In acute bacterial RTIs, the drug... and NCApt during hospitalizations in years of 2005 and 2006, the 95% confidence intervals of antibiotic cost and relative weight of diagnosis-related group for NC-Apt were compared monthly. In the first half of year 2007, the months with average cost of antibiotics greater than the breakthrough, which was derived from the prior two-year analysis, were selected to further identify the principle diagnoses and antibiotics needed to have special attention. RESULTS: There were statistically significant higher average antibiotic costs of Capt in July in 2005 and January, April, May and July, 2006. Given the NTD 15,500 (USD = 455) was recognized as breakpoint of average antibiotic cost for cancer patients in 2007, visits hospitalized in May due to receiving radiotherapy, chemotherapy, management for acute myeloid leukemia, cervical cancer and so on should be paid more attention on infection management. Ten parenteral antibiotics (e.g., Tazocin, Targocid), accounted for 89.64% of total antibiotic costs in May, were selected for rigorous controlled dispersions in the second half of year 2007 and later. CONCLUSIONS: Sustained control on item quality assessment on those visits receiving radio- and chemo-therapy and using specific spectrum antibiotics during hospitalizations are necessary to improve antibiotic use and infection control in hospitals.

RESPPIRATORY-RELATED DISORDERS – Clinical Outcomes Studies

SMOKING CESSATION AND ITS PREDICTORS: RESULTS FROM COMMUNITY BASED PHARMACY TOBACCO CESSATION PROGRAM IN NEW MEXICO

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OBJECTIVES: 1) To assess tobacco quit rates among a convenient sample of current smokers who participated in the community pharmacist based cessation program; 2) to identify the predictors of quitting over a 6-month period among the study population. METHODS: Each year approximately 200 patients were enrolled across 15 pharmacies throughout New Mexico. Pharmacists, who had received the Rx for Change training, provided the cessation program with administrative and clinical support from the Pharmacy Technicians. Patients were provided counseling services at no charge and, if necessary, received medications without charge. Patients did not receive any monetary compensation for participation. Data on patient’s demographic information, smoking status, and readiness for quitting was collected at the initial encounter. The primary outcome of interest was rate of quitting status was collected at 1, 3, and 6 months. Statistical Analysis: Missing data on follow-up was imputed using the last observation carry forward method. Smoking cessation rates were calculated at 1, 3, and 6 months. Multiple Logistic regression analysis was performed to assess predictors of quitting. Standard errors were adjusted for repeated observation. RESULTS: Final sample size was 456 participants. The average quit rate at the end of 6 months was 25%. Significant predictors of quitting were high confidence levels in quitting at baseline (OR = 2.628; p = 0.000), who had their first cigarettes at least 30 minutes after waking, first cessation attempt, and non-white patients were more likely to quit. CONCLUSIONS: Smoking cessation program delivered through trained community pharmacists is an effective approach in reducing smoking. Future research should be conducted to compare the effectiveness of pharmacists with other providers of tobacco cessation services.

DOES ADD-ON EVENING DOSE OF FORMOTEROL IMPROVE LUNG FUNCTION FOR COPD PATIENTS RECEIVING FIXED-DOSE OF TIOPTOPUM AND FORMOTEROL?

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OBJECTIVES: To investigate change in lung function after 24 hours when an evening dose of formoterol is administered to chronic obstructive pulmonary disease (COPD) patients after a morning dose of tioxotropium + formoterol. Guidelines recommend treatment with mono or combination of long-acting bronchodilators for COPD. Recently, daily fixed-dose combination of tioptopum + formoterol has been used to treat COPD. Tioxotropium has 24 hour duration of action, whereas the effect of formoterol wears off after 12 hours. An add-on evening dose of formoterol may be required to retain the additive effect of the combined dose. METHODS: A double-blind, placebo controlled randomized study of three groups of 20 moderate to severe COPD patients was conducted. Group A received morning dose of tioxotopum; group B received tioxotropium + formoterol; and group C received tioxotropium + formoterol, followed by formoterol inhalation after 12 hours. Lung function was observed at baseline, 0.5, 1, 2, and 12 hours after the morning dose. After 12 hours, evening dose of either placebo (group A and B) or formoterol (group C) was given and parameters were recorded at 12:30 and 24 hours. RESULTS: After 30 minutes, tioxotropium alone improved lung function (FEV1 and FVC) until 24 hours. Tioxotropium + formoterol improved lung function at 30 minutes. This improvement increased with time till 12:30 hours. After 24 hours, lung function was same as that observed after 12 hours. Add-on dose of formoterol after 12 hours did not improve lung function at 24 hours. However, add-on evening dose of formoterol enhanced the lung function for mild COPD and moderate COPD patients after 12 hours, evening dose of either placebo (group A and B) or formoterol (group C) was given and parameters were recorded at 12:30 and 24 hours. CONCLUSIONS: Addition of formoterol to tioxotropium was beneficial. No improvement was associated with add-on formoterol dose except among patients with mild COPD who showed significant improvement in lung function. A larger study is needed to replicate this finding.