rehabilitation in 1997. Treatment episodes required a 30 day depression and alcoholism diagnosis-free period. Use of medications and therapy was examined in the year after the index diagnosis. Healthcare costs, utilization, and suicide diagnosis were examined in patients with depression and alcoholism and patients with depression alone in the two years after the diagnosis. RESULTS: The 1-year prevalence rate of depression, alcoholism, and depression with alcoholism in 2000 was: 40 per 1000, 2 per 1000, and 1 per 1000. The percent of persons with depression and alcoholism receiving psychotherapy, alcoholism rehabilitation, alcoholism detoxification, alcoholism medications, or antidepressant mediations was 58%, 2%, 3%, 24%, and 79%, respectively. Persons with depression and alcoholism had much higher outpatient, inpatient, and pharmaceutical mental health and substance abuse and total costs than persons with depression alone. Persons with depression and alcoholism had much higher rates of suicide (11% versus 0.5) and emergency room admissions than persons with depression alone. CONCLUSION: Providers need to better identify persons with comorbid alcoholism and depression and more effective treatment needs to be developed and implemented.

OBJECTIVE: To examine healthcare utilization and adherence to antipsychotic medications in depressed and alcoholic patients. METHODS: This was a retrospective, observational cohort analysis of a pharmacy and medical claims database from a southeastern US health plan. The pharmacy claims of subjects between the ages of 6 and 65 years were retrospectively identified from the health plan database. Inclusion criteria included the initiation of a single antipsychotic agent between July 1, 1999 and September 30, 2000; no antipsychotic medication usage 180 days prior to the index prescription date; and continuous health plan enrollment for a 6-month period before and 12-month period after the index prescription date. Negative binomial regression was utilized to compare: 1) office-based outpatient utilization; 2) hospital-based outpatient utilization; 3) inpatient admission; and 4) emergency room utilization. RESULTS: A total of 469 patients met initial study criteria. Atypical and typical antipsychotics were prescribed to 384 and 85 patients, respectively. Mean length of therapy (days) for the atypical cohort was significantly longer (136 vs. 80; p < 0.001). The atypical cohort was significantly more adherent to therapy than the typical cohort (mean medication pos-

session ratio (MPR) = 0.53 vs. 0.24; p < 0.001). After adjusting for differences in demographics, baseline utilization, MPR, and length of therapy, (atypical N = 305, typical N = 72), the atypical cohort experienced significantly fewer office visits (2635 vs. 4249 per 1000 patients per month [P1000PPM]; p = 0.005), significantly fewer inpatient admissions (197 vs. 511 P1000PPM; p = 0.032), and significantly fewer emergency room visits (124 vs. 354 P1000PPM; p = 0.002). Differences in hospital outpatient visits were not statistically significant (307 vs. 634 P1000PPM; p > 0.05). CONCLUSIONS: Atypical antipsychotic users were more adherent and remained on therapy longer. In addition, patients using atypical antipsychotic agents were shown to have lower rates of healthcare resource utilization. This study confirms thoughts that there is a relationship between adherence to medication and use of healthcare resources.

THE IMPACT OF MIRTAZAPINE COMPARED TO NON-TCA ANTIDEPRESSANTS ON WEIGHT CHANGE IN NURSING FACILITY RESIDENTS

OBJECTIVES: Depression and weight loss are common problems in older nursing facility (NF) residents. Mirtazapine is among the interventions clinicians use to prevent weight loss in depressed, frail elderly because it has been reported to be associated with weight gain. Nevertheless, limited data in weight outcomes of depressed NF residents are available. Our objective was to examine changes in weight associated with the use of mirtazapine compared to other non-TCA antidepressant therapies in the NF population. METHODS: A retrospective chart review was conducted for 189 NF residents with new single-antidepressant treatment regimens with at least 6 months of post-treatment weight data. OLS regression was performed to assess weight change and percentage weight change at three months and six months. Mirtazapine-treated subjects served as the controlled group (n = 27). Other factors affecting weight were included as explanatory variables, such as gender, age, co-morbidities, baseline weight and relative therapeutic dose. RESULTS: We found no statistical significant differences in weight change at three months and at six months between mirtazapine and all non-TCA antidepressants except fluoxetine which was associated with a gain of four pounds relative to mirtazapine at three months (p = 0.0482). A hypertension diagnosis was associated with significant weight gains at 3 months (2.2 lbs., p = 0.0439 or +1.7%, p = 0.0361) and at 6 months (3.99 lbs., p = 0.0051 or +3.1%, p = 0.0048). A diagnosis of diabetes was associated with weight loss at 6 month (–3.6 lbs., p = 0.0370; –3.1%, p = 0.0187). Baseline weight was associated with increased weight loss in women at 6 months (–0.089 lb (per pound baseline), p = 0.0388). CONCLU-
EVALUATING THE EFFECTIVENESS OF FLUOXETINE 90 MG ADMINISTERED EVERY WEEK AND EVERY 2 WEEKS IN NURSING HOME RESIDENTS

