Supplementary Online Content


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eAppendix 2. AREDS2 IRB Roster

eAppendix 3. Adjudication Process

eTable 1. Summary of Adjudicated Cardiovascular Outcome Study (COS) Events by Docosahexaenoic Acid Plus Eicosapentaenoic Acid (DHA/EPA) and No DHA/EPA

eTable 2. Summary of Adjudicated Cardiovascular Outcome Study (COS) Events by Lutein Plus Zeaxanthin (LUT/ZEA) and No LUT/ZEA

eFigure 1. Time to First Cardiovascular Disease (CVD) Mortality/Morbidity Event by Docosahexaenoic Acid Plus Eicosapentaenoic Acid (DHA/EPA) and No DHA/EPA (All Events)

eFigure 2. Time to First Cardiovascular Disease (CVD) Mortality/Morbidity Event by Lutein/Zeaxanthin vs no Lutein/Zeaxanthin (All Events)

This supplementary material has been provided by the authors to give readers additional information about their work.
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(057) Doheny Eye Institute USC
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(072) Colorado Retina Associates PC
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### eAppendix 2. AREDS2 IRB Roster

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<td>Retina Consultants, PLLC</td>
<td>Ethical &amp; Independent Review Services</td>
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<td>University of Iowa, Dept. of Ophthalmology</td>
<td>Univ. of Iowa IRB</td>
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<td>Wills Eye Institute IRB</td>
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<tr>
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<td>Ethical &amp; Independent Review Services</td>
</tr>
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<td>Medical College of Wisconsin IRB</td>
</tr>
<tr>
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<td>University of Utah IRB</td>
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<tr>
<td>No.</td>
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<td>Baylor College of Medicine IRB</td>
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<td>UNC Department of Ophthalmology</td>
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<td>Univ. of Missouri Health Care IRB</td>
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<td>University of Tennessee HSC IRB</td>
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<td>Mayo Clinic IRB</td>
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<td>Yale University</td>
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<td>Univ. of Illinois at Chicago IRB</td>
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<td>085</td>
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<td>UCLA OHRP</td>
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<td>086</td>
<td>Univ. of Alabama at Birmingham</td>
<td>Univ. of Alabama at Birmingham IRB</td>
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<td>UT Southwestern Medical Center IRB</td>
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<td>Ohio State Univ. Biomedical IRB</td>
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<td>Univ. of California, Davis, IRB</td>
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<td>North Shore-Long Island Jewish Health System IRB</td>
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<td>University of Florida HSC</td>
<td>University of Florida HSC IRB</td>
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<td>Univ. of California San Diego HRP Program</td>
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<td>Univ. of Rochester Research Subjects Review Board</td>
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<td>NorthShore University HealthSystem IRB</td>
</tr>
<tr>
<td>179</td>
<td>Washington University</td>
<td>Washington University School of Medicine HRP</td>
</tr>
</tbody>
</table>
eAppendix 3. Adjudication Process

The following describes the procedures that were used in AREDS2 to classify the events that constitute the primary outcome for the AREDS2 Cardiovascular Outcome Study.

At the Clinical Site the coordinator who follows the participant completed the appropriate electronic CRF(s) and obtained a current medical record release from the participant. The medical releases were faxed to the Cardiovascular Collections Unit (CCU) to be reviewed for completeness. The CCU then requested medical records from the hospital or clinic using the information provided by the clinical site and the signed medical release. Once complete medical records were received at the CCU they were de-identified and prescreened before forwarding to Coordinating Center. All cases of cardiac catheterizations and hospitalized chest pain were reviewed to determine whether they were for interventional purposes or cardiac related, respectively. Events reviewed and deemed not cardiovascular related or performed for interventional purposes were filed at the CCU and not forwarded for adjudication. For events where medical records were not obtained due to inaccurate events date or location, the site coordinator was requested to obtain correct information, if possible. If the coordinator was unable to obtain the information, such events were filed at the CCU and reason noted. The complete, masked packet of medical records for each event was mailed or electronically transferred using a secure website to the Coordinating Center monthly. All event information from the site and medical records were recorded electronically on the appropriate CRF. The Coordinating Center reviewed the case packet for completeness and to ensure that all participant identifiers were removed from the documents. A Participant Endpoint Status Report (including previous adjudicated cardiovascular events with date and outcome adjudicated and any pending events still being adjudicated) were added to the Case Packet prior to sending to the adjudicators. Each case packet was randomly assigned to one of four cardiologists.

