tients on monotherapy had mean reductions of 17.4 mm Hg systolic and 13.3 mm Hg diastolic BP. Those on combination therapy with HCTZ averaged reductions of 18.7/12.1 mm Hg.

Particularly impressive was the fact that there were essentially no drug-related side effects, Dr. Sica continued. The incidence and type of adverse events didn't differ between patients on 150, compared with 300 mg of the direct renin inhibitor. And during the double-blind month-long treatment withdrawal phase, the side effects of patients switched to placebo were similar to those who remained on aliskiren monotherapy.

Aliskiren has favorably impressed other investigators as well.

"This is going to be a big drug," Dr. Charles Kilo predicted in an interview. "It's going to be the drug of choice, probably in combination with the diuretic, because the side effect profile is that of placebo."

Dr. Kilo, professor of medicine at Washington University, St. Louis, was principal investigator in a 256-patient study he presented at the congress that showed combining aliskiren with ramipril suppressed the undesirable rise in plasma renin typically caused by ACE inhibitor therapy.

In another trial presented at the conference, Mark A. Munger, Pharm.D., reported that adding 150 mg/day of aliskiren to patients whose blood pressure wasn't adequately controlled with 5 mg/day of amlodipine brought their BP down to levels seen in patients switched to amlodipine monotherapy at 10 mg/day—and with far less of the peripheral edema that often limits calcium channel–blocker therapy.

The incidence of peripheral edema was 11.2% in patients on 10 mg of amlodipine, 3.4% with 5 mg amlodipine, and 2.1% with 150 mg aliskiren plus 5 mg amlodipine, according to Dr. Munger, who is a professor of pharmacotherapy at the University of Utah, Salt Lake City.

Dr. Sica said short-term studies indicate aliskiren has a prominent left ventricular hypertrophy–reducing effect and strong compartmentalization in the kidneys. This suggests the drug might provide clinical benefits beyond simply its BP-lowering effect. This possibility will be explored in a series of soon-to-start large clinical trials with cardiac and renal event rates rather than surrogate markers as end points. The studies will include patients who have heart failure, diabetes, or are post MI. Results are 3-5 years away.

All of the aliskiren studies presented at the congress were funded by Novartis. ■

Hypertension Tied to Sexual Dysfunction

NEW YORK — Women with hypertension were twice as likely to have sexual dysfunction as were normotensive women in a study of 417 women.

The results also showed that women with controlled hypertension had a significantly lower prevalence of sexual dysfunction than did women whose hypertension failed to reach goal levels during treatment, Dr. Michael Doumas reported at the annual meeting of the American Society of Hypertension.

But a third finding was that women who were treated with antihypertensive drugs had a higher prevalence of sexual dysfunction than did untreated women. Dr. Doumas speculated that this was caused by the effects of certain antihypertensive drugs, such as diuretics and β-blockers. Treatment with other drug types, the angiotensin-receptor blockers and ACE inhibitors, appeared to reduce sexual dysfunction, said Dr. Doumas, a physician in the department of internal medicine at the Hospital of Alexandroupolis in Athens.

The study enrolled 216 women with hypertension and 201 normotensive women. Their average age was about 48, and all were sexually active. The women completed a 19-question form that has been validated as a way to evaluate sexual function. Of the women with hypertension, 42% had scores indicating sexual dysfunction, compared with 19% in the normotensives, a significant difference.

Sexual dysfunction increased significantly with the duration of hypertension. Among women who had been hypertensive for fewer than 3 years, 16% had a score indicating sexual dysfunction; the rate rose to 33% in women with hypertension for 3-6 years and 79% in women with hypertension for more than 6 years. Age also showed a significant interaction with prevalence. Among women aged 31-40 years, the prevalence of dysfunction was 21%; the rate rose to 38% in women aged 41-50 and to 57% in women older than 50.

The prevalence of sexual dysfunction was 48% among women treated for hypertension, compared with 33% in the untreated hypertensives, a significant difference.

—Mitchel L. Zoler