with elevated clinic BP and ambulatory daytime BP ≥130/85 mm Hg were randomised double-blind to receive AML 5 mg (n=47) or LOS 50 mg (n=46). Doses were increased to AML 10 mg or LOS 100 mg and combined with hydrochlorothiazide and other antihypertensive agents excluding ACE inhibitors in order to reach target clinic BP< 130/85 mm Hg. Clinic and ambulatory BP, UAE and glomerular filtration rate (GFR) were assessed at baseline and at prespecified timepoints during the 3-year period.

At the end of the study, the mean doses used for AML and LOS were respectively 8.7 mg and 89.9 mg, daily. Apart from the study medication, the AML and the LOS treatment groups respectively received 2.0 and 1.8 additional antihypertensive agents. Both treatment groups exhibited significant and similar decreases in systolic/diastolic clinic BP, from 26.47 to 16.26 mm Hg. Systolic/diastolic ambulatory BP were also significantly reduced by both AML-based (from 26.47 to 16.26 mm Hg) and the night-time (14/-9 mm Hg) BP. Systolic/diastolic ambulatory BP were also significantly decreased by both treatments during the daytime (20/-13 mm Hg) and the night-time (14/-9 mm Hg) periods. UAE was similarly decreased by both AML-based (from 26.47 to 16.26 μg/min) and LOS-based (from 16.46 to 7.46 μg/min) treatment regimens. Five normoalbuminuric patients (3 on AML, 2 on LOS) developed microalbuminuria while one patient (AML group) developed macroalbuminuria during the study. In contrast, 9 out of 25 patients and 9 out of 16 patients respectively treated with AML and LOS regressed to normoalbuminuria from microalbuminuria. GFR was significantly and similarly decreased by both AML (from 98.4 ±2.6 to 91.3 ±3.3 ml/min) and LOS (from 94.1 ±2.6 to 83.0 ±3.5 ml/min) treatment regimens during the first 24 weeks of treatment but remained stable thereafter. In conclusion, the results of the present long-term study allow us to conclude that an AML-based treatment is as effective as a LOS-based treatment in delaying the occurrence of macroalbuminuria and in the regression to normoalbuminuria in ambulatory hypertensive patients with type 2 diabetes.

Key Words: Angiotensin receptor antagonist, Calcium channel blockers, Diabetes

EFFECT OF LERCANIDIPINE, FELODIPINE, AND NIFEDIPINE GITS ON BLOOD PRESSURE AND HEART RATE: LERCANIDIPINE IN ADULTS STUDY

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The aim of the Lercanidipine in Adults (LEAD) study was to compare the efficacy and tolerability of lercanidipine, felodipine, and nifedipine gastro-intestinal therapeutic system (GITS) in adults (aged 31 to 74 years) with mild-to-moderate essential hypertension (SBP 140-180 mm Hg and DBP 95-109 mm Hg). A total of 325 patients were randomized in this multicenter, double-blind, parallel-group trial. After a 1-week washout period and a 2-week placebo run-in, patients received 1 of the following 8-week treatments: lercanidipine 10 mg/d (n=109), felodipine 10 mg/d (n=110), or nifedipine GITS 30 mg/d (n=106). After 4 weeks of treatment, the dosage was doubled in nonresponders (DBP ≥95 mm Hg and DBP reduction <10 mm Hg from baseline). Heart rate (HR) was measured via electrocardiogram tracings at rest and under stress (mental stress and isometric stress). At 8 weeks, significant reductions in BP were observed in all 3 groups (P<0.01). Increases in HR induced by stressful conditions before and after treatment were not exacerbated during active treatment in all 3 groups. Lercanidipine and nifedipine GITS were better tolerated than felodipine. In particular, the incidence of edema with lercanidipine was 5.5% versus 6.6% with nifedipine GITS and 13% with felodipine. The incidence of discontinuations due to any adverse event was 4.6% in the lercanidipine group, 9.4% in the nifedipine GITS group, and 15.5% in the felodipine group (P<0.05). These results demonstrate that although the 3 dihydropyridine calcium antagonists significantly and equally decreased SBP and DBP, lercanidipine exhibited a superior tolerability profile.

Key Words: antihypertensive drug therapy, lercanidipine, calcium antagonist

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INTEGRATION BETWEEN IN-HOSPITAL AND OUT-HOSPITAL ASSISTANCE: A NON-PHARMACOLOGICAL THERAPY FOR HEART FAILURE (HF)

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Operators: Physicians and nurses from In-Hospital HFU; Out-Hospital physicians (practitioners); AVULSS volunteers.

Methods: So. Lo. per il cuore project; stage for nurses and volunteers enrolment of patients from three Hospitals (Somma Lombardo, Gallarate, Angera) or of outpatients.

Information to the patients and their relatives about the project; written informations to family physicians.

Volunteers with a nurse’s help will phone the patients periodically on the base of their situations and needs; during the telephone call they administer a questionnaire with items about patients’ illness and all necessary informations.

Later a specialist will analyse the questionnaires and will decide if the patient needs hospitalization or a new telephone call or nothing at all.

Results: Ninety two enrolled patients (from Nov 2001 to Dec 2002), 67 M and 25 F, 72.5 y old (from 46 to 90 y old), M were 72 y old (from 46 to 90 y old) and F were 74 y old (from 61 to 88 y old). NYHA class: 54 p. (39%M, 15F) were in II class (59%); 21 p. (15M, 6F) were in I class (23%); 15 p. (12M, 3F) were in III class (16%); 2 p. (1M, 1F) were in IV class (2%).

27 p. (NYHA class: 8 in I, 13 in II, 6 in III). From these patients 18 (67%) had no hospitalization during one year; 1 (NYHA III) died for stroke; 8 (30%) had hospitalization.

Among the patients that had hospitalization 3 (NYHA class I) because of ischaemic cardiopathy (1 PTCA, 1 AMI), or COPD (1 p.); 3 (NYHA class II) because of diabetes and pacing (1), gastroenteric haemorrhage (1), stroke (1); 2 (NYHA class III) because of TIA and neuropathy (1) or in Day Hospital for worsening of HF (1).

Conclusions: Our experience shows that a good integration between In-Hospital and Out-Hospital assistance is the best management of HF and the role of integration is growing as an important non pharmacological therapy.

Key Words: Heart Failure, non pharmacological therapy, in and out hospital assistance

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MEDICATION COMPLIANCE AND EFFECTS OF COGNITIVE-BEHAVIORAL INTERVENTION IN WOMEN WITH TREATED HYPERTENSION

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Research using electronic monitoring of medication taking patterns is emerging as the “gold standard” for assessing medication compliance. The purpose was to examine patterns of medication-taking after a cognitive-behavioral intervention (CBI) comprised of a 30- day home based program involving reading tailored messages and or home blood pressure only. The CBI was designed to structure knowledge or cognitive representations of medication-taking behavior and to improve sense of...