Paris Abstracts

1.6); moderate 73.2% (4.2); severe 65.1% (4.8); very severe 4.5% (4.2; significant reduction

9.1%); the severity of the disease was mild in 136 (46.3%), moderate in 114 (38.0%), severe in 30 (10.0%), very severe in 17 (5.7%). With regard to the use of health resources in the previous year, the mean values were: visits to physician 7.27 ± 1.2, and hospital admissions 8.16 ± 0.31. The mean SF-36 scores for patients with mild COPD in the physical component before and after therapy were 84.5 ± 4.2 and 91.2 ± 5.8 with Δ% value (9.2 ± 1.6); moderate 73.2 ± 3.1 and 77.6 ± 4.6 with Δ% value (6.0 ± 1.5); severe 42.2 ± 1.2 and 45.2 ± 2.6 with Δ% (4.5 ± 1.4); very severe 19.8 ± 2.4 and 23.5 ± 3.8 with Δ% value (4.2 ± 1.4). Similarly, the mean SF-36 scores on mental component of all groups of patients under study, ranging from mild to very severe were 69.0 ± 2.1 and 72.3 ± 3.4 with Δ% value (3.1 ± 2.3); 54.6 ± 2.2 and 56.7 ± 1.7 with Δ% value (4.2 ± 1.3); 38.0 ± 2.3 and 35.6 ± 3.1 with Δ% 3.9 ± 0.8, 28.2 ± 1.1 and 29.1 ± 2.4 with Δ% value (4.2 ± 1.3). CONCLUSIONS: Patients had an increase functional dynamic index (Δ%) of SF-36 in the physical component, and significant reduction was only seen in mental component of patients with severe and very severe cases.

RESPIRATORY-RELATED DISORDERS – Health Care Use & Policy Studies

PRES45

CLINICAL AND ECONOMIC OUTCOME OF MECHANICALLY VENTILATED PATIENTS UNDER DRG 475: A POPULATION-BASED STUDY

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OBJECTIVES: Mechanical ventilation for acute respiratory failure is likely to be a reliable indicator of critical care resource requirements on a population level. Our aim is to analyze the costs and discharge status for patients with respiratory failure needing mechanical ventilation (DRG code 475) in Spain and to examine the impact of age in terms of hospital outcome. METHODS: From the 2004 National Hospital Discharge Database, patients aged 21 6 years with a final DRG code 475 were retrieved. This DRG is defined as “respiratory system diagnosis with mechanical ventilation”, includes three procedure codes and is applied to patients undergoing mechanical ventilation for a variable period of time. Demographic characteristics, clinical outcomes and hospital-related resource utilization were examined. An exploratory logistic regression analysis was performed to identify factors associated with in-hospital mortality. To depict the amount of resources spent to procure a given level of desired outcome (hospital survival) we determined the cost per survivor based in the average national charges for chronic obstructive pulmonary disease (COPD) and asthma, anecdotal evidence suggests general practitioners prescribe similar formulations and doses for both diseases. For patients with COPD, where the licences are more restricted, this may lead to “off-label” prescribing. The objective of this study was to examine the frequency and nature of “off-label” prescribing of combination products in COPD patients. METHODS: This was a retrospective cohort study using data from the General Practice Research Database (GPRD), a large nationally representative UK primary care database. All combined salmeterol/fluticasone and formoterol/budesonide prescriptions written between Jan 2006 and Dec 2007 for patients with a Read code for COPD were identified. “Off-label” prescribing was defined as any formulation and/or dose of salmeterol/fluticasone or formoterol/budesonide not licensed for COPD. The proportion of “off-label” prescriptions was calculated for each of the 2 treatments and “off-label” prescriptions were further subdivided into whether they were “off-label” with respect to formulation or dose. All calculations were replicated at the patient level and reported in relation to age, sex and smoking status. RESULTS: The analyses were based on a total of 21,137 COPD patients receiving combination products (salmeterol/fluticasone: 17,115; formoterol/budesonide: 4,089) between 2006-2007. The majority of “off-label” prescriptions were “off-label”, 71% for an incorrect formulation and 6% for an incorrect dose. 86% of salmeterol/fluticasone prescriptions were “off-label” (85% formulation, 1% dose) versus 37% of formoterol/budesonide prescriptions (10% formulation, 27% dose). The most frequently prescribed unlicensed formulations were salmeterol 25 mcg/fluticasone 250 mcg pMDI (45%) and salmeterol 25 mcg/ fluticasone 125 mcg pMDI (20%). CONCLUSIONS: “Off-label” prescribing of combination therapy in COPD patients is very common in the UK. The impact of off-label prescribing on efficacy and patient safety is unknown; “off-label” prescribing potentially results in wasteful prescribing practice.

