mm Hg vs 82.2 ± 9.7, p<0.05; 49.7 ± 25 vs 42 ± 26.4, p<0.04, respectively). Men 55-64 y had larger waist circumference than <44 y (p<0.04). Overweight women or with waist circumference >88 cm had higher mean 24 h PP (p<0.05) than lean. In both genders, PP increased with age (p<0.001) and dippers are younger than non-dippers (women 56.7 ± 10.6 vs 61.4 ± 12.6 y, p<0.01; men 49.9 ± 14.3 vs 53.8 ± 15.6 y, p<0.05). We conclude that overweight men have higher DBP levels and hypertensive load; and waist circumference is greater in those >55 y. In overweight women or with large waist circumference, PP is higher than in lean women or with small waist circumference. In both genders, PP increased with age, and the lack of nocturnal decrease of BP rises with age. All this factors increase the cardiovascular risk.

Key Words: pulse pressure, waist circumference, BMI.

P-27
ARE ACCEPTABLE THE DIFFERENCES BETWEEN HBPM VS ABPM TO EVALUATE THE CONTROL OF HYPERTENSIVE PATIENTS. PRELIMINARY RESULTS OF THE ZANYCONTROL STUDY?
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To determine if the value of BP measurements obtained in the patient’s home using HBPM compared to 24-hour ABPM is trustworthy and consistent.

Multicentric, cross-over study to evaluate diagnostic tests used to validate HBPM in the patient’s home (automatic electronic BP monitor, 3 readings with a period of 1-2 minutes) compared to the results of BP office. This is a substudy of a large study called Zanycontrol. We built a table 2*2 with a matched data and we calculated the Kappa Concordance index, false positives (f+) and negatives (f-). In order to evaluate disagreements we used the statistic tool of Mc Nemar

939 patients were included in this substudy, attained consecutively of the global sample, who had all the data required. We obtained the value of BP measurements obtained in the office by the physicians (3 times separated by 1-2 minites) and patient’s home using HBPM (3 times with a period of 1-2 minutes). We considered bad control values of SBP > 135 mm Hg or values of DBP > 85 mm Hg in the HBPM and SBP > 140 mm Hg or values of DBP > 90 mm Hg in the office readings BP

BP Office vs HBPM Comparison

<table>
<thead>
<tr>
<th>BP Office/HBPM</th>
<th>Good Control</th>
<th>Bad Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good control</td>
<td>467</td>
<td>168</td>
</tr>
<tr>
<td>Bad control</td>
<td>62</td>
<td>232</td>
</tr>
</tbody>
</table>

I. Kappa = 0.463 P = 0.057; F+ = 19% (LC 95%; 16.5%; 21.5%); F- = 6.6% (LC 95%; 5%; 8.2%)

The results are (see table above)

We quanticificate the percentage of hypertensives patients with bad control, with the casual readings BP in the office if we considered HBPM the gold standard. We need to have in mind this results (specially the F+) in the follow up of this patients.

Key Words: HBPM, BP Office

P-29
UTILITY OF AN AUTOMATED BLOOD PRESSURE (BP) MEASURING DEVICE (BPTRU) IN CLINICAL DECISION MAKING
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Hypothesis: Accurate BP measurement is critical to decision making in the hypertensive patient. It often is poorly done because of time constraints. The BpTRU is an automated multiple BP measuring device that could replace the gold standard nurse (GSN) JNC VI-recommended multiple office BP measurement.

Methods: 106 pts referred for ambulatory monitoring had 3 GSN ausculted BP in the same arm simultaneously with 2-5 BpTRU BP measurements. The BpTRU device controlled inflation and deflation. The 2 techniques were compared for systematic differences by signed rank test and for random differences by summarizing the inter-method differ-