mitral replacement. To assess how experience may impact the efficacy of mitral repair on patients with increasing complexity, we examined 941 consecutive patients who underwent mitral valve repair from July 1992 to January 2000. METHODS: All patients underwent primary mitral repair for regurgitation. Of the 941 patients, 750 had their operations between July 1992 and December 1998 (A), and 191 between January 1999 and January 2000 (B). Outcomes were analyzed for incidences of STS co-morbid criteria and concomitant cardiac procedures (valvular, arch, or CABG) performed during the study periods. RESULTS: For the 941 patients, 530 (56%) were male, patient age was 62 ± 13.3 years (range 20–88). Group A included 204/750 with comorbidities (27.2%) vs. 176/191 (92%) in Group B (p < 0.0001). Overall incidence of concomitant procedures in the 2 groups was similar (58% A, 57% B (p = NS)). Cross clamp times were reduced from 104.9 ± 12.5 min in Group A to 84.9 ± 10.4 min in Group B (p < 0.0001). There were no differences in atrial fibrillation between groups (27.6% A, 28.3% B). There were a total of 53 30-day mortalities (5.6%), with a trend towards reduced mortality in Group B (6.1% Group A, 3.7% Group B (p = 0.19]). Average LOS decreased from 12.2 ± 14.9 days in Group A to 8.7 ± 8.5 days in Group B (p = 0.02). CONCLUSIONS: Mitral valve repair remains a safe and effective treatment for patients with mitral regurgitation including those with valve repair remains a safe and effective treatment for patients with mitral regurgitation including those with co-morbid criteria and concomitant cardiac procedures. As experience is gained with reparative techniques, surgeons may be more willing to safely apply them to an increasingly complex patient population.

CHOICE OF FIRST-LINE TREATMENT FOR HYPERTENSION IN THE UK: DOES CURRENT PRIMARY CARE PRACTICE REFLECT BRITISH GUIDELINES?

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OBJECTIVES: This study set out to explore the adherence to British Hypertension Guidelines in choosing first-line treatment for blood pressure by general practitioners (GPs) in the UK. These currently recommend thiazide diuretics as the preferred choice and beta-blockers as an alternative initial treatment for most patients. METHODS: The data on choice of blood pressure treatment recorded at first diagnosis of hypertension were obtained from a UK GP computer database, IMS Disease Analyzer—Mediplus. The records covered the 1-year period March 2002 to February 2003. The database holds the records of 564 GPs and 948,958 registered patients. RESULTS: Of 8,540 patients with at least three months history on the database and a new diagnosis of hypertension within the year of analysis, initial treatment was as follows: 36.5% thiazide diuretic; 22.4% beta-blocker; 17.8% ACE inhibitor; 10.1% calcium channel blocker; 4.0% angiotensin-2-receptor antagonist; 2.1% alpha-blocker. Of those, 16.4% were not started immediately on antihypertensive therapy. Of those that did, 4.6% received first treatment as a combination of two drugs (hence the total figures do not add up to 100%). CONCLUSIONS: This study suggests that first-line treatment is often using a drug that is not in accord with current National policy as only 58.9% were started on recommended first-line therapy. Choices from other drug classes tend to be more expensive, and there is less evidence of benefit. In particular the 4.6% starting treatment with combination therapy appears at odds with the policy to start with a single agent. Co-morbidity such as diabetes or bladder outflow obstruction may explain the choice of other agents; for example angiotensin-inhibiting drugs in diabetes, but the prevalence of these conditions is not sufficient to explain this variation from the guidelines. This choice of drugs may reflect heavy marketing of these newer products rather than evidence-based medicine.

THE USE OF SHORT MESSAGES TO THE PATIENT’S MOBILE PHONE AS HEALTH CARE TOOL IN HYPERTENSION: THE HTA-ALERT STUDY AND THE INFONET PROGRAM

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OBJECTIVES: To demonstrate the feasibility and patient acceptance of a health care intervention using the patient’s mobile phone (HTA-Alert Study), and to describe the pattern of use of this tool in the usual clinical practice (INFONET Program) in hypertensive (HT) patients. METHODS: 1) HTA-Alert Study: 20 primary care investigators were randomized to Control (CG) or Intervention (IG) group. Investigators of IG registered their patients in a free SMS service. These patients received two short-messages per week, during 24 weeks. Messages addressed issues related with compliance and health habits. 2) INFONET Program: 40 Hypertension Units (UHTA) asked patients to enter periodically blood pressure into a private web site, where physicians had access to data. Physicians were asked to send free-text SMSs to the patient mobile phone via web application at their own convenience. RESULTS: 1) HTA-Alert: 33 Patients CG and 34IG were studied. There was a relevant reduction in weight (from 80.47 ± 9.76kg to 76.84 ± 8.92; p < 0.001) in the IG. Hypertension was reduced in
both groups, but IG patients showed an earlier control (61.8% control in IG vs 36.4% in CG at 12 weeks; \( p = 0.038 \)). 2) INFONET Program: The first 250 SMS were analysed. Percentages of SMS sent by physicians were: support (50.3%), Therapeutic compliance (2.7%), Asking for data (29.5%), Scheduling visits to surgery (6.0%), Modifying medication (1.6%), Others (9.9%). The most frequent scheduling was one SMS every 12 days. CONCLUSIONS: In the usual practice (INFONET Program), physicians use the SMS system in a different way than predicted (HTA-Alert). They tend to give support and to ask for data, instead of addressing compliance and life-habits messages. Frequency of messages was also lower. The use of SMS seems to be a useful tool for educational programs, and it would be convenient to explore in more detail its effectiveness in health outcomes.

