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Coronary artery disease (CAD) are closely linked to hypertension.They constitute the main cause of disability,morbidity and mortality in hypertensive patients. On the other hand epidemiologic studies revealed that hypertension is a major risk factor for CAD .Furthermore,CAD are predicated to be the main techniques,drugs and therapeutic interventions that are introduced in the management of coronary patients. for these reasons, the EHS organized a working group on CAD with the objective of writing a practical manual.targeted to the internists and cardiologists and contains the Guidelines.

The book is expected to be available before the end of this year ,it consists of four sections covering the diagnosis and management of the different coronary syndromes.including values and limitations of the commonly used diagnostic procedures,drugs and interventions in the treatment of coronary patients.special resuscitation in his everyday handling of the coronary patients.stress has been given to practical questions such as clinical evaluation of chest pain,how to predict the need for hospitalization,the role of ECG-Stress testing, the values and limitation of coronary angiography and other imaging techniques, management of acute coronary syndromes with a detailed chapter on acute myocardial infarction.

This is the second book produce by the EHS, the first book was published two years ago consisting of a brief review and guidelines for the management of hypertension in Egypt, The success of this firs book,which became an important source of information for many of the practicing physicians was an important factor behind the idea of writing a new practical manual about CAD these two books fit within the educational goals of the EHS and are available at no coast to all Egyptian physicians.the production and printing of both books was through the generous support of the Egyptian drug industry,namely,Hoechst Marion Roussel And Merck Sharp & Dhome-Egypt.

These two books were the result of collaboration of a number of Egyptian experts from different Universities and will help the Egyptian practitioner to catch with the rapid developments in the fields of hypertension and coronary Artery Disease.

M.Mohsen Ibrahim, MD

**Prof. & Chairman Department of Cardiovascular Medicine-Cairo University
president of the Egyptian Hypertension ,Society**

THE PRESIDENTS MESSAGE

THE PRESIDENTS MESSAGE CORONARY ARTERY DISEASE EHS GUIDELINES

Coronary artery disease (CAD) are closely linked to hypertension.They constitute the main cause of disability,morbidity and mortality in hypertensive patients. On the other hand epidemiologic studies revealed that hypertension is a major risk factor for CAD .Furthermore,CAD are predicated to be the main techniques,drugs and therapeutic interventions that are introduced in the management of coronary patients. for these reasons, the EHS organized a working group on CAD with the objective of writing a practical manual.targeted to the internists and

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M.Mohsen Ibrahim, MD
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Editorial

HYPERTENSION IN THE ELDERLY

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There are two patterns of hypertension in the elderly combined systolic and diastolic hypertension and isolated systolic hypertension (ISH)> 65y their prevalence change with age as evidenced in framingham study ,where the types of HPT between age 70-79 were (20% ISH & 50% borderline ISH). However this should not be admixed with pseudohypertension [White coat effect or artifactually elevated with modest lowering utilities .in this situation measurements is better assessed by finger recording.

The retrieved data ,from the so many clinical trials conducted on elderly hypertensives[AUSTRALIAN.EWPHE,WARRENDER,SHEP,STOP-HT,MRC.STONE,..etc.]cleared that risks of morbidity&morbidity is high specially in those without treatment for 2 years also mortality from CHD & stroke is much higher than in normal population.in such a category the systolic pressure [SBP] is more predictor of cardiovascular[CV] risk even more in ISH where there is 1% increase in the rate of mortality with each 1mm increase in SBP in the very old>85y; lowest mortality was achieved at BP range of [140-169/70-99].Moreover,in general,higher BP predisposes to dementia (Alzheimer) the basic pathophysiological mechanism of hypertension in the elderly is the loss of distensibility & elasticity in large arteries with an increase in pulse wave velocity & an early return of plus wave reflection in systoli with or without a decrease in diastolic pressure[DBP]. the cardiac output,intravascular filling, renal blood flow & PRA Decrease while PVR, LV wall thickness and mass increase .if an abrupt increase in SBP & DBP occurs , one should suspect atherosclerosis &/or renovascular disease.