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OBJECTIVE: To evaluate the effectiveness of fluoxetine 90 mg every week/every 2 weeks in elderly nursing home residents. METHOD: Twenty patients were randomly selected who had been stabilized on 20 mg fluoxetine daily for 3 months were switched to fluoxetine 90 mg every week. An additional 20 patients were randomly selected who had been stabilized on 10 mg fluoxetine daily for 3 months and switched to fluoxetine 90 mg every 2 weeks. The Geriatric Depression Scale (GDS) was administered to all patients to assess effectiveness one week before and six weeks after the switch. Costs were calculated as drug acquisition cost, nursing time, and pharmacy time. Generic fluoxetine was used in both cases calculated as drug acquisition cost, nursing time, and pharmacy time. Generic fluoxetine was used in both cases.

RESULTS: Subject Characteristics: Fluoxetine Weekly Group/Fluoxetine Every 2 Week Group Respectively: Age: 81 ± 8/82 ± 9, Sex: 14 females/8 females, Ethnicity: 6% AA, 1% Hispanic/7% AA, 1% Hispanic. Effectiveness: There was no statistically significant difference in GDS scores before or after the switch for either the fluoxetine 90 mg weekly group or the fluoxetine 90 mg every 2 weeks group. Costs: Costs ($) for a 2-week period before and after the switch were as follows: Fluoxetine 90 mg Weekly Before/After Respectively: Drug acquisition costs—1.68/33.38, Nursing costs—21.00/3.00, Pharmacy costs—23.38/3.34, Total—46.06/39.72, P > 0.05. Fluoxetine 90 mg every 2 weeks Before/After Respectively: Drug acquisition costs—0.84/16.69, Nursing costs—21.00/1.50, Pharmacy costs—23.38/3.34, Total—45.22/19.03, P < .05. CONCLUSION: This suggests that fluoxetine 90 mg weekly and fluoxetine 90 mg every 2 weeks are effective in nursing home patients. The costs associated with the administration of medication may be a more significant factor to consider when evaluating cost effectiveness. Our findings are limited by the small sample size and did not account for other costs due to adverse effects, noncompliance, and medication errors.

CONCLUSIONS: A typal antipsychotic (AAP) drugs are recommended as a first-line pharmacotherapeutic strategy for schizophrenia. Although these drugs offer an improved neurological side-effect profile, they can be associated with important weight gain, increased serum triglyceride levels, glucose intolerance, and diabetes mellitus. Clustering of these effects is associated with the metabolic syndrome, which can greatly increase the risk of coronary heart disease (CHD). The objective of this study was to examine the impact of metabolic induced changes by AAPs on the development of CHD in schizophrenic patients. METHODS: A Markov model was constructed using disease state probabilities derived from published PROCAM logistic regression model and published literature to link risk factors to disease incidence in order to estimate the risk of developing CHD. Based on the presence or absence of potential CHD risk factors, persons were assigned transition probabilities of remaining in good health or moving into developing CHD (absorbing phase). The main outcome of the study was the risk of developing CHD in a hypothetical cohort, and in turn, to estimate the proportion remaining disease-free. RESULTS: The relative risk of CHD associated with triglyceride level and obesity was examined. Clustering of these two metabolic effects, seen in patients treated with certain AAPs, is associated with a two-fold increased risk of CHD in men. The model generated realistic results, which are in total agreement with previously published literature. CONCLUSIONS: This model can be used as an effective instrument for assisting in the care of persons at high risk of CHD. Moreover, it can be used to estimate the impact of AAP induced metabolic changes on the risk of CHD in individual patients. Physicians can also use this tool to assess the benefit/risk ratio of patients that respond well to AAPs but develop metabolic side effects.

PHARMAOCOLOGIC TREATMENT OF HOSPITALIZED PATIENTS WITH BIPOLAR DISORDER

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Objective: To assess recent pharmacologic treatment patterns for hospitalized bipolar patients. METHODS: Using