regimen contributes to the practice-outcome gap, in which clinical guidelines are implemented but expected benefits are not realized. Fixed-dose combinations have the potential to improve compliance by reducing the pill burden (polypharmacy) (Oparil S, Calhoun DA, 1998). A meta-analysis of nine studies which compared fixed-dose combinations versus free-drug components of the regimen, showed that fixed-dose combinations decreased the rate of non-adherence by 26% compared with free-drug component regimens (Bangalore et al. 2007).

Furthermore, a subgroup analysis of the four studies on hypertension showed that fixed-dose combination decreased the risk of medication noncompliance by 24% compared with free-drug combination regimens. The fixed-dose combination containing the antihypertensive agent amiodipine and the statin, atorvastatin, is the first combination of its kind designed to treat two risk factors for cardiovascular disease (Blank et al. 2005, Hobbs et al. 2006, Preston et al. 2007, Flack et al. 2008, Erdine at al. 2009).

In a multicenter trial it has been found that the number of patients who were receiving combination therapy (atorvastatin and amlodipine) achieved their blood pressure goal more than those patients receiving amlodipine and more patients receiving combination therapy achieved their LDL-C goal than patients receiving atorvastatin alone. Furthermore, more patients receiving combination therapy achieved both their BP and LDL-C goals compared with those receiving a single-agent therapy alone (Messerli et al. 2006; Preston et al, 2007) and the estimated 10-year CHD risk has been found to be reduced from mean baseline values of ~17% to endpoint value of 9% in patients receiving combination therapy (Preston et al. 2007).