It is worth noting that postural hypotension [A fall in SP of 20mm Hg after 1 min quite standing] is common in elderly hypertensive. in SHEP the incidence was 10 % at 1 min & 12% At 5 min 17% at either. the prevalence is higher if rising from a supine position ,I.e the higher the basal SBP the greater the postural fall observed the most common mechanism, for this is ;venous pooling in the legs,autonomic insufficiency,reduction in baroreceptor sensitivity, splanchnic blood of

after eating &/or shifts in the threshold of cerebral autoregulation.

Therapeutic intervention to control hypertension in the elderly proved of value in 13 randomized controlled trials and 6 large high quality trials . the conclusion from such trials is that; the morbidity & mortality of the treated group were significantly better I.e only 18 elderly hypertensive and 15 ISH patients needed treatment for 5y to prevent CV events ,A number of explanation for this greater benefit has been proposed namely ;the elderly start with much higher risk and smoke less [better response to antihypertensive].Also being more recent ,the drugs assessed in most of such trials were those of greater cardioprotection. however treatment with low-dose diuretics or B-blockers was still claimed by some to be of benefit whether in diastolic or ISh .However ,the disclaimers to the general agreement of such trials argue that they may not accurately reflect what can be accomplished in clinical practice and that benefits may be lessened in the very old (over age 80) and had been only shown in those using diuretics or calcium channel blockers [CCBs],but not B-blockers.

Yet at this juncture,one has to Admit That only A small minority of elderly hypertensive are being treated ,thought Treatment of this category Seems The judicious decision as; millions of people over the age 65 have hypertension [predominantly or purely systolic], their risk are significant ,and the benefits of their treatment have been documented so therapy of such patients should be gentle & gradual due to their increases risk and be more cautious in the very elderly>80y for fear of increased mortality.

The need for lifestyle modification is one of the therapeutic objective, as enough data is available to document its efficacy,so non drug therapy should be applied before or instead of drug therapy ,dietary Na should be moderately restricted (100-120 mmo1/day) though its reduction is sometimes difficult in the elderly.

Among drug treatment recommendations that have been stated is; consider treatment for patients up to age 80 with SBP>160/90 mm Hg.; the choice of therapy should be individualized according to the presence of concomitant conditions, first line therapy should be low dose of diuretics,CCB and ACE Inhibitors can be good alternatives and B-blockers are not the first choice except in and ischaemics,other recommendations suggest that; long action CCBs are an appropriate alternative to diuretics and that home BP recording May be particularly useful.

The golden therapeutic rule is ;start with a lower dose better with (once-daily)smoothly working preparation and watch out for drug interactions.

It is worth noting that the factors that might contribute to the increased risk of pharmacological treatment in the elderly are; the decrease in baroreceptor activity [orthostatic hypotension].the impairment in cerebral autoregulation [cerebral ischaemia with small falls in BP],the decrease in intravascular volume [volume depletion, hyponatraemia,],muscular weakness],the decrease in existence of polypharmacy[drug accumulation],the existence of polypharmacy[drug interaction], and the CNS changes [depression & confusion] and the CNS changes [depression & confusion].

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Background : We examined the frequency, course,and treatment of hypertension in the NINDS rt-PA stroke trial. Method: blood pressure (BP) was measured at the time of admission ,at randomization ,and then 36 times during the first 24 hours after randomization. patients with a systolic BP of >185 mm Hg and a defined as hypertensive before randomization, and those with a systolic BP of >105 mm Hg or a diastolic BP of > 105 mm Hg within the first 24 hours after randomization were defined as hypertensive after randomization. standardized clinical assessments were conducted at 24 hours and at 3 months .post association of antihypertensive therapy with clinical outcomes Result:of the 424 patients,121(19%) had hypertension on admission and 372 (60%) had hypertension in the 24 hours after randomization .the use of antihypertensive therapy before randomization (tPA 9%,placebo 29%) was similar between placebo and tPA-treated patients NO. adverse Effects of pre randomization antihypertensive therapy on 3-month favorable outcome were detected for either the placebo or tPA-treated Groups. for either the placebo or tPA-treated groups .for placebo patients with hypertension in the 24 hours after randomization ,clinical outcome measures were similar for those patients who did and did not receive antihypertensive therapy after randomization ($p>0.26$); antihypertensive therapy was not associated with declines in BP ($p=0.44$) or with abrupt declines ($P=0.14$), those tPA patients who were hypertensive after randomization and received antihypertensive therapy were less likely to have a favorable outcome at 3 months ($P<0.01$) than those who were hypertensive and did not receive antihypertensive therapy Conclusion :the frequency of hypertension and the use of antihypertensive therapy were similar between the tPA and placebo group in the NINDS rt-PA stroke Trial .in the placebo group, antihypertensive therapy was not associated with less favorable outcomes at 3 months; postrandomization antihypertensive therapy was associated with less favorable outcomes for the tPA patients who were hypertensive, however ,because of the nonrandomized post hoc comparisons leading to type 1 errors,the significance of this observation is unclear .careful attention to BP and gentle management remain warranted for stroke patients treated with tPA..

stroke 1998;29:1504-1509.

