impact of this on the treatment of asthma. METHODS: Our submission to NICE, reviewing the relative value of alternative products, utilised a cost-minimisation approach, recognising that there was little evidence of clinical differentiation between the ICS. RESULTS: It was estimated that a total switch to QVAR upon withdrawal of CFC based BDP, would result in only a modest 6% increase in costs to the NHS, but could result in overall cost savings if it were substituted for more costly ICS alternatives, such as fluticasone propionate or budesonide. CONCLUSION: There remain concerns that NICE may overlook the current political and socioeconomic imperatives and provide Guidance that does not consider appropriate BDP dosing or recognise that the environment will change over its period of jurisdiction.

PHYSICIANS EDUCATIONAL EFFORTS: A TOOL FOR IMPROVING MANAGEMENT OF ASTHMA IN THE COMMUNITY

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OBJECTIVES: Frequent use of short-acting beta agonists (SABA) inhalers, along with insufficient use of concurrent steroid inhalers, is often the cause of suboptimal management of the disease. The aim of the study is to identify the heavy purchasers of SABA and improve the management of there disease. METHODS: All Maccabi Healthcare Services (MHS) patients in two areas in the Shfela district who consumed at least 4 SABA inhalers during 2005 were identified using MHS’s computerized database. The patients’ primary care physicians (PCPs) were briefed with the findings and where presented the current evidence based medicine (EBM) clinical guidelines for proper asthma treatment in a group meetings with pulmonologist. Later the PCP attend to two days workshop dealing with appropriate asthma treatment, patient’s adherence and practicing clinical scenarios with professionals. A 3rd meeting included case presentations and further discussions with a pulmonologist. A control group consisted of patients of PCPs in other areas in the Shfela district which didn’t participate in the study. RESULTS: One hundred six patients were in the intervention group. 85 required more than 2 SABA inhalers in the first 6 month after intervention (decrease of 20%). In the control group there was a 4% increase in patients using more than 2 SABA inhalers during the same period (185 to 193). CONCLUSION: We have observed a significant improvement in SABA consumption. This improvement applies that educational efforts on applying EBM clinical guidelines for proper asthma treatment and providing simple tools for dealing with patients’ adherence, can improve management and control of asthma and can lower asthma’s treatment expenses. We suggest similar interventions on other chronic diseases.

A RETROSPECTIVE STUDY COMPARING TREATMENT PATTERNS, OUTCOMES, AND RESOURCE USE BETWEEN TWO FIXED COMBINATIONS OF INHALED CORTICOSTEROIDS AND LONG-ACTING B2-AGONIST (ICS/LABA) IN ASTHMATIC PATIENTS IN GERMANY

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OBJECTIVES: Formoterol/budesonide (BUD/FORM) and salmeterol/fluticasone propionate (SAL/FLU) have been shown to be effective in the treatment of asthma. This retrospective, observational study compared characteristics of patients initiating treatment with BUD/FORM or SAL/FLU in routine clinical practice, subsequent treatment outcomes and resource utilisation.

METHODS: A cohort of German patients diagnosed with asthma, followed from 12 months before to 12 months after treatment initiation with BUD/FORM or SAL/FLU, was extracted from a longitudinal, primary care database of records collected from June 2000 to June 2006. The primary outcome was the proportion of successfully treated patients defined according to utilisation of short-acting beta-agonists (SABA) and switches or addition of controller medications during the post-index year. Secondary outcomes included resource utilisation and acute exacerbations, defined as at least one oral corticosteroid (OCS) prescription and/or hospitalisation related to asthma. Regression models were used to adjust for patient characteristics, including treatment history. RESULTS: The BUD/FORM and SAL/FLU groups included 1,436 and 982 patients, respectively. Prior to treatment initiation, patients in the BUD/FORM group received less asthma-related OCS prescriptions (mean difference: −0.049, p = 0.0328) but utilisation of SABA, ICS and LABA was similar. In the year following treatment initiation, patients initiating on BUD/FORM had a greater probability of treatment success (OR = 1.34, p = 0.0001), fewer acute exacerbations...
OBJECTIVES: Medical care costs for rhinitis are primarily driven by patient care-seeking behavior and physician prescribing patterns, which may evolve over time. Estimating a model of real-world rhinitis treatment from clinical trial data is not feasible due to short trial durations and protocol-driven care. This study examined physician adherence to EPR-2 asthma medication prescribing guidelines and determine patient and physician factors associated with prescribing of asthma medications.

METHODS: This study was a cross-sectional retrospective analysis of complex NAMCS physician visit survey data from 1998 through 2004. Data were extracted on all patients with an ICD-9 code for asthma (493.XX) and reason for visit as 'asthma'. Unit of analysis was individual patient visit. Independent variables in analyses were specific type of drug class. Independent variables were various patient and physician factors. Logistic regression analysis was used to assess study objectives.

RESULTS: Asthma patients in 2002 were 3.3 times more likely to be prescribed controller medications compared in 1998. Findings in 2004 were not significant. Elderly patients were 54% as likely to receive controller medication compared to the 35–64 year age group. Patients other than whites or African Americans are 40% as likely to receive controller asthma medication compared to whites. Physicians were 6.3 times more likely to prescribe long acting beta agonists compared to 1998. Physicians without ownership stake in their practice were 1.9 times more likely to provide asthma education to their patients compared to those who owned their practice. CONCLUSION: This study using US outpatient setting data provides evidence that physician prescribing of asthma pharmacotherapy in the US does not adequately comply with EPR-2 treatment guidelines.

CONCLUSION: Using claims data and Markov-modeling techniques, we found that budgetary impact can be materially affected by rates of treatment switching/add-on. Detailed, claims-based data are required for this type of analysis, given the real-world nature of treatment patterns and associated medical costs.