**PCV10**

**IMPROVED COMPLIANCE AND PERSISTENCE WITH ATORVASTATINE THROUGH A PHARMACY-BASED INTERVENTION**

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**OBJECTIVES:** To establish the effect of a pharmaceutical care program on compliance and persistence with once-daily atorvastatine treatment in patients with elevated cholesterol levels. **METHODS:** An open-label, prospective controlled trial of 1-year duration was conducted in Belgium, stratified by language region. A French speaking and a Flemish speaking region were randomized to a Measurement Guided Medication Management (MGMM) intervention consisting of review by the patients’ pharmacist of the electronically compiled dosing history, a “beep-card” that reminds patient of the dosing time and educational reminders. The control group received care as usual, also stratified between the 2 regions. Compliance was measured in all patients using the Medication Event Monitoring System (MEMS®), AARDLEX, Switzerland, defined as the % doses taken as prescribed (once-daily). Nonpersistence was defined as the % of patients who stopped using atorvastatine before the end of the study. Because of the skewed nature of compliance data, statistical reporting includes medians, 25–75% interquartile ranges, and non-parametric tests. **RESULTS:** A total of 393 patients were included: intervention group: n = 194, control group: n = 199. After 1-year follow-up and stratification by region, the median % of doses taken as prescribed (25% quartile−75% quartile) was 96.1 (92.7–98.2) in the intervention group versus 89.9 (77.1–95.6) in the control group (\( p < 0.0001 \)). Other compliance variables showed similar results % prescribed doses taken: 98.9 (96.3–100.3) vs 95.2 (83.0–98.9), \( p < 0.001 \), % doses within prescribed interval \( \pm 25\% \): 92.8 (83.9–95.9) vs 84.4 (63.0–92.5), \( p < 0.001 \) and Therapeutic Coverage: 96.1 (92.9–97.8) vs 93.6 (84.6–96.6), \( p < 0.001 \). Persistence was significantly better in the intervention group: 87.1% vs 76.9% in the control group (\( p = 0.02 \)). Explanatory analysis showed that the Flemish patient group and an elevated cardiovascular risk score were significantly related to better compliance and persistence. **CONCLUSIONS:** Measurement Guided Medication Management improved patient compliance and persistence with atorvastatine.

**PEV11**

**PREDICTIVE VALUE OF TROPONIN T LEVELS FOR HEART FAILURE AFTER UNSTABLE ANGINA OR NON ST-SEGMENT ELEVATION MYOCARDIAL INFARCTION**


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**OBJECTIVE:** Troponin T levels (TnT) predict hard ischemic events and prognosis in patients (p) with unstable angina (UA) or non ST-segment elevation myocardial infarction (NSTEMI). There are no reports on their ability to predict the development of heart failure (HF) in that population. **METHODS:** In order to determine the ability of TnT to predict the incidence of NYHA class III or IV HF along three months after an episode of unstable UA or NSTEMI, TnT levels were measured to 352 p between the fifth and 24th hour from hospital admission due to an acute episode attributable to such diagnosis, being 231 men and 121 women, mean age 67.6 years (range 20 to 88). Personal or phone interview of patients or relatives were obtained three months after the acute episode looking for signs or symptoms of advanced heart failure. **RESULTS:** TnT levels were higher than or equal to 0.1 ng/ml in 135 p (TnT+ group) and less than 0.1 ng/ml in the other 217 p (TnT− group). Both groups were comparable in age (69 vs 66) and slightly different in proportion of women (42% vs 32%). Three patients died after episodes of class IV HF and all three pertained to the TnT+ group. Odds ratios (OR) and their 95% confidence intervals (CI) for the development of class III or IV HF are reflected in the table. **CONCLUSIONS:** Patients admitted with the diagnosis of unstable angina or non ST-segment elevation myocardial infarction have much more episodes of advanced heart failure in the following three months when Tropo T levels are elevated in the first 24 hours of the acute ischemic episode, TnT+ TnT− n(%) n(%) OR 95% CI p NYHA III/IV 11(8.9) 5(2.4) 3.85 1.3–11.3 < 0.03 NYHA IV 7(5.5) 2(0.9) 5.88 1.2–28.7 < 0.05.

**PEV12**

**EFFECT OF EPROSARTAN ON PULSE PRESSURE PREDICTIVE FACTORS OF RESPONSE**

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**RESULTS:** TnT+ TnT− n(%) n(%) OR 95% CI p NYHA III/IV 11(8.9) 5(2.4) 3.85 1.3–11.3 < 0.03 NYHA IV 7(5.5) 2(0.9) 5.88 1.2–28.7 < 0.05.