ARTERIAL HYPERTENSION: THE NATIONAL PROGRAM OF ITS PREVENTION AND TREATMENT IN UKRAINE

Gorbos I, Smyrnova I,Svisclienko E,Sirenko Y
Ukrainian Research Institute of Cardiology,Kiev,Ukraine.

Arterial hypertension (AH) is one of the commonest disease in Ukraine. About 5 million persons with arterial hypertension were registered in 1997 Annually ,In the course of people's primary visits to medical-prophylactic institutions almost 430000 patients with arterial hypertension were identified .According to the data of the epidemiological investigation ,there are nearly 13 million people with arterial hypertension in the country. and in half of them a border-line arterial hypertension is established.62.0% of all patients are aware of arterial hypertension presence, 23% receive treatment with an effective outcome in only 12.8% of them.

An unfavorable epidemiological situation with regard arterial hypertension and its complications that has been established in Ukraine can be Drastically improved provided that high arterial blood pressure has properly controlled, however, the population is inadequately instructed about arterial hypertension and possibilities for prevention of its complications, not all arterial hypertension patients are identified as yet. the mercury sphygmomanometer is lacking the arterial hypertension diagnosis and treatment leave much to be desired in Ukraine the production of modern antihypertensive drug,accessible and affordable,is still at low level and dose not meet needs of the patients. there do not exist mechanism encouraging people to maintain and strengthen their health. there is no state policy aiming to formulate healthy life style. thus, arterial hypertension constitutes a national social challenge that requires state support and CO-ordinated efforts of different ministries and departments, in this connection the national and program for arterial hypertension prevention and treatment in Ukraine has been worked out .the program is focusing to reduce morbidity associated with arterial hypertension coronary heart disease and cerebrovascular diseases.presented in 26Th. Annual meeting of the Egyptian Society of Cardiology , Cairo,Egypt.February 1999.

SODIUM REDUCTION & WEIGHT LOSS IN THE TREATMENT OF HYPERTENSION IN OLDER

PERSONS.

RANDOMIZED CONTROL TRIAL OF Nonpharmacologic INTERVENTIONS IN THE ELDERLY [TONE]
WELTON PK, APPEL LJ, ESPELAND MD, APPELGATE WB, ETTINGER WH, KOSTIS JB, KUMANYKA S, LACY CR,
JOHNSON KC, FOLMAR S, CULTER JA..
TONE Collaborative Research Group, New Orleans, USA

Context : Nonpharmacologic intervention are frequency recommended for treatment of hypertension in the elderly ,but there is a paucity of evidence from randomized controlled trials in support of this recommendation.

objective : to determine whether weight loss or reduced sodium intake is effective in the treatment of older persons with hypertension.

Design : Randomized controlled trial.

Participants : A total of 875 men and women aged 60 to 80 years with systolic blood pressure lower than 145 mm Hg and diastolic blood pressure lower than 85 mm Hg while receiving treatment with a single antihypertensive medication.

Setting : four academic health centers .

Intervention : The 585 obese participants were randomized to reduce sodium intake, weight loss , both or usual care, and the 390 nonobese participant were randomized to reduce sodium intake or usual care withdrawal of antihypertensive medication was attempted after 3 months of intervention .

main Outcome Measure :Diagnosis of high blood pressure at 1 or more follow-up visits,or treatment with antihypertensive medication , or a cardiovascular event during follow-up (range, 15-46 months;median,29 months).

