17 without significant changes in our final results for total CV events (RR=3.44 [95% CI: 2.14 to 5.51]; P<0.001).

**baEI and all-cause mortality (sensitivity analysis):** Exclusion of one study 13 that used a composite endpoint of all-cause mortality and initiation of hemodialysis showed a similar risk (RR=2.36 [95% confidence interval: 1.72 to 3.24], P<0.001) for high vs low baEI, but the overall risk estimate remained statistically significant. Exclusion of one study 13 that used a composite endpoint of all-cause mortality and initiation of hemodialysis showed a somewhat higher risk (RR=1.08 [95% confidence interval: 1.00 to 1.16]) for 1 m/s increase of baEI, but the overall risk estimate remained statistically significant.

**Discussion**

We intentionally included unpublished data from grey literature to gain a thorough estimate of risk and reduce the possibility of publication bias. 24 However, we should note that exclusion of these studies in sensitivity analysis did not substantially affect results for total CV events.
References


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### Table S1. Overview of studies on the association between brachial-ankle pulse wave velocity index and clinical end points.

<table>
<thead>
<tr>
<th>First Author, Year (Ref #)</th>
<th>Population (Sample Size)</th>
<th>Age (Years)</th>
<th>% Men</th>
<th>Follow-up, Duration (months)</th>
<th>Events</th>
<th>Modality</th>
<th>Distance*</th>
<th>Reproducibility</th>
<th>baEI in m/s (mean±SD or median)</th>
<th>baEI cutoff (High vs. Low)</th>
<th>baEI modeled in</th>
<th>Adjusted for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tomiyama et al., 2005²</td>
<td>215 patients with acute coronary syndrome</td>
<td>63.07</td>
<td>77.7</td>
<td>26±10</td>
<td>46 post-hospitalization CV events (18 major events and 28 coronary re-interventions)</td>
<td>A volume plethysmographic apparatus (FORM/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>The Interobserver coefficient and intraobserver coefficient were 8.4% and 10.0%, respectively</td>
<td>15.47 per 1 m/s, ≥17 (cutoff)</td>
<td>Continuous, cutoff</td>
<td>Age at the time of admission, LVEF, fractional PP, GRACE score and presence of DM</td>
<td></td>
</tr>
<tr>
<td>Kitahara et al., 2005³</td>
<td>785 hemodialysis patients (671 of them were used in the)</td>
<td>60.2±1.25</td>
<td>64.5 (64.9 for CV mortality)</td>
<td>33.8±1.08</td>
<td>85 CVD deaths, 46 non-CVD deaths</td>
<td>A waveform analyzer (Form PWV/ABI, Colin)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>21.4±6.8 m/s (upper quartile)</td>
<td>≥23 m/s (cutoff)</td>
<td>Quartiles</td>
<td>Age, ABI, DM, CAD, CeVD, albumin, male sex, dialysis duration,</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Age (mean±SD)</td>
<td>Smoking History</td>
<td>Excluded Variables</td>
<td>Smoking History</td>
<td>BP, BMI, calcium-phosphorus product, total cholesterol level, Ht, and Kt/V</td>
<td>Smoking History</td>
<td>BP, BMI, calcium-phosphorus product, total cholesterol level, Ht, and Kt/V</td>
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<tr>
<td>Matsuo et al., 2005^4</td>
<td>245 elderly participants</td>
<td>78.93 ± 39.98</td>
<td>40.34</td>
<td>5 CVD deaths</td>
<td>A volume plethysmographic apparatus (FORM/ABI)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>20.97</td>
<td>per 200 cm/s per 500 cm/s, &gt;25 (cutoff)</td>
<td>Continuously, cutoff</td>
<td>Age and HDSR (in continuous model)</td>
<td></td>
</tr>
<tr>
<td>Meguro et al., 2009^5</td>
<td>72 HF patients</td>
<td>68±14</td>
<td>56.9</td>
<td>14</td>
<td>A waveform analyzer (Form PWV/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>17.18</td>
<td>≥17.5 (cutoff)</td>
<td>Cutoff</td>
<td>SBP, BNP, age, gender, heart rate, PP and cause of CVD deaths</td>
<td></td>
</tr>
<tr>
<td>Study Authors and Year</td>
<td>Sample Size</td>
<td>Age (Median)</td>
<td>Sex Distribution</td>
<td>CVD Deaths</td>
<td>Non-CVD Deaths</td>
<td>Aortic Stiffness Measurement</td>
<td>Methodology</td>
<td>ABI, FMD and NMD</td>
<td>Statistical Analysis</td>
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<tr>
<td>Morimoto et al., 2009⁶</td>
<td>176 hemodialysis patients</td>
<td>61±13 56 43.2±1.0 14 CVD deaths and 10 non-CVD deaths</td>
<td>A volume-plethysmographic apparatus (PWV/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>19.17 ≥18 (median)</td>
<td>Continuous, Median</td>
<td>ABI, FMD and NMD (continuous model)</td>
<td></td>
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<tr>
<td>Orlowa et al., 2009⁷</td>
<td>224 men with CAD</td>
<td>56.2±8.9 100 42 38 MACE</td>
<td>Oscillometric method (VaSera)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>13.5 14.3 (upper tertile)</td>
<td>Tertiles</td>
<td>Age and SBP</td>
<td></td>
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<tr>
<td>Miyano et al., 2010⁹</td>
<td>530 community-dwelling elderly subjects</td>
<td>76.4±5.6 39.1 36 11 CVD deaths and 19 non-CVD deaths</td>
<td>A volume-plethysmographic apparatus (FORM/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>18.9±4.0 Per 1m/s, ≥18.6 75 (Median)</td>
<td>Continuous, Median</td>
<td>Age, sex, SBP, medical history of CVD</td>
<td></td>
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<tr>
<td>Turin et al., 2010¹⁰</td>
<td>2480 subjects with no CVD</td>
<td>58.42 33.83 78 59 deaths</td>
<td>A validated automatic device (BP-203RPE II)</td>
<td>Based on anthropometric data</td>
<td>Not reported</td>
<td>Not reported ≥17 (upper tertile)</td>
<td>Tertiles</td>
<td>Age, sex, BMI, HDL, LDL,</td>
<td></td>
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<tr>
<td>Nakamura et al., 2010(^{11})</td>
<td>191 diabetics with established CAD</td>
<td>65.6</td>
<td>82.2</td>
<td>25.4</td>
<td>12 deaths from any cause, 2 non-fatal MI, 49 revascularizations, 6 readmission for HF</td>
<td>A volume plethysmographic apparatus (FORM/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>17.80</td>
<td>≥17.3 (median)</td>
<td>Median Age, gender, presentation (presence or absence of acute MI), BMI, eGFR, presence or non-presence of anti-hypertensive and anti-diabetic medication, TG, HbA1c, history of smoking and drinking habits</td>
<td>SBP level, history of anti-hypertensive and anti-diabetic medication, TG, HbA1c, history of smoking and drinking habits</td>
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</tbody>
</table>
absence of hypertension, congestive HF on admission, presence or absence of dyslipidemia, use of DES, CABG and progressive arterial stiffness defined as baEl ≥ 17.3 m/s

