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AGGRESSIVE BLOOD PRESSURE CONTROL IN GENERAL PRACTICE (ABC-GP) STUDY: STEPWISE VERSUS INDIVIDUALIZED TREATMENT STRATEGY
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Objective: The International Society of Hypertension (ISH) recommended lower blood pressure (BP) targets in hypertension management using an individualized treatment strategy (ITS) and referral to a hypertension specialist if target is not reached within 6 months. This study was designed to test the hypothesis that in general practice the ITS may fail to achieve target BP within 6 months in a high proportion of patients, whereas a stepwise treatment strategy (STS) (as in the outcome studies, e.g. the HOT study) may be superior.

Methods: GPs were trained in the ISH guidelines and were randomized to achieve in their patients the new BP targets within 6 months using ITS or a fosinopril based STS. Untreated or treated uncontrolled hypertensives were included (validated automated oscillometric devices, device-printed measurements).

Results: 21 GPs were randomized (STS/ITS 11/10 GPs, 231/211 patients). There were no differences between groups in age (65 ± 9 years), treatment status (70% treated) and target BP (51% with target < 130/85 mm Hg). Baseline BP was higher in the STS (166.7/90.7 mm Hg; difference 4.7/2.3 mm Hg, p < 0.05). At 6 months the decline in BP was similar in the two groups (30/11 and 28/10 mmHg, for STS and ITS respectively, p < 0.0001) whereas there were no differences in BP neither in the proportion of subjects who achieved target BP (54%/48% for STS/ITS). More drugs were administered in the STS group (combined therapy in 68%/59% for STS/ITS, p = 0.06).

Conclusions: In general practice both the ITS and the STS fail to achieve the new BP targets within 6 months in about 50% of patients.

Key Words: Target Blood Pressure, Blood Pressure Control, Drug Treatment

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ARE DOCTORS AND PATIENTS USING STATINS EFFECTIVELY FOR THE PREVENTION OF CORONARY HEART DISEASE?
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The aim of this study was to determine whether HMG-CoA reductase inhibitors (statins) are used in line with current recommendations for the prevention of coronary heart disease and to identify factors which determine patient response.

Patients attending the Cardiovascular Risk Clinic in Aberdeen were prospectively screened for statin use. Gender, age, current statin and dose, treatment start date, pre- and most recent post-treatment lipid measurements were recorded.

407 patients receiving a statin were identified of whom 355 had a complete lipid data set. 194 (54.6%) failed to meet the recommended total cholesterol (TC) target of < 5.0 mmol/L. Failure to meet target levels was associated with a significantly higher pre-treatment TC (7.66 ± 1.37 vs 6.61 ± 1.13 mmol/L, p < 0.001), statin treatment for primary prevention (47.9% vs 34.8%, p < 0.05), and a significant increase in length of time since the last lipid measurement (13.00 ± 9.36 vs 11.05 ± 8.03 months, p < 0.05). Although the average duration of treatment was greater for the failed group (32.7 ± 20.0 vs 27.7 ± 15.0 months, p < 0.05), 71.1% of patients had not had a serum lipid estimation within the preceding 6 months and 40.6% within the preceding year. Despite similar levels of statin usage in both groups (21.1 ± 10.1 vs 19.4 ± 7.8 mg/day of simvastatin), failed vs met, p = 0.086) patients in the failed group had a significantly lower response to statin therapy (21.34 ± 12.80% vs 32.45 ± 12.10, p < 0.001) indicating poor patient compliance or the existence of a group of poor responders. To identify factors other than pre-treatment TC which might explain treatment failure, 116 patients were matched for pre-treatment TC (58 met, 58 failed) and data analysed. The only significant difference between these two groups was the response to statin therapy, which was greater in those who had met target (33.6 ± 7.6% vs 14.1 ± 9.0%, p < 0.001).

At the present time we are failing to meet recommended cholesterol targets. The reasons for this are evident from the low doses of statin prescribed (mean 20.15 ± 8.82 mg/day), and failure to measure response appropriately. Pre-treatment TC should determine the starting statin dose which then should be up-titrated according to response. There are also a group of individuals who have a poor response to statin therapy regardless of pre-treatment TC raising the possibility of poor compliance. Although statins may be used in appropriate patients they are not used to achieve optimal CHD risk reduction indicating the need for further doctor and patient education.

Key Words: HMG-CoA Reductase Inhibitors, Efficacy, Poor Responders

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PRACTICE-BASED COMPARISON OF HYPERTENSION CONTROL IN DIABETICS USING DIFFERENT GUIDELINES
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Several different blood pressure (BP) goals for diabetics have been recently promulgated by various guideline-writing groups. The Healthplan Employer Data Information Set (HEDIS) 2000 uses a goal BP of < 140/90 mm Hg; the Sixth Report of the Joint National Committee (JNC VI) recommended < 130/85 mm Hg; and the American Diabetes Association (ADA) and National Kidney Foundation (NKF) recommend < 130/80 mm Hg. To compare BP control rates using these recommendations, a chart review was performed. Among the 437 consecutive patients first seen in the Rush University Hypertension Center from September, 1998 to February, 2000 were 86 diabetics (47% male, 61 ± 12 years old). The mean initial BP was 156 ± 24/ 89 ± 12 mm Hg and, after at least one year in clinic, decreased to 137 ± 16/78 ± 10 mm Hg at the most recent visit. Goal BP achievement varied depending on which guideline criteria were applied.

<table>
<thead>
<tr>
<th>HEDIS Non-diabetic</th>
<th>HEDIS-Diabetic</th>
<th>JNC VI-Diabetic</th>
<th>ADA/NKF Diabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Control</td>
<td>59</td>
<td>52</td>
<td>22</td>
</tr>
<tr>
<td>% Systolic Control</td>
<td>63</td>
<td>55</td>
<td>23</td>
</tr>
<tr>
<td>% Diastolic Control</td>
<td>86</td>
<td>73</td>
<td>68</td>
</tr>
</tbody>
</table>

Overall, diabetic patients reached goal BP less commonly than non-diabetic patients, but the difference was statistically significant only when a lower goal BP was considered for diabetics (P < 0.001 by chi-square, using either JNC VI or ADA/NKF goals; P = 0.22 for HEDIS criteria). Similarly, the trend for controlled hypertension decreased significantly as the goal BP declined, whether or not the non-diabetics were included in the analyses (all P < 0.001). This trend was significant for both systolic (chi-square = 25, P < 0.001) and diastolic BP (chi-square = 14, P < 0.001). Control of systolic BP was less commonly achieved than diastolic, regardless of which goal BP was used (P = 0.025 by chi-square). BP control among diabetics is, therefore, less common when more stringent goals are used, even among patients seen in a specialized Hypertension Center with a high prevalence of controlled hypertension. These data suggest that achieving the recently-recommended lower BP...