Results :The combined outcome measure was less frequent among those assigned Vs not assigned to reduced sodium intake (relative hazard ratio,0.69;95% confidence interval [CI],0.59-0.81;P<0.001) and , in obese participants ,among those assigned Vs not assigned to weight loss (relative hazard ratio, 0.70; 95% CI,0.57-0.87;P<.001) .relative to usual care, hazard ratio among the obese participants were 0.60 (95% CI, 0.45-0.80;P<.001) for reduced sodium intake alone, 0.64 (95% CI , 0.49-0.85; P=.002) for weight loss alone , and 0.47 (95% CI , 0.35-0.64; P<.001) for Reduced sodium intake and weight loss combined . the frequency of cardiovascular events during follow-up was similar in each of the treatment group

Conclusion : Reduced sodium intake and weight loss constitute a feasible, effective and save Nonpharmacologic therapy of hypertension in older persons.

JAMA 1998,279;839-846.

ABSTRACT OF LOCAL LITERATURE

ECHOCARDIOGRAPHY FINDINGS IN HYPERTENSIVE EGYPTIANS RESULTS FROM THE EGYPTIAN NATIONAL HYPERTENSION PROJECT (NHP)

Helmy SM,Gharib S,Sharaf Y ,Ibrahim MM Department of Cardiology,faculty of Medicine, Cairo University.

Background : inspite of the well recognized role of echocardiography in defining LV changes yet there is lack of survey studies utilizing this technique this resulted in the limited data available about the effect of elevated blood pressure on LV structure and function among large populations specially the untreated and uncomplicated case

Objectives : 1) to study the prevalence of different cardiac diseases as diagnosed by echocardiography in a nation wide survey study including hypertensive and normotensive population , 2) to study changes in LV structure and function in hypertensive Egyptians

Patient population : Among 2313 cases surveyed in phase 11 of the Egyptian NHP, 1559 were hypertensive (BP> 140/90 mmHg or receiving antihypertensive medications) and 754 were gendermatched normotensive Echocardiography was attempted on all individuals those with limited image quality (90%) were excluded , different cardiac disease (5.8%) pericardial disease (1.2%) regional wall motion abnormalities (5.9%) cardiomyopathies (1.2%),and other cardiac disease (1.8%).

results : the prevalence of different cardiac disease was less in normotensives (N) compared to hypertensives (H) as follows: significant valvular heart Disease in 2.8% of N Vs 7.4% of H;pericardial disease in 0.6% of N Vs 1.6% of H; regional wall motion abnormalities in 3.4% of N Vs 7.2% of H; cardiomyopathy in 0.1 Tc of N Vs 0.8% of H;and others cardiac disease in 0.4% of N Vs 2.5% of h the remaining population (n=1796,77.6%;751 N and 1145 H) was further studied for the prevalence of LV hypertrophy and changes in LV geometry. Of those 4.8% had LV

hypertrophy ;1.2% of N and 6.9 of H Prevalence of normal LV (Nr), Concentric remodeling (CR) , concentric hypertrophy (CH) and Eccentric Hypertrophy (EH) was as follows; Total : 1796 [N : 651 & H:1145] -NR : 88.6 % [N:96.6% & H:84.1%]-CR : 6.5% [N : 2.1% & H: 9.0%-CH :3.6% [n : 0.19% & h: 5.1%] -EH :1.3% [N :03 % & H : 1.8%].

Conclusion : results of echocardiographic survey study of hypertensive Egyptian revealed a higher prevalence of different cardiac involvement of compared to normotensives. the prevalence of cardiac involvement was (15.9) with LV Concentric hypertrophy is the least encountered presented at 3rd scientific meeting of the Egyptian hypertension society,port said ,Egypt ,December 1998.

IMPACT OF HYPERTENSIVE LVH ON QT DISPERSION : A COMPARISON BETWEEN ECHO EVIDENCE AND ELECTROCARDIOGRAPHIC EVIDENCE OF HYPERTROPHY

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Cardiology Department , Faculty of Medicine ,Ain shams University.

Objectives :This study sought to examine whether the QT dispersion (QTD) was affected by left ventricular hypertrophy (LVH) in Systemic Hypertension and if there is any difference in the degree of QT dispersion between patients with (LVH) detected only by the Echocardiogram (Echo) & those with LVH detected by both Electrocardiogram (ECG) and ECHO.

Background : This study sought to examine whether the QT dispersion (QTD) was affected by left ventricular hypertrophy

(LVH) in systemic hypertension and if there is any difference in the degree of QT dispersion between patients with (LVH) detected only by the Echocardiogram (Echo) & those with LVH detected by both Electrocardiogram (ECG) and ECHO .