Review of an Event by the Adjudication Committee:

1. Using the definitions discussed later in this chapter the adjudicator will classify the endpoint event and complete the appropriate Adjudication Outcome form(s) to the Coordinating Center via the AREDS2 AdvantageEDC.

2. Ten percent of the events will be assigned to two adjudicators for quality assurance. For these cases, if the two reviewers do not agree, the event will be scheduled by the Coordinating Center for an annual review of events by the full adjudication committee, or

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more frequently if needed. If many of these cases occur in which there is no agreement reached then a higher percentage of events adjudicated twice will be considered.

3. Any committee member may request full review of a case by the entire committee.

4. All stroke cases will be reviewed by the neurologist on the adjudicating committee. To assess intra-rater agreement ten percent of adjudicated stroke cases will be re-adjudicated by the same neurologist.

5. Events that need to be re-reviewed by the full committee or a full committee review is requested, events will be classified by consensus or vote.

13.5. Event Definitions
The following definitions will be used by the Cardiovascular Outcome Study Adjudication Committee to determine whether a potential outcome meets the requirements of endpoint for the study.

13.5.1. Sudden death
Death of cardiac origin that occurred unexpectedly within 1 hour of the onset of new symptoms or a death that was unwitnessed and unexpected, unless a specific non-cardiac cause of death was confirmed.

13.5.2. Fatal myocardial infarction (MI)
Death within 30 days of the onset of documented MI (see 13.5.5)

13.5.3. Fatal Congestive Heart Failure (CHF)
Death due to clinical, radiological or postmortem evidence of CHF (see 13.5.10) without clinical or postmortem evidence of an acute ischemic event.

13.5.4. Fatal Stroke
Death due to stroke occurring within 30 days of the signs and symptoms of a stroke (see 13.5.6)

13.5.5. Myocardial Infarction
13.5.5.1. Definite MI: Diagnosis based on the occurrence of a compatible clinical syndrome (chest pain or anginal equivalent such as shortness of breath, arm pain, fatigue) with prolonged ischemic symptoms and elevated cardiac enzymes, associated with the development of new significant Q waves or ST-T waves changes that are consistent with ischemia. If Q waves are not present, there must be diagnostic elevation of cardiac enzymes that will include: increase in CK-MB mass or index to a level ≥ twice the upper limit of normal, or increase in troponin level ≥ twice the upper limit of normal or above
the level that indicates myonecrosis at the local laboratory. Only in the case that both troponin and CK-MB mass measurements are not available, would the elevation of total CK to ≥ twice the upper limit of normal qualify for diagnostic. See Exhibit 13-1 for a complete description of the components necessary for a definite MI.

13.5.5.2. Probable MI: Diagnosis based on the occurrence of a compatible clinical syndrome with prolonged ischemic symptoms and, the development of new and persistent significant ST-T changes or equivocal EKG changes and equivocal enzymes, or EKG changes consistent or suggestive of an MI with supporting abnormal or equivocal cardiac enzyme changes but no compatible clinical syndrome. Only in the case that both troponin and CK-MB mass measurements are not available, would the elevation of total CK to ≥ twice the upper limit of normal qualify for diagnosis. See Exhibit 13-1 for a complete description of the components necessary for a definite MI.

13.5.5.3. MI after cardiovascular invasive interventions: Diagnosis based upon the occurrence of CK-MB or Troponin elevations to a level ≥ 3 times normal or exceeding the local lab level for myonecrosis, occurring within 24 hours of cardiac catheterization, arrhythmia ablation, angioplasty, atherectomy, stent deployment or other invasive coronary, carotid or peripheral vascular intervention.

13.5.5.4. MI after coronary bypass graft surgery: Diagnosis based upon the occurrence of CK-MB or Troponin elevations to a level increased ≥ 5 times normal, occurring within 30 days of cardiac surgery.