SEASONAL VERSUS NEEDS-BASED IMMUNIZATION SCHEDULES—THE EXAMPLE OF RSV

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OBJECTIVES: Due to cost reaching $10,000/season, respiratory syncytial virus (RSV) immunoprophylaxis is limited to high-risk periods, but season determination is heavily debated and absolute risk varies significantly by geographic location. We present monthly RSV incidence rates to estimate absolute burden of disease and numbers needed to treat (NNT) to provide an alternative to a dichotomous season definition. METHODS: Medicaid fee-for-service recipients 2 years old from California and Florida (1999-2004) were selected if they met high-risk criteria for RSV infections (chronic lung disease or congenital heart disease based on ICD-9 codes, or prematurity within the previous year, the mean values were: visits to physician 7.27 ± 1.2, and hospital admissions 8.16 ± 0.31. The mean SF-36 quality of life questionnaire were administered to all patients. RESULTS: The mean SF-36 quality of life questionnaire were administered to all patients.

CONCLUSIONS: Patients had an increase functional dynamic index (Δ%) of SF-36 in the physical component, and significant reduction was only seen in mental component of patients with severe and very severe cases.

PRES46

OFF-LABEL PRESCRIBING OF INHALED CORTICOSTEROID/ LONG ACTING BETA-AGONIST COMBINATION PRODUCTS IN COPD PATIENTS

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OBJECTIVES: Despite different licences for the use of inhaled corticosteroids/long acting beta—agonist combination products for Chronic Obstructive Pulmonary Disease (COPD) and asthma, anecdotal evidence suggests general practitioners prescribe similar formulations and doses for both diseases. For patients with COPD, where the licences are more restricted, this may lead to “off-label” prescribing. The objective of this study was to examine the frequency and nature of “off-label” prescribing of combination products in COPD patients. METHODS: This was a retrospective cohort study using data from the General Practice Research Database (GPRD), a large nationally representative UK primary care database. All combined salmeterol/fluticasone and formoterol/budesonide prescriptions written between Jan 2006 and Dec 2007 for patients with a Read code for COPD were identified. “Off-label” prescribing was defined as any formulation and/or dose of salmeterol/fluticasone or formoterol/budesonide not licensed for COPD. The proportion of “off-label” prescriptions was calculated for each of the 2 treatments and “off-label” prescriptions were further subdivided into whether they were “off-label” with respect to formulation or dose. All calculations were replicated at the patient level and reported in relation to age, sex and smoking status. RESULTS: The analyses were based on a total of 21,137 COPD patients receiving combination products (salmeterol/fluticasone: 17,115; formoterol/budesonide: 4,089) between 2006-2007. The majority of “off-label” prescriptions were “off-label”, 71% for an incorrect formulation and 6% for an incorrect dose. 86% of salmeterol/fluticasone prescriptions were “off-label” (85% formulation, 1% dose) versus 37% of formoterol/budesonide prescriptions (10% formulation, 27% dose). The most frequently prescribed unlicensed formulations were salmeterol 25 mcg/fluticasone 250 mcg pMDI (45%) and salmeterol 25 mcg/ fluticasone 125 mcg pMDI (20%). CONCLUSIONS: “Off-label” prescribing of combination therapy in COPD patients is very common in the UK. The impact of off-label prescribing on efficacy and patient safety is unknown; “off-label” prescribing potentially results in wasteful prescribing practice.

A SURVEY OF TOBACCO CESSATION INTERVENTIONS IN THE CLINICAL SETTING IN JAPAN: COMPARISON OF NNTs BY GEOGRAPHIC REGION AND ATTITUDES TOWARDS TOBACCO CESSATION EDUCATION, AND BARRIERS TO CESSATION COUNSELING

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OBJECTIVES: Tobacco has been identified as a major risk factor for lung cancer, heart disease, and respiratory disease. Adults rarely visit their physicians for preventive care. This may put dentists in a better position to implement tobacco cessation interventions. The aim of the study was to investigate the tobacco cessation interventions conducted by dental practitioners in Japan. METHODS: The study used a survey mailed to dentists (n = 1489) in three prefectures (Tokyo, Ibaraki, and Yamaguchi) asking about the practitioners’ tobacco cessation interventions, their professional characteristics, barriers to counseling, and attitudes towards tobacco in 2008. RESULTS: The response rate was 57% (n = 847). Dentists advised 22% of patients to cease tobacco. More than half of them used a pamphlet or other printed materials. However, nicotine replacement therapy was prescribed infrequently (nicotine patches in 3.2% and nicotine gum in 2.2% of patients). Asked whether dentists should perform tobacco cessation interventions in their offices, 76% said yes. The main barrier to cessation counseling was insufficient time, followed by a lack of knowledge and a fear of overwhelming patients. Many dentists did not think that their cessation interventions were well received. None of the dentists had ever received education or training promoting tobacco cessation. Twenty-two percent of all respondents were smokers. CONCLUSIONS: Few dentists perform tobacco cessation interventions in their offices. Nicotine replacement therapy was hardly prescribed at all. Dentists have a positive attitude towards tobacco cessation interventions and