Background QT dispersion is a predictor of myocardial instability hypertensive subject QTD is due to anatomic modification induced by LVH .these anatomic changes have the same effect on arrhythmia substrate

Methods : Thirty consecutive newly diagnosed hypertensive subject with hypertension ,not on treatment were age and gender matched for LVH (n=16) versus no LVH as a control group (n=14). LVH patients were diagnosed by 12 lead surface ECG and /or by 2d Echo, divided into 2 groups : group 1 patients with LVH by Echo only (n=7) ,group 11 .patients with LVH by Echo & ECG (n=9) QTD was manually measured on 12 lead surface ECG .A computerized channel Holter system was used to study the average number of premature ventricular beats/minute

Results : QTD was significantly high in the whole study population (96.33 +21.48 msec.)compared to those of control group with no LVH (57.14 + 15.4 msec.) (p=0.001) . QTD was greater in patients of group 11 than those group 1 (p=0.004) the LVH evidenced by ECHO only septum (13.14 + 1.8) post wall (11.17 + 1.25) QTD (65.71 + 21.4) , while LVH evidenced by ECG & ECHO septum (16.96 + 2.5) post wall (15.14 + 2.06) QTD (91.11 + 11.6) .patients of group II had higher septal and posterior wall thickness than those of 1 .premature ventricular beats were more prevalent in group II with a mean rate of (10.66 +0.7) beat/minute (p=0.0008) VS (5.02 + 10.7) beat minute

(p=0.1) in Group I the frequency of ventricular arrhythmia's was greater in patients with QTD (n=17 patient)

Conclusions : QTD is greater in Hypertensive Subjects particularly those with LVH evident by EGG and ECHO (with greater LV .wall thickness) tan that diagnosed by ECHO only significant QTD is associated with higher incidence of ventricular arrhythmia's hypertensive patients.

presented in the 26 Th. Annual Meeting of the Egyptian Society of Cardiology ,Cairo,Egypt, February 1999.

AMBULATORY BLOOD PRESSURE CHANGES DURING EPISODES OF SILENT ISCHAEMIA

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Background : Silence of ischaemia does not speak of mildness and silent ischaemia (SI) is expressed first as regional wall motion abnormalities (detected by ECHO) ,and then as ST segment depression (by ECG) before pain may be evoked . less well known is the possible occurrence of altered autonomic function which classically accompanies pain episodes, namely, changes in blood pressure.

Methods : to address this issue ,we studied 22 pts with Ischaemic heart disease (8 females and 14 males , mean age 45 + 8.4y) with the diagnosis of unstable angina pectoris in 15 pts and post infarction angina in 7 pts

with the purpose of recording BP changes during Ischaemic episodes using 24 hour BP recording . Ambulatory recording was periodically carried out for BP and continuously for ECG ,BP was recorded every 15 minutes and a reading was taken at the time of Ischaemic episodes detected by ST depression .

Results : out of 22 patients studied , 18 (27 %) exhibited episodes of silent ischaemia , 13 (59%) did not show ischaemia at one time or another , while only 4 (18%) did not show ischaemia during recording. Systolic BP average $144 + 20.09$ mmHg , (range 120-, 180) during silent ischaemia. $140 + 16.31$ mmHg (rang 120-176) during manifest Ischaemia versus $125.8+22.1$ (range 120 - 184) with ischaemia free periods. diastolic BP ranged from 66 to 108 (mean $82+10.83$) mmHg during silent Ischaemic episodes, from 47 to 112 ($74.3+14.34$) mmHg during Ischaemia free episodes and from 54 to 107 (mean $81.61 +14.68$) mmHg during manifest Ischaemic .

Conclusion : Despite the limitations inherent to ambulatory BP recording ,our data suggest that myocardial ischaemia ,whether manifest or silent ,is associated with an increase in BP .Cause and effect relation between both are to be elucidated , but the fact remains that BP is increased in Silent ischaemia and adversely affected haemodynamics would aggravate Ischaemic and set a viscous circle.

Presented at the 3rd Scientific meeting of the Egyptian Hypertension Society, Port Said , Egypt, December 1998.

