Snapshot of Prescribing Practice for Clopidogrel and Esomeprazole Co-Prescription and Cost Evaluation of Guidelines Application

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in Greece a substantial increase of the households with at least one chronic condition patient which are subjected to GHI is recorded. There is a need for countermeasures or/and an alternative policy context in order to reduce this catastrophic effect of economic crisis.

PCV167 SNAPSHOTS OF PRESCRIBING PRACTICE FOR CLOPIDOGREL AND ESOMEPRAZOLE CO-PRESCRIPTION AND COST EVALUATION OF GUIDELINES APPLICATION

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OBJECTIVES: Through CYP2C19, the antiplatelet clopidogrel and the proton-pump inhibitor esomeprazole demonstrate a pharmacokinetic interaction that could translate into clinical inefficacy of clopidogrel. No medical consensus has been reached to date and therefore different guidelines are available. We aimed to evaluate the prescribing practices in the University Hospitals of Geneva (HUG) by means of their electronic records. The prescription was studied in 2013 and 2014. In addition, we measured the Omeprazole-Clopidogrel-Aspirin (OCLA) study impact on clopidogrel use in our hospital.

METHODS: Patient’s medical orders and nurse’s drug administration planning’s were analysed from January 2013 to April 2014 and the hospitalisation period of patients under clopidogrel had a co-prescription of esomeprazole during the study period. Among them 15% (54/1’000) had a medical order staggering the co-prescription (more than 10 hours apart), 16% a concomitant prescription and 64% no clear information. Five patients had 40 mg daily twice daily indicating the possibility of staggering. Surprisingly we found a higher rate of patients having a nurse’s schedule of more than 10 hours (39%, 417/1’071). Switching drugs was in accordance with the tests for HUG of the same pre-surgery, €34/€950 for pantoprozal and €5/€205 for ranitidine. A statistical significant decrease in trend of clopidogrel use was observed after the OCLA study publication. This suggests that the medical order’s configuration time should be mandatory in order to improve the transmission throughout the whole information system and allow a clear staggering of clopidogrel-esomeprazole co-prescription avoiding drug-drug interactions when possible. Nurses take the initiative to stagger the co-prescription when these are not clearly defined by medical orders.

PCV168 REGIONAL VARIATION IN HOSPITAL MORTALITY, LENGTH OF STAY AND COST OF ISCHEMIC STROKE PATIENTS IN ALBERTA


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OBJECTIVES: This study examines the association of 30-day in-hospital mortality, length of stay (LOS) and hospitalization costs during one year after acute ischemic stroke by type of hospital and by stroke centre status. METHODS: New ischemic stroke (ICD-10 code I63) patients (no previous stroke in the last one year) between April 1, 2006 and March 31, 2007 (N=6,783) were followed for one year using hospital Discharge Abstract Database. The severity of the stroke was obtained from the ambulatory care database. Median hospital costs by CMG+ group were obtained from Alberta Health. Hospitals were classified as teaching/mixed urban, large community medium, medium, and small community hospitals. Hospitals were also classified as comprehensive stroke centre, urban and rural primary stroke centres, and other urban and rural hospitals. The adjusted risk factors in Bayesian Model included sex, age, all disease-specific co-morbidities, and disease severity. The results for four hospital types and five stroke centre categories were calculated using the observed/expected approach. RESULTS: The 30 days mortality rates (95% CI) were lowest for teaching hospitals 10.1% (9.0%-11.2%) and large community hospitals (10.0%, 8.3%-11.8%), and the small community hospitals had the highest mortality rates (12.8%, 9.9%-15.8%). The mean LOS (95% CI) varied from 21.7 (20.9-22.6) days in teaching hospitals to 34.2 (28.6-41.0) days in comprehensive stroke centres. LOS varied significantly higher costs ($624,400; 949,000-7,800) than the community large hospitals ($32,900; $29,900-36,200) and teaching hospitals ($57,200, $34,900-93,200). Both comprehensive stroke and urban stroke centers had lower 30 day mortality rates (95% CI): 9.9% (8.8%-11.1%) and 9.7% (7.3%-12.0%); shorter LOS 21.6 (20.7-22.5) and 25.0 (22.7-26.7) days; and median levels of costs $39,300 ($36,100-$40,700), compared to other hospitals. CONCLUSIONS: The study shows the hospital type and stroke centre had limited effects on the mortality but significant impact on LOS and costs.

PCV171 IN-PATIENT HOSPITAL COSTS OF STROKE: A FOCUSED LITERATURE REVIEW

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OBJECTIVES: Stroke is the third leading cause of mortality worldwide, with significant implications on in-patient hospital costs. This study aims to investigate Stroke admission and cost-effectiveness in English from 2000 to 2014. We aimed to determine the possibilities of staggering. Surprisingly we found a higher rate of patients having a nurse’s schedule of more than 10 hours (39%, 417/1’071). A statistical significant decrease in trend of clopidogrel use was observed after the OCLA study publication. This suggests that the medical order’s configuration time should be mandatory in order to improve the transmission throughout the whole information system and allow a clear staggering of clopidogrel-esomeprazole co-prescription avoiding drug-drug interactions when possible. Nurses take the initiative to stagger the co-prescription when these are not clearly defined by medical orders.

METHODS: Published search was performed using the keywords: hospitalization, cost analysis, acute stroke, and cost-effectiveness. Studies of Stroke hospitalization and post-procedure controls.

RESULTS: Stroke is the third leading cause of mortality worldwide, with significant implications on in-patient hospital costs. This study aims to investigate Stroke admission and cost-effectiveness in English from 2000 to 2014. We aimed to determine the possibilities of staggering. Surprisingly we found a higher rate of patients having a nurse’s schedule of more than 10 hours (39%, 417/1’071). A statistical significant decrease in trend of clopidogrel use was observed after the OCLA study publication. This suggests that the medical order’s configuration time should be mandatory in order to improve the transmission throughout the whole information system and allow a clear staggering of clopidogrel-esomeprazole co-prescription avoiding drug-drug interactions when possible. Nurses take the initiative to stagger the co-prescription when these are not clearly defined by medical orders.

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