13.5.5.5. MI after non-cardiovascular surgery: MI (as defined above) occurring within 30 days of non-cardiovascular surgery.
### Exhibit 1: Criteria for Determining Type of MI

<table>
<thead>
<tr>
<th>ECG Pattern/Symptoms</th>
<th>Cardiac Enzyme Interpretation (see Exhibit 2)</th>
<th>Abnormal</th>
<th>Equivocal</th>
<th>Unavailable</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac pain present:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evolving Q wave and evolving ST-T abnormalities</td>
<td>Definite MI</td>
<td>Definite MI</td>
<td>Definite MI</td>
<td>Definite MI</td>
<td></td>
</tr>
<tr>
<td>Equivocal Q wave evolution; or evolving ST-T abnormalities; or new left bundle branch block</td>
<td>Definite MI</td>
<td>Definite MI</td>
<td>Probable MI</td>
<td>No MI</td>
<td></td>
</tr>
<tr>
<td>Q waves or ST-T abnormalities suggestive of an MI and not classified above</td>
<td>Definite MI</td>
<td>Probable MI</td>
<td>No MI</td>
<td>No MI</td>
<td></td>
</tr>
<tr>
<td>Other ECG, ECG absent or uncodeable</td>
<td>Definite MI</td>
<td>No MI</td>
<td>No MI</td>
<td>No MI</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac pain absent:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evolving Q wave and evolving ST-T abnormalities</td>
<td>Definite MI</td>
<td>Definite MI</td>
<td>Definite MI</td>
<td>Probable MI</td>
<td></td>
</tr>
<tr>
<td>Equivocal Q wave evolution; or evolving ST-T abnormalities; or new left bundle branch block</td>
<td>Definite MI</td>
<td>Probable MI</td>
<td>No MI</td>
<td>No MI</td>
<td></td>
</tr>
<tr>
<td>Q waves or ST-T abnormalities suggestive of an MI and not classified above</td>
<td>Probable MI</td>
<td>No MI</td>
<td>No MI</td>
<td>No MI</td>
<td></td>
</tr>
<tr>
<td>Other ECG, ECG absent or uncodeable</td>
<td>No MI</td>
<td>No MI</td>
<td>No MI</td>
<td>No MI</td>
<td></td>
</tr>
</tbody>
</table>

### Exhibit 2: Cardiac Enzyme Interpretation

<table>
<thead>
<tr>
<th>Cardiac Enzyme</th>
<th>Abnormal</th>
<th>Equivocal</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CK-MB or troponin</td>
<td>$\geq 2x\text{ULN}$ (as %, index, or units) or “present without quantification” OR $\geq 3\text{ULN}$ if drawn after cardiovascular intervention OR $\geq 5x\text{ULN}$ if drawn after CABG</td>
<td>$1-2x\text{ULN}$ (as %, index or units); OR “weakly present”</td>
<td>WNL</td>
</tr>
<tr>
<td>CK (no MB available)</td>
<td>N/a</td>
<td>$\geq 2x\text{ULN}$</td>
<td>WNL</td>
</tr>
</tbody>
</table>

### 13.5.6. Stroke

13.5.6.1 Definite ischemic stroke: CT or MRI scan within 14 days of onset of a focal neurological deficit lasting more than 24 hours with evidence of brain infarction (mottled cerebral pattern or decreased density in a compatible location), no intraparenchymal hemorrhage noted in the CT/MRI most proximal to the onset of symptoms, no
significant blood in the subarachnoid space by CT/MRI or by lumbar puncture. A nonvascular etiology must be absent.

13.5.6.2 Definite primary intracerebral hemorrhage: Focal neurological deficit lasting more than 24 hours. Confirmation of intraparenchymal hemorrhage in a compatible location with CT/MRI scan within 14 days of the deficit onset or by lumbar puncture.

13.5.6.3 Subarachnoid hemorrhage: Sudden onset of headache, neck stiffness, loss of consciousness. There may be a focal neurological deficit, but neck stiffness is more prominent. Blood in the subarachnoid space by CT/MRI or lumbar puncture or intraventricular by CT/MRI.

13.5.6.4 Stroke of unknown type etiology: Focal neurological deficit lasting more than 24 hour compatible with a stroke when CT or MRI are not done. Information is inadequate to diagnose ischemic (infarction), intracerebral hemorrhage, or subarachnoid hemorrhage. A nonvascular etiology must be absent.