THERAPEUTIC AWARENESS NECESSITATES :

Knowing that ,the recently introduced ,long acting non dihydropyridine Ca entry blocker [CCBs], Mibefradil : which blocks both the T [transient] & L [long] type Ca channels ,bears life threatening drug-drug interactions. The manufactures issued a warning letter to physicians describing the suppression of SA node activity, occurring special in the elderly whom are on concurrent B-blockers and emphasised that use of the drug with digoxin, verapamil , diltiazem requires great caution , Later on june 8th last year, the drug was temporary voluntary withdrawn by the manufact-urers after the postmarketing surveillance had cleared that the drug inhibits cytochrome P-450 enzyme CYP 3A4 and interferes with the metabolism of at least 26 other medicines. The dihydropyridine CCBs were not included , yet since case reports unmasked the hazard of begining with such group of CCBs in patients who are already on mibefradil an B-blockers ,This has called the issue of another warning supplement by June 12th this advises a delay after discontinuation of miberfridil [half life up to 25 hours] to allow a prolonged washout period of 7 days before considering begining B-blockers & other CCBs THis period is to be increased to 14 days in case of felopidine and timolol and is not required in case of ACE inhibitors ,AT1 antagnoists & diuretics.

Due to such interactions, if myocardial depression or hypotension issue high dose glucagon [5-10mg I.V. diluted safer with or saline] to increase cAMP ,so as to enhance a positive inotropic , dromotopic and chronotropic effects is recommended .Repeated doses of Ca, vasopressors and temporary pacing are often necessary.

JAMA 1998;280:157-8

DIAGNOSTIC UTILITY IMPLIES :

Considering the pulse pressure a predictor of C.V. morbidity & mortality, This was apparent in a french follow up study conducted on 19,083 men aged 40-69 subjected to routine examination .it was found that men whose pluse pressure were greater than 65 mmHg had a three fold increase in faftal coronary heart disease over than those who had pulse pressure 45 mmHg or less . this sinifites that pulse pressure is a good diagnostic predictor. Thus, it is assumed that wilde pluse pressure indicates indicates increased stiffness of larger arteries and calls for aggressive therapy, it is proposed that drugs that prevent or reverse sclerosis may be needed in addition to the rational antihypertensives used ,

Hypertension 1997 ;3 (12):1410-5

EHS News & Calendar

EHS NEWS :

The annual Ramadan social gathering was held last January at cairo sherton, New ideas to expand the service of the society to the different governorates was raised and will be organized by Prof ,Dr . Fathi Maklady ,Public awareness and education at their social gathering was also suggested.

The editorial committee of the News Letter of Egyptian Society of Hypertension, is due to change in the coming edition Prof. Dr. Mohsen Ibrahim has nominated Prof Dr. Hassan Khaled Prof. of Cardiology Alexandria University editor in chief and is whole heartily thanking Dr. Mohamed Hamed the former editor for his executive elegant and distinguished collaboration in making this News Letter come to reality and progress throughout previous years.

CALENDER:

World Hypertension League 18Th Council Conference and workshop on Hypertension in the Elderly	May 7,1999 Buenos Aires, Argentine.	Dr.Patrick J.Mulrow, Secretary General, World Hypertension League Medical College of Ohio ,Po Box 10008 Toledo,OH 43699-0008,USA e-mail : gmonhollen@mco.edu
Fourteenth Annual Scientific Meeting of the American Society of Hypertension	May 16-19,1999 New York USA	American Society of Hypertension 515 Madison Avenue ,Suite 1212 New York NY 10022,USA.
Symposium on "what is new in hypertension	13th May ,1999 Cairo Sheraton.	Contact : Mrs Amany Kandeel Tel (202)362 4803-Fax (202) 363 9895

A STEP AHEAD WITH PERINDOPRIL

A major challenge to meet when tempting to control a hypertensive patient is the emergence of prehypertrophic or the establishment of overt left ventricular hypertrophy [LVH] as a segregated or consecutive entity to the existing pressure constrain. Once exists, it becomes a notion of warning to the treating physician that the spectrum of hypertensive heart disease [HHD] is now on the roll and that one should be cognizant of its morphological and functional alterations so as to try and halt its progression by every possible mean.

