Old age, male gender, poor medical compliance, hospitalization and coexistent anti-platelet agents were the other significant risk factors of developing stroke in these uncomplicated hypertensive patients treated with various antihypertensive agents.

CLINICAL EXPERIENCE IN DYSLIPIDEMIC PATIENTS TREATED EITHER WITH ROSUVASTATIN 10 MG/DAY OR EZEZIMIBE/SIMVASTATIN 10/20 MG/DAY IN MEXICO CITY. A RETROSPECTIVE ANALYSIS

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OBJECTIVES: To compare efficacy of rosuvastatin (RSV) and ezetimibe/simvastatin (E/S) to take dyslipidemic patients to their LDL-C goals according to ATP III guidelines in the cardiology clinical practice. Secondary objective was to compare the efficacy of both treatments to change lipids levels (LDL-C, TC, TG, HDL-C ApoB/ApoA1 index) from baseline to week 8.

METHODS: Files from dyslipidemic outpatients in the Cardiology Unit of a 3rd level hospital in Mexico City were reviewed between Jan 2004–Dec 2005. Patients treated with either RSV 10 mg/day or E/S 10/20 mg/day and lipid determinations before (basal) and after 8 weeks of treatment were included. Regression models were used to adjust outcome measures for age, sex, CHD, baseline LDL-C, and therapy duration. To assess the primary objective, patients were classified as achieving lipid goals or not according to ATP III. Logistic regression analysis was made with a proportion test. For secondary objectives, the mean percent lipid change (MPLC) achieved by each treatment was noted and differences detected by Student’s t test with a p < 0.05 for significance.

RESULTS: Files from 98 (age 63.1 ± 12.8 years) treated with RSV and 89 (age 65.8 ± 12.8 years) treated with E/S were reviewed. There were no significant differences between groups at baseline. A total of 81.4% and 46.4% RSV patients achieved their LDL-C goals more than E/S patients. RSV treatment reduced more LDL-C, TC and ApoB/ApoA1 index: RSV −46.7 ± 13.6 versus E/S −35 ± 21.3 (p < 0.001); TC: RSV −33.6 ± 12.7 versus E/S −25.8 ± 16.7 (p < 0.001); HDL-C: RSV 9.9 ± 16.9 versus E/S 4.17 ± 16.5 (p = 0.012). ApoB/ApoA1 index: RSV −21 ± 29 versus E/S −10.7 ± 20 (p = 0.019). There were no reports of adverse events with any treatment. CONCLUSION: More RSV patients achieved their LDL-C goals than E/S patients. RSV treatment reduced more LDL-C, TC and ApoB/ApoA1 index (atherogenic lipid profile) and higher HDL-C levels than E/S in the usual clinical practice in Mexican patients.

CUMULATIVE PERSISTENCE OF ANTIHYPERTENSIVE MEDICATION AS A NEWLY PRESCRIBED DRUG IN A MEDICAID POPULATION

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OBJECTIVES: To compare two-year persistence rates associated with categories of antihypertensive medications among patients who were newly prescribed antihypertensive medications in a Medicaid Population. METHODS: The study is composed of all continuously enrolled Maryland Medicaid patients aged 18 years or older, with at least one prescription for selected antihypertensive agents between 7/1/02 and 12/31/02, and no such prescriptions in the preceding 6 months. Patients were followed for two years since their index date. Selected antihypertensive agents include angiotensin-converting enzyme inhibitors (ACEI), angiotensin II antagonists (AIIA), beta-blockers (BB), calcium channel blockers (CCB), diuretics, and fixed-dose combinations. Medication Possession Ratio (MPR) was assessed at 120, 240, 360, 480, 600 and 720 days after index date. Persistent was defined as MPR >= 80%. We used logistic regression and generalized estimating equation (GEE) approaches to compare persistence rates for each drug class at 720 days and over two years, respectively. RESULTS: A total of 2967 patients qualified for inclusion in the study. Persistence rates in the whole study sample at 120, 240, 360, 480, 600 and 720 days were 41.6%, 29.9%, 22.4%, 17.7%, 14.4% and 11.1%, respectively. ACEIs were associated with significantly higher two-year persistence rates than other classes, followed by CCBs. For the GEE model, over two years, persistence rates among patients treated with ACEIs were significantly higher than patients treated with diuretics, BBs, CCBs, and mixed dose combination therapy. ACEIs were also associated with a slightly higher yet non-significant persistence rate than AIIAs. There were no significant differences in persistence rates among other classes. CONCLUSION: In this Medicaid population, the antihypertensive medication persistence rates among patients who were new users were critically low. Persistence rates for ACEI are higher than those for CCBs, BBs, AIIAs, diuretics and fixed dose combinations.

HYPERTENSION MAY NOT INFLUENCE CARDIOVASCULAR BENEFITS OF STATIN THERAPY. RESULTS FROM A META-REGRESSION ANALYSIS OF 69,984 PATIENTS

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OBJECTIVES: We performed a meta-analysis to determine the overall effectiveness of statins among hypertensive and non-hypertensive patients. METHODS: We systematically reviewed Medline publications from 1985 onwards for placebo-controlled randomized trials that examined the effect of statins on cardiovascular morbidity and mortality. Only trials that followed at least 1000 patients for two or more years were included in the meta-analysis. Outcomes of interest included cardiac or cardiovascular death, major coronary events, or major cardiovascular events. Pooled estimates of relative risk were calculated separately for (i) trials that prospectively randomized hypertensive patients to statin therapy (ASCOT-LLA & ALLHAT-LLT); (ii) trials that provided post-hoc cardiac event rates for subgroups of hypertensive patients and non-hypertensive patients; (iii) trials that provided only the baseline percentage of hypertension in the trial population; and (iv) trials in (ii) and (iii) combined. The moderating effect of the percentage of hypertensive patients at baseline on the effectiveness of statins was tested using meta-regression. RESULTS: Besides the ASCOT-LLA and ALLHAT-LLT, 12 trials enrolling a total of 69,984 patients met the inclusion criteria. Overall, in these 12 trials, statin therapy reduced cardiac death by 24% (relative risk [RR]: 0.76; 95% confidence interval [CI]: 0.71–0.82). Pooled relative risk for cardiac morbidity and mortality was similar for trials in groups i, ii, iii, and iv and ranged from 0.73–0.78. Relative risk estimates for hypertensive patients (RR: 0.78; 95% CI: 0.72–0.84) and non-hypertensive (RR: 0.76; 95% CI: 0.72–0.80) subgroups were also similar. Consistent with the subgroup analysis, the meta-regression showed that the effect of statins on cardiac morbidity and mortality was not moderated by the percentage of hypertensive patients at baseline (Q estimate = 1.48; P = 0.22). CONCLUSION: Statin therapy effectively reduces CV morbidity and mortality in both hypertensive and non-hypertensive patients.