Results: This approach resulted in a significant enhancement of the quality of care criteria analyzed:

<table>
<thead>
<tr>
<th>Documented in the medical record</th>
<th>Before (n = 115)</th>
<th>After (n = 93)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent focus of the disease</td>
<td>79 (60%)</td>
<td>88 (75%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Presence of follow-up</td>
<td>33 (28%)</td>
<td>40 (44%)</td>
<td>0.002</td>
</tr>
<tr>
<td>Presence of risk factors</td>
<td>14 (12%)</td>
<td>21 (23%)</td>
<td>0.002</td>
</tr>
<tr>
<td>PEF before treatment</td>
<td>22 (19%)</td>
<td>38 (42%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PEF after treatment</td>
<td>8 (7%)</td>
<td>17 (18%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Steroid therapy</td>
<td>56 (48%)</td>
<td>71 (76%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Follow-up after ED discharge</td>
<td>1990 (21%)</td>
<td>3547 (37%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Discussion and Conclusion: Implementation of locally developed guidelines with the participation of all healthcare personnel was time consuming but had a significant impact on the ED management of asthma patients. This program should be continued to even further increase the quality of patient care. The impact on clinical outcome is currently being assessed.

P1286

Undertreatment in asthmatic outpatients with mild bronchial obstruction
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Undertreatment is one of the reasons for symptoms, sleep disturbance and limitation of activities in asthmatics. Inhaled anti-inflammatory drugs, in particular steroids, are very effective in controlling asthma symptoms in patients of all ages and severity.

The aim of our study was to evaluate, in asthmatics with mild bronchial obstruction, the difference between the domiciliary treatments carried out by outpatients (Ops) and that prescribed by the specialists (Sps) based on the severity of symptoms referred.

A retrospective study of 121 consecutive Ops (51 males, 61 females; mean age: 29 years, range: 13-63) with FEV1 > 70% (mean 99%, range: 70-144%) was performed.

The patients' histories and disease severity score in the previous four weeks (DSS) were investigated and the therapy (level 0-4) used by the Ops and prescribed by the Sps was compared. Spearman's rank correlation was used for nonparametric data.

Only 6 out of 112 (5%) Ops did not report symptoms of asthma (DSS equal to 0) after domiciliary treatment.

We found a significant difference between the therapy used by Ops at home and that prescribed by the Sps (median: home therapy = 0.5; Sps = 2; p < 0.0001, Wilcoxon test), even if a correlation did exist between them (r = 0.39, p < 0.0001).

The total DSS was not associated with the therapy used by the Ops, unlike that of the Sps (r = 0.24, p < 0.001).

We found a significant correlation between the domiciliary therapy and day symptoms only (r = 0.20, p < 0.03) and shortness of breath due to exertion (r = 0.19, p < 0.04); on the contrary there was significant correlation between Sps' therapy and day symptoms (r = 0.22, p < 0.01), shortness of breath due to exertion (r = 0.23, p < 0.01) and also night symptoms (r = 0.21, p < 0.02).

In conclusion, in asthmatics with mild bronchial obstruction: 1) the treatment used by the Ops at home is different from that prescribed by the Sps and their treatment level is indicated by the severity of day symptoms and shortness of breath due to exertion; 2) the domiciliary therapy is not used regularly; therefore the night symptoms are probably still present.

P1287

Non-participation in early intervention with inhaled steroids in asthma and chronic obstructive pulmonary disease (COPD): The role of 'fear of steroids'. Results of the 'DIMCA' study
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Established and validated questionnaires have been shown to be useful research tools with which to assess asthma morbidity (Juniper 1993), but they too time consuming for routine clinical practice. We have used four questions that the doctor would usually ask in each consultation (coughing during night waking, relieves daytime symptoms, daytime breathing and/or activity of disturbances) to produce an 8-point score that requires no extra time from the clinician. We have assessed this short questionnaire score (Q score) with the Juniper morbidity score (total score and symptom score), with levels of PEF, and with the UK asthma guidelines treatment step (Q: r = 0.47, J: r = —0.36, all p < 0.01) although there was considerable scatter for the latter. The Q score correlates well with both the established longer questionnaire and also shows similar relationships to lung function and to severity.

The Qscore was negatively correlated with the Juniper symptom score (r = 0.79, p < 0.01) and total score (r = —0.73, p < 0.01) and both Qscore and Juniper correlated with level of resting FEV1 (Q: r = 0.44, J: r = —0.42) and with the severity of asthma as indicated by the treatment step (Q: r = 0.47, J: r = —0.36, p < 0.01) although there was considerable scatter for the latter. The Q score correlates well with both the established longer questionnaire and also shows similar relationships to lung function and to severity. If it also shows sensitivity to changes in asthma status over the next year it may provide a practical tool with which to estimate asthma morbidity in routine practice.

P1289

Effects of patient education to the life quality in asthma patients: 3 years experience
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Acceptance and application of the International Asthma Report by most countries made asthma therapy more than a simple prescription. It may be expected that patient education in addition to drug treatment will improve the life quality and prognosis of patients. For this reason, we studied randomly selected 25 cases (group I) that given special education for 1 year and randomly selected 27 cases (group II) that given special education for 1 year. The acceptance and application of the International Asthma Report by 27 cases (group II) that given special education for 1 year was significantly different from the group I that given special education for 1 year. The acceptance and application of the International Asthma Report by 27 cases (group II) that given special education for 1 year was also different from the group I that given special education for 1 year. The acceptance and application of the International Asthma Report by 27 cases (group II) that given special education for 1 year was also different from the group I that given special education for 1 year. The acceptance and application of the International Asthma Report by 27 cases (group II) that given special education for 1 year was also different from the group I that given special education for 1 year.