ducted using patient costs from billing records, and three different effectiveness measures [all based on a 0 (worst) to 100 (best) scale]. The primary CE analysis used Subject General Well-Being score (SGWB), which was a general health assessment question. Two other effectiveness measures were β-mediated treatment effect (BMTE) and Disease Symptom Assessment (DSA) scores.

RESULTS: LEV patients required fewer total nebulizations (median 10 vs 12; \( p = 0.031 \)), and the two groups were not statistically different with respect to the number of rescue nebulizations, length of hospital stay, and total hospital cost. For the primary CE analysis, LEV was as effective (70.0 vs 68.3) and cost $164 less per patient compared with RAC. For CE analyses using BMTE and DSA, LEV was again as effective (86.9 vs 79.0 and 59.2 vs 57.2, respectively) and cost $174 less per patient. Bootstrap re-sampling analyses found that approximately 65%–77% of the 10,000 simulations for LEV fell within the dominant quadrant on a CE plane. CONCLUSION: In this study, LEV patients required significantly fewer total nebulizations without an increased need for rescue nebulizations. CE analysis indicated that LEV was at least as effective as RAC with a $164 savings in costs.

QUALITY-ADJUSTED LENGTH OF STAY ANALYSIS OF HOSPITALIZED PATIENTS WITH ASTHMA OR COPD TREATED WITH LEVALBUTEROL OR RACEMIC ALBUTEROL

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OBJECTIVES: This was a prospective, randomized, multicenter, open label study to determine the cost-effectiveness (CE) of lev- albuterol versus racemic albuterol in patients hospitalized for acute asthma or COPD; here we present a subset CE analysis of levalbuterol versus racemic albuterol in patients hospitalized for acute asthma or COPD. We present a subset CE analysis of levalbuterol versus racemic albuterol in patients hospitalized for acute asthma or COPD. We present a subset CE analysis of levalbuterol versus racemic albuterol in patients hospitalized for acute asthma or COPD.

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