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THE RELATIONSHIP BETWEEN BODY MASS INDEX AND PULSE PRESSURE IN OLDER ADULTS WITH ISOLATED SYSTOLIC HYPERTENSION

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Many longitudinal studies have reported excess cardiovascular mortality among lean hypertensive subjects suggesting that obesity may mitigate the cardiovascular risk of hypertension. Available evidence also suggests that in middle-aged and older hypertensive subjects pulse pressure may be a better predictor of cardiovascular complications. However there are limited data on the relationship between body mass index (BMI) and pulse pressure. Using data from the third National Health and Nutrition Examination Survey we assessed the convergence validity of pulse pressure as a predictor of cardiovascular complications and examined the relationship between BMI and pulse pressure in 1192 older adults with isolated systolic hypertension and receiving no blood pressure medicine. There was a good concordance between high pulse pressure and most of the selected cardiovascular risk factors examined in this study. Pulse pressure is higher in the lean (BMI<25) than in the overweight (BMI>=25) (79mmHg vs 74mmHg p<0.001) and decreases significantly from 82mmHg in the first BMI quintile to 76mmHg in the fifth BMI quintile. Pulse pressure continues to decrease with increasing BMI until the index exceeds 30.1. This negative correlation persists in a multivariate model with statistical adjustment for age, gender, diabetes mellitus and hypercholesterolemia.

Key Words: Pulse pressure, Body Mass Index, Elderly

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FIRST RESULTS IN 34 PATIENTS WITH PRIMARY ALDOSTERONISME TREATED BY CT GUIDED PERCUTANEOUS ETHANOL

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Hiperaldosteronism in adrenal adenoma is a curable cause of secondary high blood pressure(HBP). Primary aldosteronism characterised by raised values of serum aldosterone with blunted renine levels in patients with adrenal adenoma was until now usually treated by open surgery or more recently by video-laparoscopy. These invasives therapies are frequently associated with complications and more aggressive, much more expensive and time consuming when compared with the CT guided percutaneous ethanol injection (PEI). The aim of this study is the evaluation of ethanol induced ablation of adrenal adenomas in secondary HBP

Material and Methods:
PEI is a sclerosing technique already used for the ablations of tumors. With previous consent of the Ethical Commission of our Hospital we performed CT-guided PEI in 34 patients (13 males and 21 females) for the ablation of functioning adrenal adenomas, diagnosed by CT. Patients were released after 72 hours. All patients were submitted to a new hormonal and imagologic study 6 months after PEI.

Results:
The series submitted to surgical treatment was considered for evaluation as the “golden standard” . In 72% of the patients we achieved normal blood pressure 48 to 72 h after PEI. Control examinations (6 months after) confirmed that in 67% of the patients we achieved normal blood pressure (< 139/89 mmHg) and clinically we got an absence of the major symptoms due to hiperaldosteronism (easy fatigue, caimbras,…). The hormonal levels tend also to be normal.

Conclusion:
Preliminary results for this technique are most promising and definitelly as good as those obtained with surgical treatment.

Key Words: renine, aldosterone, primary aldosterone

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EPINEPHRINE PRODUCING PHEOCHROMOCYTOMA

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One of the most common signs of pheochromocytoma is paroxysmal or persistent hypertension. But according to the latest data 12% of all pheochromocytomas are found incidentally and 20% of patients with pheochromocytoma have normotension. We refer two cases of pheochromocytoma without hypertension. Both patients were referred to our department with a finding of adrenal incidentaloma and without symptoms typical for pheochromocytoma. Imaging techniques (CT and USG) confirmed the findings of adrenal gland tumors (9x8 cm and 7x6 cm respectively). For excluding hormonal activity, we performed a complete biochemical screening. In one patient we found 20-times higher levels of epinephrine and 3-times higher levels of dopamine in 24-hour urine, in the second patient there were 8-times higher levels of epinephrine alone. Norepinephrine in urine, as well as values of all adrenal cortical hormones were normal. The hormonal activity was confirmed in both cases by 131I-MIBG scan. Both patients were indicated for adrenalectomy, which was performed without complications. The levels of catecholamines in urine after the surgery normalized.

Conclusion: The clinical manifestation of pheochromocytoma is variable, the levels of single catecholamines (epinephrine, norepinephrine, dopamine) is important. Epinephrine or dopamine producing pheochromocytoma is often oligo- or asymptomatic. Impaired glucose tolerance and hypercholesterolemia can be the only signs of epinephrine producing pheochromocytoma.

We stress the importance of complete hormonal screening in all cases of adrenal incidentalomas, with the necessity of measuring the levels of single catecholamines and its metabolites (metanephrine, normetanephrine). MIBG scan should be considered. In patients with epinephrine producing pheochromocytoma a screening for MEN II (S-calcitonin, USG of thyroid gland) is to be performed.

Key Words: pheochromocytoma, catecholamine levels, adrenal inciden
taloma

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THE CAPOTRIPIL TEST FOR THE SCREENING OF PRIMARY ALDOSTERONISM

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Aldosterone-to-plasma renin activity ratio (ALDO/PRA) has been proposed as a screening test for primary aldosteronism (PA). However, remarkable overlap between values in patients (pts) with essential hypertension (EH) and pts with PA, particularly in the case of low-renin EH, curtails the accuracy of usual ALDO/PRA determinations for the screening PA in unselected hypertensive populations. The capotril test has been suggested as a useful means to increase the specificity and accuracy of ALDO/PRA for the identification of cases of PA. We formally compared the sensitivity and specificity of ALDO/PRA for the screening of PA before and after a single oral capotril dose in a group of 75 hypertensive pts, including 53 essential hypertensives with baseline PRA < 1ngAI/ml/h after 4 days of controlled Na intake (approximately 100 mmol/day) and 22 historical pts with PA (16 pts with idiopathic hyperaldosteronism (IHA) and 8 pts with unilateral aldosteronoma (A)). Lack of ALDO suppression following an intravenous saline load was