X.5.6.5 Non-fatal stroke after cardiovascular invasive interventions: Stroke (as defined in 13.5.6.1 – 13.5.6.4) associated with the intervention within 30 days of cardiovascular surgery, or within 24 hours of cardiac catheterization, arrhythmia ablation, angioplasty, atherectomy, stent deployment or other invasive coronary or peripheral vascular interventions.

13.5.6.6 Non-fatal stroke post non-cardiovascular surgery. Stroke (as defined in 13.5.6.1 – 13.5.6.4 ) occurring within 30 days of non-cardiovascular surgery.

13.5.6.7 Aborted Stroke: A focal neurological deficit that resolves after the administration of thrombolytics.

13.5.6.8 Transient Ischemic Attack (TIA): a sudden focal neurologic deficit lasting for less than 24 hours, of presumed vascular origin, and confined to an area of the brain or eye perfused by a specific artery

13.5.6.9 Carotid artery angioplasty, stent placement, or endarterectomy

13.5.7. Coronary revascularization

Includes:
• Coronary artery bypass surgery
• Percutaneous transluminal coronary intervention (PTCI) including angioplasty, placement of cardiac stents and atherectomy

13.5.8. Resuscitated cardiac arrest

13.5.8.1 Definite resuscitated cardiac arrest. Discharged alive from hospital after witnessed cardiac arrest. Cardiac arrest is defined as no pulse or respiration and unresponsive lasting at least 30 seconds with documentation of any of the following cardiac rhythms at the time of unresponsiveness: ventricular fibrillation, ventricular tachycardia, asystole (absence of any QRS complex for 6 seconds), severe bradycardia (11-50 beats per minute), pulseless electrical activity. Cardiac arrest events occurring within one week of a documented MI will be excluded.

13.5.8.2 Probable resuscitated cardiac arrest. Discharged alive from hospital after witnessed probable cardiac arrest. Cardiac arrest is defined as no pulse or respiration and unresponsive lasting at least 30 seconds. Documentation of cardiac rhythm at time of arrest is unavailable.

13.5.9. Placement of implantable cardioverter defibrillator (ICD)

Includes placement of any type of implantable cardiac defibrillator as either inpatient or outpatient.

13.5.10. Hospitalized Congestive Heart Failure

Compatible clinical syndrome with pulmonary edema/congestion documented on a radiology report and dilated left ventricle or poor left ventricular systolic or diastolic function (e.g., by echocardiography, radionuclide ventriculogram (RVG)/multigated acquisition (MUGA), or other contrast ventriculography). Individuals must be hospitalized primarily for the treatment of heart failure.

13.5.11. Hospitalized Unstable Angina

Participant hospitalized overnight for cardiac related chest pain or anginal equivalent (shortness of breath, arm pain, fatigue) that occurs with exertion or at rest and is associated with at least one of the following:

a. chest pain or equivalent plus EKG #2 or 3 but cardiac enzymes do not meet criteria for MI or
b. angiographic (CT of coronary arteries also acceptable) findings of at least 70% stenosis of epicardial coronary artery or at least 50% stenosis in the left main coronary artery, or  
c. reversible ischemic stress test

Criteria for an MI must not be met (i.e. if the participant has a compatible clinical syndrome, EKG changes, and the cardiac enzymes meet the criteria for an MI, the event is adjudicated as an MI)

Chest pain cases meeting the following criteria will be forwarded on for adjudication by the AREDS2 cardiovascular committee:

- Participant was hospitalized for chest pain at least one night AND
- EKG and cardiac enzyme levels checked during hospitalization AND
- Medical record documents elevation of cardiac enzyme levels OR acute ischemic changes in the EKG with no enzyme levels available
- In addition to the above, all medical records that list an acute myocardial infarction in the discharge summary regardless of the cardiac enzyme results or EKG results will be referred for AREDS2 cardiovascular adjudication
<table>
<thead>
<tr>
<th>COS Outcome*</th>
<th>DHA/EPA N (%)</th>
<th>No DHA/EPA N (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carotid Artery Intervention</td>
<td>2 (0.09%)</td>
<td>2 (0.10%)</td>
<td>4 (0.10%)</td>
</tr>
<tr>
<td>Coronary Revascularization</td>
<td>60 (2.79%)</td>
<td>53 (2.58%)</td>
<td>113 (2.69%)</td>
</tr>
<tr>
<td>Coronary Revascularization and ICD Placement</td>
<td>1 (0.05%)</td>
<td>1 (0.05%)</td>
<td>2 (0.05%)</td>
</tr>
<tr>
<td>Definite CHF</td>
<td>13 (0.61%)</td>
<td>13 (0.63%)</td>
<td>26 (0.62%)</td>
</tr>
<tr>
<td>Definite Hemorrhagic Stroke</td>
<td>3 (0.14%)</td>
<td>1 (0.05%)</td>
<td>4 (0.10%)</td>
</tr>
<tr>
<td>Definite Ischemic Stroke</td>
<td>40 (1.86%)</td>
<td>31 (1.51%)</td>
<td>71 (1.69%)</td>
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<tr>
<td>Definite MI</td>
<td>28 (1.30%)</td>
<td>30 (1.46%)</td>
<td>58 (1.38%)</td>
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<tr>
<td>Definite Resuscitation</td>
<td>1 (0.05%)</td>
<td>1 (0.05%)</td>
<td>2 (0.05%)</td>
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<tr>
<td>Fatal CHF</td>
<td>2 (0.09%)</td>
<td>0 (0.00%)</td>
<td>2 (0.05%)</td>
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<tr>
<td>Fatal MI</td>
<td>3 (0.14%)</td>
<td>0 (0.00%)</td>
<td>3 (0.07%)</td>
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<tr>
<td>Fatal Stroke</td>
<td>4 (0.19%)</td>
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<td>11 (0.26%)</td>
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<tr>
<td>Fatal/Non-Fatal Strokes</td>
<td>48 (2.24%)</td>
<td>41 (1.99%)</td>
<td>89 (2.12%)</td>
</tr>
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<td>ICD Placement</td>
<td>8 (0.37%)</td>
<td>7 (0.34%)</td>
<td>15 (0.36%)</td>
</tr>
<tr>
<td>Probable CHF</td>
<td>21 (0.98%)</td>
<td>21 (1.02%)</td>
<td>42 (1.00%)</td>
</tr>
<tr>
<td>Probable MI</td>
<td>5 (0.23%)</td>
<td>10 (0.49%)</td>
<td>15 (0.36%)</td>
</tr>
<tr>
<td>Probable Resuscitation</td>
<td>0 (0.00%)</td>
<td>1 (0.05%)</td>
<td>1 (0.02%)</td>
</tr>
<tr>
<td>Stroke of unknown type/etiology</td>
<td>1 (0.05%)</td>
<td>1 (0.05%)</td>
<td>2 (0.05%)</td>
</tr>
<tr>
<td>Subarachnoid Hemorrhagic</td>
<td>0 (0.00%)</td>
<td>1 (0.05%)</td>
<td>1 (0.02%)</td>
</tr>
<tr>
<td>Sudden Death</td>
<td>7 (0.33%)</td>
<td>9 (0.44%)</td>
<td>16 (0.38%)</td>
</tr>
<tr>
<td>TIA</td>
<td>15 (0.70%)</td>
<td>17 (0.83%)</td>
<td>32 (0.76%)</td>
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<tr>
<td>Unstable Angina</td>
<td>6 (0.28%)</td>
<td>12 (0.58%)</td>
<td>18 (0.43%)</td>
</tr>
<tr>
<td>Participants with at least one Cardiovascular Event</td>
<td>183 (8.52%)</td>
<td>187 (9.10%)</td>
<td>370 (8.80%)</td>
</tr>
</tbody>
</table>

* Multiple outcomes within participant counted once

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eTable 2. Summary of Adjudicated Cardiovascular Outcome Study (COS) Events by Lutein Plus Zeaxanthin (LUT/ZEA) and No LUT/ZEA