<table>
<thead>
<tr>
<th>Study</th>
<th>Number (Type)</th>
<th>Age</th>
<th>Event Rate</th>
<th>Waveform analyzer (Form PWV/ABI)</th>
<th>Method</th>
<th>Mean difference</th>
<th>Not reported</th>
<th>Tertiles</th>
<th>All baseline valuables with p&lt;0.05 by univariate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanaka et al., 2011</td>
<td>445 hemodialysis patients</td>
<td>63±11</td>
<td>59.3</td>
<td>43±17</td>
<td>206 CV events, 36 fatal CV events, 42 fatal non-CV events</td>
<td>Based on anthropometric data for</td>
<td>Mean difference 0.43 ±2.24 m/s, r=0.92, after 1 week</td>
<td>Not reported</td>
<td>≥23.10 (upper tertile)</td>
</tr>
<tr>
<td>Study</td>
<td>Type of Analysis</td>
<td>Number</td>
<td>Age</td>
<td>Gender</td>
<td>CeVD</td>
<td>Albumin</td>
<td>LDL</td>
<td>Ht</td>
<td>eGFR</td>
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<tr>
<td>Chen et al., 2011</td>
<td>Japanese analysis</td>
<td>145</td>
<td>68.6±1</td>
<td>1.49±3</td>
<td>17 started hemodialysis and 8 died</td>
<td>An ABI-form device (VP1000)</td>
<td>Not reported</td>
<td>20.6±9.2</td>
<td>Per 1 cm/s increase, ≥19.64 (median)</td>
</tr>
<tr>
<td>Inoue et al., 2011</td>
<td>Japanese analysis</td>
<td>197</td>
<td>66.3±1</td>
<td>69±45</td>
<td>89 CV events</td>
<td>A volume-plethysmographic apparatus (Form/ABI)</td>
<td>Not reported</td>
<td>19.3±6.5</td>
<td>Per 1 m/s</td>
</tr>
</tbody>
</table>

