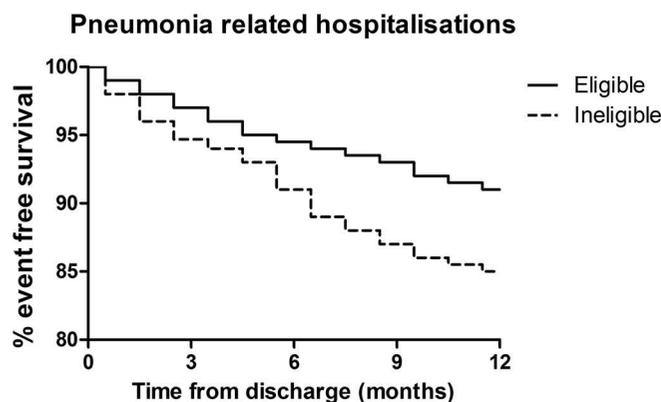


pneumonia hospitalisations in patients eligible and ineligible for TORCH.

There were 376 patients with COPD included from the Edinburgh pneumonia study. The 30-day mortality rate was 12.0%. 186 patients (38.0%) would have been ineligible for TORCH. After adjustment for relevant confounders, ICS use in patients classified as ineligible for TORCH was associated with increased risk of 30-day mortality (HR 1.85 95% CI 1.00–2.41).

Conclusion Patients ineligible for RCTs such as TORCH are at increased risk of ICS related pneumonia mortality and hospitalisation. Existing studies may therefore underestimate the true impact of ICS related pneumonia in the “real-world” setting.



Abstract P224 Figure 1.

P225 INHALER USE AND MISUSE ON THE WARDS OF HOSPITAL

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Clinicians are aware that inhalers are often improperly used incorrectly by patients. However, it is often difficult to assess, because at present there is no tool that directly quantifies adherence. We designed a device, the INCA device that makes an acoustic recording each time an inhaler is used. Opening the device starts the recording, this electronic sound file is “time-stamped” which means that the timing of drug administration is recorded, while analysis of the acoustics identifies the technique of inhaler use. When the INCA device is retrieved and acoustic analysis performed, the steps involved in using the inhaler are determined. Hence, both inhaler technique and the time when the inhaler was used can be identified. Together this means gives an objective quantitative assessment of inhaler adherence.

In this study we attached the INCA device to a diskus dry powder inhaler and studied inhaler use by people in Hospital who were prescribed a diskus inhaler.

Initial results from three general Hospitals (n = 50) indicated that there were errors in both overuse 15% of doses, missed doses in 30% of patients and poor inhaler technique was seen in 45% of patients, in no case was it suggested that the device be changed. Overall, <40% of inhaler doses were administered on time and in the correct manner. Investigation indicated that inhaler administration was not supervised which together meant that errors in inhaler use were not rectified. Subsequently we undertook an institution wide comprehensive practice change involving prescription review, changes to storage and

administration policy, supervised inhaler administration to correct inhaler misuse and a follow-up when inhaler misuse persisted despite ward level instruction. Six months after the introduction of practice change a series of follow on audits were performed. One audit indicated that the storage and administration practice was adopted on the wards. The second indicated in 100 consecutive admissions that observed inhaler technique was adequate in 33% of patients on admission, improved in 33% and was unchanged by discharge in 33%. Thirdly, studies with the INCA device, (n = 40) indicated that overdosing was documented in only 2% of recordings, missed doses were reduced to 20% and 10% of patients were changed from one device to a more suitable one. Hence, data from the INCA device prompted a change in practice. Improvements in inhaler use on the wards were achieved by a simple quality improvement intervention.

P226 INHALATION CHARACTERISTICS WITH SPIROMAX® AND TURBUHALER® DRY POWDER INHALERS (DPI) IN HEALTHY ADULTS AND PATIENTS WITH ASTHMA OR CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): BEFORE AND AFTER ENHANCED TRAINING

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Introduction and Objectives Acceleration of inhaled flow from a DPI is important to facilitate de-aggregation of the metered dose and to ensure delivery of an appropriate dose. Patients need to inhale as fast as possible from the beginning of their inhalation manoeuvre and continue inhaling until their lungs are full.¹ This study investigated inhalation characteristics when patients and healthy adults (HA) inhale through placebo Spiromax® and placebo Turbuhaler® DPIs and assessed the impact of enhanced DPI technique training.

Methods This was a randomised, open-label, crossover study involving children (6–11 years old, [CA]), adolescents (12–17 years old [AA]) and adults with asthma [ADULT], COPD patients and HA. Study participants were trained to use the Spiromax and Turbuhaler DPIs according to the Patient Information Leaflets. Inhalation characteristics were measured.

Each participant received enhanced training using an In-Check Dial™ to measure inspiratory flow (IF). Participants were encouraged to increase their IF by inhaling more quickly. Inhalation characteristics were measured in the same way as before enhanced training.

Results Before enhanced training, peak inspiratory flow (PIF) and maximum change in pressure (P) were significantly higher with Spiromax versus Turbuhaler (p < 0.05; all patient groups). There were also trends towards slightly higher inspiratory acceleration (ACC) with Spiromax.

Table 1 shows the pre-training inhalation characteristics. Enhanced training significantly improved PIF, ACC and P (p < 0.05) in all subjects and in both inhalers except P with Spiromax in patients with COPD. Percentage improvements in P and ACC are shown in Table 1. Significantly greater improvements (p < 0.05) were seen with Spiromax versus Turbuhaler (post training) for PIF (all groups), P in AA, ADULT and patients with COPD, and for ACC in ADULT and COPD patients.

Conclusions Patients achieved faster IF and greater positive change in pressure with Spiromax versus Turbuhaler. Enhanced