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ADVERSE EFFECTS AND REASONS FOR SWITCH REPORTED BY PATIENTS ON ANTIHYPERTENSIVE MEDICATIONS

Antihypertensive therapy choice depends upon a patient’s clinical characteristics and response to prior therapy. Benefits of therapy are influenced by likelihood of continuation and switching, which may be affected by adverse effects. The purpose of this study was to better understand, in a naturalistic setting, participant experience with adverse events, likelihood of continuation, and switching behavior across different antihypertensive drug classes. An online survey was performed in September 2003 to obtain data from 1,256 patients (23% response rate), 57.9% female and mean age 56.8 ± 14.2 years old, with a diagnosis of hypertension and on monotherapy for greater than 1 month. Patients reported adverse effects, likelihood of continuing their medication, drug switching behavior, and primary reasons for switching if they had previously used different medications. Data were analyzed for 5 classes: angiotensin II receptor antagonists (ARB) (n=241), diuretics (n=235), ACE inhibitors (n=258), calcium channel blockers (CCBs) (n=293), and β-blockers (n=229). To increase generalizability, data were adjusted with weights obtained from the NHANES database. Pair-wise comparisons were conducted with Tukey adjustment. Likelihood of continuation differed by drug class with ARB having the highest and CCBs the lowest (P<0.05). Most-frequently-reported adverse effects among all patients were frequent urination, sexual dysfunction, and fatigue ranging from 7.0% to 9.6%. Across drug classes, ARB had the lowest reported frequencies of all abovementioned adverse effects. Among the primary reasons for switching, physician recommendation was the most frequently reported in all classes except diuretics. Having adverse effects was the second most frequent reason for switching. Among the 5 classes, patients switched to ARB reported the highest rate of having had adverse effects with previous medications. The likelihood of continuing medications differed by drug class as well as by adverse effect frequency, with ARB having a positive profile in both areas. Moreover, adverse effects are an important reason for patients to switch medications. Patients can only receive antihypertensive therapy benefits if they continue on a prescribed regimen. These patients’ data may aid physicians in medication selection and ongoing monitoring.

Key Words: Patient Reported Side Effects, Patient Reported Reasons for Switching, Antihypertensive Medication in Naturalistic Setting

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COMBINATION THERAPY WITH AN ACE-INHIBITOR (ACEI)/CALCICUM CHANNEL BLOCKER (CCB) FOR HYPERTENSIVE PATIENTS NON-RESPONSIVE TO ACE-INHIBITOR MONOTHERAPY: AN EFFICACY AND SAFETY TRIAL
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The purpose of this double-blind study was to compare the antihypertensive dose-dependent efficacy and safety of the fixed-dose combination of Amlodipine, a long-acting dihydropyridine CCB, and Benazepril, an ACEI, to Benazepril monotherapy. Following a 2-week washout period and a 4-week Benazepril 40 mg lead-in period, patients with mean sitting diastolic BP ≥ 95 mm Hg were randomly assigned to either Amlodipine 5 mg/Benazepril 40 mg for 4 weeks followed by a forced titration to Amlodipine 10 mg/Benazepril 40 mg for an additional 4 weeks or to Benazepril 40 mg for 8 weeks of treatment. Systolic BP response criteria was set at <140 mmHg at endpoint or ≥15 mm Hg decrease from baseline. Diastolic BP response criteria was set at <90 mm Hg at endpoint or ≥ 10 mm Hg reduction from baseline. BP was measured in the sitting position. A total of 298 patients completed the study comprised of 53% male and 60% Caucasian with a mean age of 53 years and a mean sitting baseline BP of 148/99 mm Hg. The titration of Amlodipine/Benazepril 5/40 mg to 10/40 mg reduced BP in a dose-dependent manner. The mean reduction from the 4-week Benazepril, 40 mg, lead-in baseline was 17/14 mg Hg with Amlodipine/Benazepril vs. 5/7 mm Hg with Benazepril (p<0.0001). In the subgroup of patients with mean sitting systolic BP ≥145 mm Hg, 76% of the patients on Amlodipine/Benazepril met the systolic response criteria compared to 37% in the Benazepril group (p<0.0001). Similarly, 80% of the patients on Amlodipine/Benazepril met the diastolic BP response criteria compared to 45% in the Benazepril group (p<0.0001). Mean changes in heart rate were similar in both treatment groups. Adverse events were infrequent and their incidence was comparable for both treatment groups. There were no deaths during the study. Only 4 incidences of serious adverse events, 1 in the Amlodipine/Benazepril group and 3 in the Benazepril group, were reported during the treatment period. The incidence of edema, an often reported adverse event with Amlodipine therapy, was low and not significantly different between treatment groups (Amlodipine/Benazepril 2% vs. Benazepril 4%). From these data, it can be concluded that high-dose Amlodipine/Benazepril (10 mg/40 mg) in a fixed-dose combination is a well tolerated, effective and safe treatment option for hypertensive patients not adequately controlled with high-dose Benazepril monotherapy.

Key Words: Amlodipine, Benazepril, Combination Therapy

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OLMESARTAN MEDOXOMIL LOWERS BLOOD PRESSURE AS RAPIDLY AS AMLODIPINE BESYLYATE IN PATIENTS WITH MILD TO MODERATE HYPERTENSION: RESULTS OF A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY
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Regarding blood pressure (BP) control, a desirable agent is one that is efficacious, has a fairly rapid onset of action, and a prolonged duration of effect. Amlodipine besylate (AML) has been shown to combine these effects, whereas most angiotensin receptor blockers have a slower onset of action. However, an integrated analysis of 7 placebo-controlled studies has demonstrated that olmesartan medoxomil (OLM) significantly reduces mean diastolic blood pressure (DBP) and systolic blood pressure (SBP) within 1 week of treatment (p≤0.007 vs placebo [PL]; data on file). In a well-controlled comparative study, OLM reduced mean SBP/DBP at the earliest time point measured (2 weeks) to a significantly greater degree than losartan, valsartan, and irbesartan in hypertensive patients (Oparil et al. J Clin Hypertens [Greenwich]. 2001;3:283–292). Based on these results, we compared the onset of BP-lowering effects of OLM and AML in patients with mild to moderate hypertension by assessing BP efficacy at the earliest point measured (2 weeks). Following a 4-week PL run-in phase, subjects were randomized to 8 weeks of double-blind therapy with the recommended doses of OLM (20 mg/d), AML (5 mg/d), or PL. The primary efficacy variable was the change from baseline in mean 24-hour DBP by ambulatory BP monitoring at week 8. Both OML and AML significantly decreased SBP/DBP to a similar extent (Chrysas et al. J Hum Hypertens. 2003;17:425–432). Secondary endpoints included the change from baseline in mean 24-hour SBP at weeks 2, 4, and 8. Treatment with OLM or AML resulted in similar SBP/DBP reductions at 2 weeks of 12.8/10.6 mm Hg and 11.9/10.0 mm Hg, respectively, versus PL of 4.1/4.5 mm Hg (p<0.001). Taken together with previous studies, OLM consistently demonstrates a rapid onset of action.

Key Words: Olmesartan, Amlodipine, Angiotensin Receptor Blockers