Age, gender, CeVD, serum albumin, LDL, Ht, eGFR, calcium, phosphate, logPTH, the use of ACE inhibitors and/or ARBs, and the use of ESAs.
<table>
<thead>
<tr>
<th>Study</th>
<th>Patients</th>
<th>Age (mean±SD)</th>
<th>Gender</th>
<th>DM</th>
<th>Calc</th>
<th>Phosphorus</th>
<th>Intact-PTH</th>
<th>Hb</th>
<th>Albumin</th>
<th>CRP</th>
<th>AoAC grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amemiya et al., 2011</td>
<td>186 patients</td>
<td>61±12</td>
<td>61.8</td>
<td>48</td>
<td>23 deaths</td>
<td>A volume-plethysmographic apparatus (Form/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Median baEI variability less than 5%</td>
<td>18.7±5.4</td>
<td>19.95 (Upper tertile)</td>
<td>Tertiles</td>
</tr>
<tr>
<td>Sugama et al., 2011</td>
<td>625 patients</td>
<td>71±26</td>
<td>14 cardiac death, 19 MI, 10 HF, 31 unstable angina, 5 stroke</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>16.6 (median)</td>
<td>Median</td>
<td>Age, LDL levels, hypertension, smoking and</td>
<td></td>
</tr>
</tbody>
</table>

Blood sugar, Hb, Calcium, Phosphorus, Intact-PTH, Albumin, CRP, AoAC grade
<table>
<thead>
<tr>
<th>Study</th>
<th>Patients Description</th>
<th>Age Median (SD)</th>
<th>Sex M:F</th>
<th>CV Events</th>
<th>Measurement Method</th>
<th>Anthropometric Data</th>
<th>Median BMI</th>
<th>RAS Inhibitors</th>
<th>Other Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Munakata et al., 2011¹⁷†</td>
<td>318 ESRD patients</td>
<td>63±14</td>
<td>67</td>
<td>98</td>
<td>A waveform analyzer (Form PWV/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>17.5 (median)</td>
<td>Not reported</td>
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<tr>
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<td>(259 of them with ABI&gt;1.03 were used for the analysis)</td>
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<tr>
<td>Munakata et al., 2012¹⁸</td>
<td>662 untreated hypertensives</td>
<td>60±12</td>
<td>45</td>
<td>24</td>
<td>A waveform analyzer (Form PWV/ABI)</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>17.5 (median)</td>
<td>Age, sex, BMI, SBP, heart rate, blood glucose, total cholesterol, plasma creatinine, smoking status and the use of RAS inhibitors</td>
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</tr>
<tr>
<td>Study</td>
<td>Subjects</td>
<td>Age (Mean ± SD)</td>
<td>Gender (M:F)</td>
<td>DM (%)</td>
<td>Time on HD (Mean ± SD)</td>
<td>Current Smoking (%)</td>
<td>ACE Inhibitor/ARB (%)</td>
<td>Mean BP (Mean ± SD)</td>
<td>Serum Creatinine (Mean ± SD)</td>
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<tr>
<td>Kato et al., 2012¹⁹</td>
<td>135 patients</td>
<td>60±11</td>
<td>67.4</td>
<td>63±4</td>
<td>22 CVD deaths, 10 non-CVD deaths, 15 non-fatal CV events</td>
<td>Based on anthropometric data for Japanese</td>
<td>Not reported</td>
<td>16.0±3.6</td>
<td>≥16.6 m/s (upper tertile)</td>
</tr>
<tr>
<td>Yoshida et al., 2014²</td>
<td>783 type 2</td>
<td>30-75 years</td>
<td>Not reported</td>
<td>65.52</td>
<td>50 coronary events and 35</td>
<td>A waveform analyzer</td>
<td>Based on not reported</td>
<td>Not reported</td>
<td>Fourth quintile</td>
</tr>
</tbody>
</table>
2012 \(^{20}\) diabetics with no history of CVD disease d strokes (BP-203RPE) anthropometric data for Japanese e (cutoff value)

* From the suprasternal notch to the elbow (Da) was obtained from superficial measurements and expressed using the following equation: 
\[ Da = 0.2195 \times H - 2.0734, \] 
where \( H \) (in cm) is patient height. The path length from the suprasternal notch to the femur to the ankle (Db) was calculated as follows: 
\[ Db = (0.5643 \times H - 18.381) + (0.2486 \times H + 30.709). \] 
The distance was calculated as Db-Da.