Focusing on how things evolve clears that with pressure constrains the myocardial texture gets disturbed namely; the myocytes, the intramyocardial coronaries and the interstium. Thus myocytes hypertrophy and get encased by endomysial fibrosis, that will enhance their stiffness and increase their O2 perfusion distance, to induce a state of localized hypoxia. This together with thickening of the intramyocardial coronaries [by medial hypertrophy & adventetial fibrosis] is abet to impair the coronary vasodilator reserve and create a state of microvascular angina. This aside the concomitant progression of perimysial fibrosis and microscars in the interstitium, coupled to the disturbed myocardial relaxation will all contribute to the diastolic dysfunction clinically characteristic to HHD. If triggers recycling such initially adaptive profile are not curtailed by an appropriate therapeutic utility, a switch to the maladaptive pole of the continuum sets in. Thus, the increase microtubular hyperpolarization within hypertrophied myocytes, will alter their viscoelastic properties and increase the load within them to impede their shortening. Also the microischaemic environment created by hypertrophy and fibrosis, will trigger myocyte apoptosis; a scenario that ends up by overt heart failure with or without ischaemic episodes.

This molecular understanding of HHD is abet to highlight the importance of having an antihypertensive like perindopril, that has much More to offer, than just a 24 hours pressure control, specially when the point of concern is its ability to improve the coronary reserve.

This has been justified in many studies, one of which has assessed the one-year utility of perindopril in hypertensive with microvascular angina pectoris. Results revealed that maximal coronary blood flow was increased by 54% and minimal coronary vascular resistance was significantly decreased [when quantified using Argon method at basal condition and after microvascular vasodilatation with pyridamole]. The calculated coronary reserve increased then by 67% while the left ventricular mass decreased by 11%, signifying that this improvement is more than expected for regression of LVH alone. This preferential improvement in coronary microcirculation validates the utility of perindopril in cutting some of the triggers that switch HHD to the maladaptive end of the continuum. Moreover, perindopril like other ACE inhibitors was shown to regress interstitial fibrosis in endomyocardial biopsies from hypertensive patients with normal coronary angiogram but with microvascular angina. This seems likely to be linked to the ability of such group to increase bradykinin that will trigger the release of arachidonic acid metabolites; prostacyclin being the one specified in particular to suppress collagen gene expression experimentally, in cardiac fibroblasts.

Thus, a drug with potentialities, that can interplay on collagen metabolism to reverse fibrosis and that can improve the coronary reserve and the existing diastolic dysfunction, will offer optimum cytoprotection, that enables it to step ahead to encompass HHD before it might deteriorate to its morbid end points.

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3. AJH 1998; 11:879.
4. Hypertension 1998; 32: 84.

Environment (E), health (H) and safety (S) (together EHS) is a methodology that studies and implements practical aspects of protection of environment, health and safety at occupation. In simple terms it is what organizations must do to make sure that their activities do not cause harm to anyone. Commonly, quality - quality assurance & quality control - is adjoined to form the company division known as HSQE. The Executive Advisory Board® is a worldwide group of managers and executives (from managers, executives, and directors of smaller companies to those in the largest corporations) who help shape the future through participating in online research surveys and online discussions. The Executive Advisory Board® is a worldwide group of managers and executives (from managers, executives, and directors of smaller companies to those in the largest Security Policy Executive eHS Board. Chief Executive Officer, eHS Chief Security Officer, eHS. eHS CIO Forum - Privacy. Working Group. Authorizing the release of, and access to, personal health information for research and other non-care related purposes. For example, The Privacy Officer could sit on the Research Ethics Review Board and assist charitable foundations affiliated with the health organization to address privacy issues. Responding to client, user or partner queries regarding information management practices. Environment, health and safety (EHS) issues are managed through an integrated system that aims to ensure issues and risks are identified, standards are established, training is provided, targets set and audits conducted. We have a clearly defined EHS management structure. Overall responsibility for EHS issues rests with the Corporate Executive Team and the Board. The Board champion for EHS is JP Garnier, the Chief Executive Officer. We also have a Corporate Responsibility Committee and Corporate EHS department. Browse 11,208 EXECUTIVE EHS job (\$45K-\$113K) listings hiring now from companies with openings. Find your next job opportunity near you & 1-Click Apply! All Titles EHS Manager (188) EHS Specialist (106) EHS Coordinator (46) Environmental Health & Safety Manager (42) Field Service Technician (39)