

AH and 39 (23%) had masked AH. Two-hundred eighteen subjects (86%) were treated with continuous positive airway pressure. Masked AH was not associated with the severity of OSAS (AHI and the percentage of total sleep time during which the oxygen saturation was <90% (SaO₂<90%). However, subjects with masked arterial hypertension have a worst metabolic risk profile compared to normotensive patients.

Conclusions. Masked hypertension is frequent in OSAS patients and is not associated with the severity of the OSAS.

Table – Results

	Masked AH n=39	No AH n=80	p
Apnea-Hypopnea Index	48.9±23.8	47.7±24.4	0.810
SaO ₂ <90%, %	12.0±15.3	14.0±17.7	0.579
Age, years	49.6±6.8	49.6±9.4	0.995
Body mass index, kg/m ²	30.1±5.5	30.0±5.4	0.947
Fasting glycemia, mg/dL	94±13	94±34	0.148
Homeostasis model assessment-estimated insulin resistance (HOMA-IR)	3.9±2.9	2.5±2.8	0.031
Fasting triglyceridemia, mg/dL	170±110	130±90	0.004
CRP us, mg/L	4.9±6.6	3.8±2.5	0.980
Metabolic syndrome, n (%) NCEP ATP III definition	13 (33)	10 (13)	0.007

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Peripheral arterial disease remains underdiagnosed even in post hospital discharge for any ischemic event

Patrick Laroche [Orateur] (1), Uwe Diegel (2)
(1) STACTIS, Paris, France – (2) GenNov, Paris, France

Objective: To evaluate the prevalence rates of peripheral arterial disease (PAD) diagnosed before and during the general practitioner (GP) consultation following hospitalization for ischemic event.

Method: In a cross sectional study, 102 Belgian GPs recruited 505 patients of ≥50 years, hospitalized within the last year for any ischemic event. The Screening CardioVascular Lab (SCVL[®], GenNov) automated combination of the oscillometric determination of the ankle-brachial index (ABI) and of the outcome of the Edinburgh questionnaire (EQ). This device integrated the case report form.

Results: The patients were 69±11 years old; men were 63%. Their other CV risk factors were: hypertension in 75%; dyslipidemia in 74%; sedentarily in 53%; abdominal obesity in 52%; familial history of CVD in 38%; smoking in 28%; diabetes in 22%. The arterial events, which induced the recent hospitalizations, were: acute in 71% of cases, planned for revascularization in 23%; coronary in 50%, cerebral in 29%, aortic/peripheral in 15%. For at least their hospitalization, 95% of patients were treated with antithrombotics, including 88% with antiplatelets. At the GP visit, PAD was unknown in 10% of cases and previously diagnosed in 19%, including an appraisal exclusively on clinical signs in 5% and a confirmation by Doppler ultrasonography or arteriography in 13%. The EQ had a positive outcome in 16% of patients: the site of claudication was typical in 85% of these; its severity, of grade 2 in 52%. The patient ABI was of 0.95±0.20, <0.90 in 37% of patients and >1.30, in 3%. The combination EQ-ABI was abnormal in 46%.

Conclusion: In patients recently hospitalized for any ischemic event, the “true” prevalence rate of PAD, as diagnosed prior to the GP visit, was 19%. The “apparent” one, by using the SCVL[®] combining the ABI determination and the Edinburgh questionnaire at the GP office, was 46%, despite the extensive antithrombotic treatment. Even in a hospital setting, PAD is widely underdiagnosed.

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Arterial hypertension profile is associated with both the severity of OSAS and metabolic syndrome

Diane Bodez [Orateur] (1), Catherine Meuleman (1), Franck Boccara (1), Ghislaine Dufaitre (1), Sylvie Lang (1), Louise Boyer-Chatenet (1), Xuan-Lan Nguyen (2), Stephane Ederhy (1), Nabila Haddour (1), Saroumadi Adavane (1), Guillaume Fleury (1), Bernard Fleury (2), Ariel Cohen (1)
(1) AP-HP, CHU Saint-Antoine, Cardiologie, Paris, France – (2) AP-HP, CHU Saint-Antoine, Pneumologie, Paris, France

Background: Obstructive sleep apnea syndrome (OSAS) is associated with an increased risk of arterial hypertension (AH) and cardiovascular complications. The aim of this study was to evaluate whether the AH profile, already known or newly diagnosed, was associated with the severity of the OSAS.

Methods: Clinical blood pressure and twenty-four-hour ambulatory blood pressure monitoring were systematically recorded in 253 consecutive patients with documented OSAS.

Results. In this cohort (mean age 51.3±9.5 years, 83% men, mean BMI 31.8±5.8 kg/m², mean Apnea-Hypopnea Index (AHI) 52.9±28.5%), 82 (32%) had known AH, 91(36%) had newly diagnosed AH and 80 (32%) had no AH including white coat effect (25 [15%]). Two hundred and nineteen patients (86%) were treated with continuous positive airway pressure with no difference with regard to the AH profile (p=0.305 for trend). The AHI was higher in OSAS hypertensive patients compared to patients without AH (Table) associated with an increased rate of the metabolic syndrome and worst insulin resistance profile.

Conclusions: We found a continuous relation between the severity of OSAS, the presence of AH whether already known or newly diagnosed and the metabolic profile in a large cohort of patients with treated OSAS.

Table – Results

	Known AH n=82	Newly diagnosed AH n= 91	No AH n=80	p
Apnea-Hypopnea Index	56.8±33.5	53.4±25.9	47.7±24.4	0.015
SaO ₂ <90%, %	19.0±22.0	18.0±20.0	14.0±17.7	0.158
Age, years	55.1±7.9	50.0±8.6	49.6±9.4	0.307
Body mass index, kg/m ²	33.9±6.2	31.4±5.3	30.0±5.4	0.299
Fasting glycemia, mg/dL	106±29	97±16	94±34	<0.001
Homeostasis model assessment-estimated insulin resistance (HOMA-IR)	4.3±3.30	3.7±3.1	2.6 ±2.5	0.06
Fasting tryglyceridemia, mg/dL	170±150	158±94	130±90	<0.001
CRP us, mg/L	3.8±2.5	4.1±4.7	3.85±3.7	0.54
Metabolic syndrome, n (%) NCEP ATP III definition	60 (73.2)	45 (50)	10 (12.5)	<0.001

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Efficiency of abdominal CT scan as first line investigation in resistant hypertensive patients with adrenal cause suspicion

David Rosenbaum [Orateur] (1), Frederic Villeneuve (1), Charles Gury (1), Xavier Girerd (2)
(1) AP-HP, CHU Pitié-Salpêtrière, Prévention des Maladies Cardiovasculaires, Paris, France – (2) AP-HP, CHU Pitié-Salpêtrière, Endocrinologie-Métabolisme-HTA – Prévention des maladies Cardiovasculaires, Paris, France

Objective: To evaluate the efficiency of adrenal imaging by an abdominal CT scan as first line investigation in subjects with resistant hypertension when