†Studies published as abstracts in large cardiovascular conventions.

§ Studies by Inoue et al. 2011\(^ {14}\) and Amemiya et al. 2011\(^ {15}\) have a part of their population in common. The Inoue et al. 2011 study\(^ {14}\) was selected for estimation of risk for total CV events per 1 m/s increase in baEI. The Amemiya et al. 2011\(^ {15}\) data were used for estimation of all-cause mortality.

baEI: brachial-ankle elasticity index; ACE: Angiotensin-converting enzyme; MI: Myocardial infarction; CV: Cardiovascular; CVD: Cardiovascular disease; CAD: Coronary artery disease; CeVD: Cerebrovascular disease; CAGB: Coronary artery bypass graft; MI: Myocardial infarction; DES: Drug-eluting stents; ESRD: End-stage renal disease; HF: Heart failure; BMI: Body-mass index; BP: Blood pressure; SBP: Systolic blood pressure; PP: Pulse pressure; HDL: High-density lipoprotein; CHD: Coronary heart disease; eGFR: estimated glomerular filtration rate; ARB: Angiotensin II receptor blockers; MACE: Major adverse cardiac events; LDL: Low-density lipoprotein; HDL: High-density lipoprotein; TG: Triglycerides; SS: Suprasternal; Ht: Hematocrit; Hb: Hemoglobin; DM: Diabetes mellitus; LVEF: Left ventricular ejection fraction; GRACE: Global Registry of Acute Coronary Events; BNP: B-type natriuretic peptide; ABI: Ankle-brachial index; HDSR: Hasegawa Dementia Scale Revised; FMD: Flow-mediated dilation of the brachial artery; NMD: Nitroglycerin-mediated dilation; PTH: Parathyroid hormone; ESAs: Erythropoiesis-stimulating agents; CRP: C-reactive protein; AoAC: Aortic arch calcification; Renin-angiotensin system: RAS.
Figures and figure legends

Figure S1

Figure S1. Box and whisker plot of pooled relative risk (Log) of clinical events by tertiles of brachial-ankle pulse wave velocity index from 4 studies. Data from 4 studies (10,12,15,19). The center line of the box denotes the median value, the extremes of the box, the interquartile range, and the bars, the upper and lower limits of 95% of the data. P value by Friedman test.
Figure S2

<table>
<thead>
<tr>
<th>Studies (N)</th>
<th>Population</th>
<th>RR</th>
<th>95% CI</th>
<th>Total CV events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>DM</td>
<td>1.51</td>
<td>1.12 - 2.04</td>
<td></td>
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<tr>
<td>5</td>
<td>ESRD</td>
<td>2.31</td>
<td>1.54 - 3.48</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>GEN/ELD</td>
<td>18.46</td>
<td>3.35 - 101.61</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>CVD</td>
<td>2.50</td>
<td>1.94 - 3.23</td>
<td></td>
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<tr>
<td>1</td>
<td>HTN</td>
<td>2.97</td>
<td>0.98 - 9.06</td>
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</tbody>
</table>

Figure S2. Pooled RR and 95% CI for baEl and total CV events, according to disease state. The diamonds and their width represent the pooled RRs and the 95% CI, respectively. CVD: cardiovascular disease; DM: diabetes mellitus; GEN: general population; ELD: Elderly; ESRD: End-stage renal disease; RD: Renal disease; HTN: Hypertensives.
Figure S3

Figure S3. Publication bias for total CV outcomes and all-cause mortality and its potential impact. (A) Total CV events, (B) CV mortality and (C) all-cause mortality. The open circles in the left and right plots represent individual studies relating ED with events, and the open diamonds are the RR and 95% CI for the meta-analysis. The solid circles in the right plots represent imputed studies, and the solid diamonds are the RR and 95% CI for the meta-analysis after adjusting for publication bias.
Figure S4

Figure S4. Relative risk (RR) of total CV events in patients with high baEI as a function of (A) Age for end-stage renal disease patients (Data from 5 studies [3,6,12,17,19]), (B) Age for cardiovascular disease patients (Data from 4 studies [2,5,7,11]), (C) Diabetes percentage in study population (Data from 9 studies [2,3,5,6,9,11,12,19,20]). Each study is represented by a circle that shows the actual coordinates (observed effect size by each one of the abovementioned variables) for that study. The size of each circle is proportional to the weight of the respective study in the analysis i.e. the inverse of the within-study variance for each study. The center line shows the predicted values by fixed-effects meta-regression. The vertical axis is on a log scale.