dominated into the trial and their demographics were recently reported (J. Hypertension 2001;19:1139–47).

Mean blood pressures at randomisation (representing a mixture of both untreated 20% and previously treated 80% patients) were 164 mmHg systolic and 95 mmHg diastolic. Target pressures are <140 mmHg systolic and <90 mmHg diastolic, except for a subgroup of patients with type 2 diabetes in whom targets are lowered to <130 mm Hg systolic and <80 mmHg diastolic.

Blood pressure changes during the first 2.5 years of follow up (treatment groups combined) are shown in the accompanying table. Patients will be followed up for a further 2.5 years on average.

Mean BP & BP change by visit—all patients

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Relative Risk, Rofecoxib vs. Celecoxib (95% CI)</th>
<th>P (Fisher exact test)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased edema</td>
<td>80 (8.5%) vs. 46 (4.8%)</td>
<td>1.85 (1.27–2.70)</td>
</tr>
<tr>
<td>SBP destabilization</td>
<td>147 (15.6%) vs. 84 (8.8%)</td>
<td>1.79 (1.39–2.27)</td>
</tr>
<tr>
<td>DBP destabilization</td>
<td>21 (2.2%) vs. 13 (1.4%)</td>
<td>1.64 (1.21–2.32)</td>
</tr>
</tbody>
</table>

Disclosure: Sponsored by Pharmacia Corporation and Pfizer Inc.

Key Words: COX-2 Specific Inhibitors, Hypertension, Edema and Systolic Blood Pressure

By 2.5 years 27% of patients remained on one antihypertensive drug and the remainder (73%) required 2 or more antihypertensive drugs. These data emphasize that to achieve currently recommended BP targets, at least 2 drugs are required for most hypertensives but that using clear treatment algorithms as in the ASCOT trial, acceptable BP control is achievable for a large proportion of patients.

Key Words: Hypertension, RCT, ASCOT

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ASSESSMENT OF THE NOVEL SELECTIVE ALDOSTERONE BLOCKER EPLERENONE USING AMBULATORY AND CLINIC BP IN 400 PATIENTS WITH SYSTEMIC HYPERTENSION: RESULTS FROM A PIVOTAL MULTINATIONAL TRIAL

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Elderly patients with hypertension (HTN) and osteoarthritis (OA), who are already at high risk of cardiovascular events, may be particularly vulnerable to the cardiorenal side effects of COX-2 specific inhibitors. Controversy exists over the prevalence of these side effects and whether they are a class effect of these drugs or molecule specific. To compare the cardiorenal effects of celecoxib and rofecoxib, we used pooled data of two similar, double-blind, randomized, controlled trials. Patients >65 years old with OA and stable, treated HTN were randomized to treatment with celecoxib 200 mg/day or rofecoxib 25 mg/day. A total of 1,902 patients were randomized; standardized assessments of edema and BP were performed at baseline and at weeks 1, 2 and 6. Significant destabilization in SBP was defined as change from baseline >20 mm Hg and over 140 mm Hg; significant destabilization in DBP was defined as change from baseline >15 mm Hg and over 90 mm Hg. Edema was assessed by a 5-point scale from 0 to 4+ along with changes in weight (3% or greater). Baseline demographics were similar for each group. Edema and blood pressure results are shown in Table 1. This pooled analysis of two large randomized trials demonstrates statistically significant destabilization of SBP and increased edema in elderly patients with OA and HTN treated with rofecoxib compared with celecoxib. Further investigation of these molecule-specific differences and their clinical importance is warranted.