Material and Methods:

In the EPICARDIAN study, we examined the factors contributing to the development of hypertension in SLE patients. We have considered the multiple logistic regression analysis.

Objectives:

The cardiovascular risk factors, the clinical subgroup and the age of elderly people were included in the analysis.

Introduction:

SLE (Systemic Lupus Erythematosus) is a chronic inflammatory disease that affects the tissue and organs, producing a wide variety of symptoms.

Results:

The average age of the patients was 42±3 years, 112 women. The average progression of SLE was 9±6 years (1–29). 20.5% of patients suffered from hypertension. The subgroup of SLE patients were articular-cutaneous 89.8%, haematologic 13.9%, nephrologic 21.9% and neurologic 23.5%. The anticardiolipin antibodies were present in 24.7% of the cases. By employing the univariate analysis, we could show that hypertension was linked significantly to anti-inflammatory pill intake (P=0.007), diabetes (P=0.1), and nephrologic (P=0.02) and neurologic subgroup (P=0.02). However, in the multivariate analysis, the model that best explained hypertension occurrence was both corticoids intake and the years of evolution SLE. Hypertension risk quadruples when taking corticoids. Furthermore, hypertension risk increases in 1.11 % every year of evolution of SLE.

Conclusions:

Hypertension in SLE patients has a prevalence of 20.5%. Hypertension risk in SLE patients is directly associated with taking corticoids and the years of evolution of SLE.

Key Words: Hypertension; systemic lupus erythematosus

G047

HYPERTENSION ASSOCIATED TO MYOCARDIAL ISCHEMIA OR PSYCHIATRIC DISORDER AT THE E.R. IN PATIENTS WITH CHEST PAIN AND NON-DIAGNOSTIC ECG

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Coronary artery disease (CAD), gastrointestinal pathology, paitiental chest pain and psychiatric disorder are usually found in different degrees, in pts with chest pain (CP) and non-diagnostic ECG. In this study, we assessed pts with a validated clinical chest pain score (including hypertension) and a first line instrumental work up, for identification of pts at risk for coronary events. During 95–99, we evaluated a total of 5936 consecutive pts with CP and non-diagnostic ECG by a clinical score based on location, radiation, character of CP, associated risk factors and symptoms (Goldman NEJM 1996, Radensky JACC 1996). Psychiatric screening was obtained by The Hospital Anxiety and Depression Scale (HADS) questionnaire. Patients considered at low risk for cardiovascular events were discharged from the E.R. (n=3964; 67%); these pts had a 2% readmission rate, but only a 0.2% final diagnosis of CAD. In this subset of pts we found a pathologic score at HADS in 12% of pts and hypertension in only one/third of pts. Patients, considered at risk for cardiovascular events, were admitted to the Chest Pain Unit (CPU), for second line investigation (n=1972; 33%). Rest or Stress MIBI myocardial scintigraphy was performed in pts >40 y or >3 risk factors. Exercise tolerance test (ETT) and stress-ECHO were performed in pts without risk factors for atherosclerosis or when the final diagnosis was still uncertain at 24 hours from admission. All pts with >1 positive test underwent urgent angiography. Evidence of CAD was found in 361 pts (6%) with no ECG abnormalities (angiographically confirmed in 93%) based on >1 test including ECG (46%), cardiac enzyme (39%), echocardiogram (15%),
nuclear scan (11%) and exercise test (9%). Only 2% of these patients had HADS high score. In 1070 pts (18%) with non-diagnostic ECG abnormalities on admission, diagnosis was obtained within the firsts hours (of which 225 acute myocardial ischemia were transferred to CCU). In this subset HADS high score was present in 1% of pts and hypertension in two/third of pts. CPU-based management allowed a 76% early discharge (67% from E.R. and 9% from CPU) in pts with CP and non-diagnostic ECG avoiding inappropriate CCU admission. Patients with CAD showed lower score at HADS questionnaire and a higher rate of hypertension.

Key Words: Hypertension; chest pain; coronary artery disease

G048
CLASSIFICATION OF JNC VI BLOOD PRESSURE STAGES AND RISK GROUPS IN THE ARIC STUDY
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The Sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI) introduces a new classification of blood pressure (BP) by stage and risk group as a tool for clinicians in making management decisions in hypertensives that accounts for total cardiovascular risk as follows: Group A - no risk factors (RF), no clinical cardiovascular disease (CVD), and no target organ damage (TOD); Group B - at least 1 associated RF other than diabetes, but no CVD and no TOD; Group C - diabetes, or CVD, or TOD.

To determine the impact of the new classification on management decisions, this analysis examines the prevalence of each Stage/Group among participants with no missing data in visit 3 of the ARIC study (1992–1995). CVD RF considered for classification included diabetes, smoking, dyslipidemia, age ≥ 60 years, male sex, and menopause. Conditions considered for clinical CVD or TOD included ECG evidence of left ventricular hypertrophy, angina or prior MI, prior coronary revascularization, peripheral vascular disease, stroke, or transient ischemic attack (no data available for CHF).

<table>
<thead>
<tr>
<th>BP Stages (mmHg)</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal (&lt;130/85)</td>
<td>7.1</td>
<td>4.0</td>
<td>11.9</td>
<td>15.6</td>
</tr>
<tr>
<td>High-normal (130–139/85–89)</td>
<td>0.8</td>
<td>1.0</td>
<td>3.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Stage 1 (140–159/90–99)</td>
<td>0.5</td>
<td>0.4</td>
<td>3.2</td>
<td>5.9</td>
</tr>
<tr>
<td>Stages ≥ 2 (&gt;159/99 or treated)</td>
<td>1.8</td>
<td>3.2</td>
<td>10.5</td>
<td>14.9</td>
</tr>
<tr>
<td>Total</td>
<td>10.2</td>
<td>8.6</td>
<td>52.2</td>
<td>63.4</td>
</tr>
</tbody>
</table>

These results illustrate the disparity of risk between blacks and whites and supports efforts to determine the causes of disparity in this risk and subsequent CVD morbidity and mortality.

Key Words: Hypertension; cross-classification; African American