lipids were analyzed: TotalCHL, HDLc, Triglycerides. LDLc was calculated according to the formula: LDLc = CHL-(HDLc+Triglycerides/5).

All the patients did not assume any antidyslipidemic treatment.

Mean sphygmomanometric blood pressure was: 150+/−19/90+/−10 mmHg; mean PP was: 60+/−15 mmHg and heart rate: 72+/−12 beats/ min. Total-cholesterol, HDL-cholesterol, Triglycerides and LDL-cholesterol were: 225+/−37 mg/dl, 56+/−15 mg/dl, 143+/−61 mg/dl and 140+/−34 mg/dl, respectively. A significant correlation was found between PP and LDL-cholesterol (linear regression analysis; r = 0.21, p<0.02), whereas the correlation between PP and Total-cholesterol, and between PP and HDL-cholesterol did not reach a statistical significance (r = 0.17, p=0.7; r = -0.13, p=.18, respectively).

In conclusion, in the population studied of resistant hypertensive patients, the correlation found between pulse pressure and LDL-cholesterol suggests that, in presence of persistently elevated blood pressure, plasma lipids may influence the vascular stiffness, expressed by pulse pressure values. Possibly, the vascular alterations linked to dyslipidemia may account for resistance versus pharmacological therapy.

Key Words: Resistant hypertension, LDL cholesterol, Pulse pressure

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PREVALENT AND CONTROL OF CARDIOVASCULAR RISK FACTORS IN A TERTIARY HYPERTENSION CLINIC
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Hypertension is but one of several risk factors that must be controlled to optimally reduce cardiovascular risk. Previous surveys of our tertiary (mostly referral) clinic have shown a high prevalence of controlled hypertension but only a moderate prevalence of controlled triglycerides, HDLc and BP. Although there are no comparable data from other clinics about these risk factors, our data suggest that, in presence of persistently elevated blood pressure, plasma lipids may influence the vascular stiffness, expressed by pulse pressure values. Possibly, the vascular alterations linked to dyslipidemia may account for resistance versus pharmacological therapy.

Key Words: cardiovascular, hypertension, risk

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CARDIOVASCULAR RISK FACTORS AND COGNITIVE AND AFFECTIVE IMPAIRMENT IN THE ELDERLY
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In the last years several studies have highlighted the considerable importance of cardiovascular risk factors in cognitive performances. Particularly, arterial hypertension is associated not only with vascular dementia, but could be also one of the underlying factors in the pathophysiology of late onset dementia of Alzheimer’s type (LO-DAT).*

In our hypertension ambulatory of Dept. of Internal Medicine and Aging, we evaluated the attending patients also with regard to cognitive and affective status with MMSE, Memory Impairment Screen, Verbal Fluency, Geriatric Depression Scale (15 items), Activity Daily Living, Instrumental Activity Daily Living and Modified Cumulative Illness Rating Scale. We used as well as OMS Hypertension Guide Lines 1999 and DCM IV criteria.

Data about 165 patients are reported. Eligible males and females, between 65-88 years old, had a systolic blood pressure below 220 mmHg and a diastolic blood pressure below 140 mmHg, and median plasmatic total cholesterol 227mg/dl. All patients were in active treatment: 37 patients in Ace-inhibitors therapy, 10 in additional therapy with diuretics and 30 in add therapy with Ca-antagonist; 4 patients in B-blockers therapy; 26 patients in Ca-antagonist; 6 patients only on a diet; 51 patients in other additional therapy. The median MMSE was 26.67±3.06 and MMSE score was: >24: 89% of patients, 23-20: 9%, <20: 2%. Median GDS was 4.913 ± 3.55 and GDS score was <6: 70% of patients, >6-10: 19%, 11-15: 11%, not completely correspondent to the clinical diagnosis. While there isn’t correlation between MMSE-GDS vs total cholesterol and MMSE vs Cardiovascular Risk (p=0.329), on the contrary we found that GDS is significantly related to CR (p=0.0406). Cognitive status (MMSE > 23) was normal 54% of patients in ACE-inhibitors therapy, in 50% in B-blockers therapy and in 38.4% in Ca-antagonist therapy. Furthermore affective status was normal (GDS < 6) in 74% of patients in ACE treatment and 28% of patient in Ca-antagonist.*

In our elderly treated patients, hypertension was associated with a low cognitive impairment and low affective disorders. Depression increases with Cardiovascular Risk.

This is the first step of prospective study that we will follow up for 1 year.*

Key Words: Elderly patients, Cognitive impairment and affective disorders, Hypertension

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PILOT PROJECT FOR REDUCTION OF CARDIOVASCULAR DISEASE IN MISSISSIPPI RURAL COMMUNITIES
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Mississippi has the highest overall cardiovascular mortality rates among the 50 states. Recognizing that research into causes of regional and racial disparities in CVD mortality is urgently needed, currently available strategies for reducing risk need to be used most effectively. The Consortium for Cardiovascular Disease Prevention Strategies in Mississippi was formed in 1999 to develop and implement comprehensive strategies to reduce CVD among Mississippi residents.

This presentation will describe the design and initial progress of a pilot study in a small, rural community. The primary intervention is a community based educational and enabling intervention, leading the community in establishing educational programs with community groups, healthcare providers, and individuals with specific risk factors. Efforts include increasing community CVD awareness, renewing emphasis on comprehensive risk factor detection, and improving access to healthcare. A baseline survey measuring risk factors in every eligible member of the community followed by an intervention over approximately 12 to 18 months will be implemented. Persons with identified risk factors will be tracked for optimal management. The main outcome variable is change in CVD risk factor status from baseline to post-intervention. Primary outcome measures are control rates for HTN, dyslipidemia, and diabetes.

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