<table>
<thead>
<tr>
<th>COS Outcome*</th>
<th>Treatment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LUT/ZEA N (%)</td>
<td>No LUT/ZEA N (%)</td>
</tr>
<tr>
<td>Carotid Artery Intervention</td>
<td>2 (0.09%)</td>
<td>2 (0.10%)</td>
</tr>
<tr>
<td>Coronary Revascularization</td>
<td>45 (2.12%)</td>
<td>68 (3.27%)</td>
</tr>
<tr>
<td>Coronary Revascularization and ICD Placement</td>
<td>1 (0.05%)</td>
<td>1 (0.05%)</td>
</tr>
<tr>
<td>Definite CHF</td>
<td>9 (0.42%)</td>
<td>17 (0.82%)</td>
</tr>
<tr>
<td>Definite Hemorrhagic Stroke</td>
<td>1 (0.05%)</td>
<td>3 (0.14%)</td>
</tr>
<tr>
<td>Definite Ischemic Stroke</td>
<td>43 (2.03%)</td>
<td>28 (1.35%)</td>
</tr>
<tr>
<td>Definite MI</td>
<td>27 (1.27%)</td>
<td>31 (1.49%)</td>
</tr>
<tr>
<td>Definite Resuscitation</td>
<td>0 (0.00%)</td>
<td>2 (0.10%)</td>
</tr>
<tr>
<td>Fatal CHF</td>
<td>1 (0.05%)</td>
<td>1 (0.05%)</td>
</tr>
<tr>
<td>Fatal MI</td>
<td>1 (0.05%)</td>
<td>2 (0.10%)</td>
</tr>
<tr>
<td>Fatal Stroke</td>
<td>8 (0.38%)</td>
<td>3 (0.14%)</td>
</tr>
<tr>
<td>Fatal/Non-Fatal Strokes</td>
<td>55 (2.59%)</td>
<td>34 (1.63%)</td>
</tr>
<tr>
<td>ICD Placement</td>
<td>8 (0.38%)</td>
<td>7 (0.34%)</td>
</tr>
<tr>
<td>Probable CHF</td>
<td>19 (0.89%)</td>
<td>23 (1.11%)</td>
</tr>
<tr>
<td>Probable MI</td>
<td>9 (0.42%)</td>
<td>6 (0.29%)</td>
</tr>
<tr>
<td>Probable Resuscitation</td>
<td>1 (0.05%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Stroke of unknown type/etiology</td>
<td>2 (0.09%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Subarachnoid Hemorrhagic</td>
<td>1 (0.05%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Sudden Death</td>
<td>9 (0.42%)</td>
<td>7 (0.34%)</td>
</tr>
<tr>
<td>TIA</td>
<td>17 (0.80%)</td>
<td>15 (0.72%)</td>
</tr>
<tr>
<td>Unstable Angina</td>
<td>5 (0.24%)</td>
<td>13 (0.63%)</td>
</tr>
<tr>
<td>Participants with at least one Cardiovascular Event</td>
<td>181 (8.53%)</td>
<td>189 (9.09%)</td>
</tr>
</tbody>
</table>

* Multiple outcomes within participant counted once

Bolded outcomes were statistically significant (<0.05)
eFigure 1. Time to First Cardiovascular Disease (CVD) Mortality/Morbidity Event by Docosahexaenoic Acid Plus Eicosapentaenoic Acid (DHA/EPA) and No DHA/EPA (All Events)

![Graph showing Kaplan-Meier probabilities of CVD event with treatment, No DHA/EPA, and DHA/EPA groups.]

Log Rank P-value: Unadjusted = 0.933, HR = 0.999, 95% CI = (0.825, 1.209)

- No DHA/EPA: 0.022, 0.047, 0.064, 0.086, 0.109
- DHA/EPA: 0.026, 0.051, 0.074, 0.092, 0.106

eFigure 2: Time to First Cardiovascular Disease (CVD) Mortality/Morbidity Event by Lutein/Zeaxanthin vs no Lutein/Zeaxanthin (All Events)

![Graph showing Kaplan-Meier probabilities of CVD event with treatment, No Lutein/Zeaxanthin, and Lutein/Zeaxanthin groups.]

Log Rank P-value: Unadjusted = 0.993, HR = 0.993, 95% CI = (0.820, 1.202)

- No Lutein/Zeaxanthin: 0.023, 0.045, 0.067, 0.087, 0.109
- Lutein/Zeaxanthin: 0.024, 0.045, 0.068, 0.091, 0.106

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