Cigarette Purchases at Pharmacies by Patients at High Risk of Smoking-Related Illness

Cigarette smoking can make managing chronic diseases more difficult. For instance, in patients with certain respiratory conditions, smoking increases the risk of acute exacerbation, can worsen disease control, and may limit the effectiveness of inhaled corticosteroids. Similarly, by raising blood pressure, smoking can make it challenging to effectively control hypertension and may increase the risk of atherosclerosis and coronary heart disease. Smoking can also increase the risk of serious adverse drug events. Oral contraceptive (OC) users older than 35 years who smoke have a 9-fold higher risk of myocardial infarction and venous thromboembolism compared with nonsmokers.

A visit to the pharmacy to fill a prescription is, paradoxically, often an opportunity to purchase cigarettes. Using a deidentified database of linked retail pharmacy purchases and prescription data, we estimated the incidence and frequency of cigarette purchases made in retail pharmacies by individuals filling prescriptions for asthma or chronic obstructive pulmonary disease (COPD), hypertension, and OC medications.

Methods | The study population was drawn from a previously defined cohort of 361 114 patients who received pharmacy benefits through Caremark and filled a statin prescription between January 1, 2011, and June 30, 2012. This cohort included linked data from all purchases at CVS retail locations made with a CVS loyalty card that patients receive as a Caremark benefit and all prescription fills in the year before the patient’s first statin prescription.

Within this cohort, we identified individuals who filled a prescription for an antihypertensive, asthma or COPD, or OC medication during the 365-day observation period and set the date of the patient’s first prescription fill for a drug of interest as the index date. We identified cigarette purchases after a patient’s index date and defined a co-purchase as a day on which an individual purchased cigarettes and had medication available, using a 7-day grace period to allow for modest nonadherence. Oral contraceptive users were restricted to women aged at least 35 years, consistent with US Food and Drug Administration label warnings. The institutional review board of Brigham and Women’s Hospital approved this study.

Results | Of 38,939 patients taking a medication in a class of interest, 6.0% of asthma or COPD medication users, 5.1% of
antihypertensive medication users, and 4.8% of OC medication users had at least 1 cigarette co-purchase (Table). Across all medication classes, patients with a cigarette co-purchase made an average of twice as many monthly store visits (1.9 vs 0.9 in all patients). Among patients who purchased cigarettes, the median number of store visits with a cigarette purchase was 2; 25% of asthma and COPD medication users had 4 to 53 visits, OC users had 4 to 94 visits, and antihypertensive medication users had 4 to 135 visits. Approximately 10% of patients with cigarette purchases were taking medications in 2 or 3 of the classes.

Discussion | Using a novel data source that links retail pharmacy purchase data to prescription dispensing data, we found that 1 in 20 patients who were taking medications in 3 classes purchased cigarettes at the pharmacy. On average, these patients made a cigarette purchase at the pharmacy every other month.

Our analysis is limited by potentially incomplete purchasing information because individuals may not use their loyalty cards for every purchase, and these data do not capture cigarette purchases made at other locations. Some of the cigarette purchases may have been made for or by another household member with whom the patient shares their loyalty card.

Nevertheless, our results highlight an opportunity to improve outcomes for patients receiving widely used treatments. The decision of some pharmacies, including CVS, to stop selling cigarettes has been met with widespread support from public health and medical organizations.6 Similar actions by other pharmacies may help prevent cigarette purchasing by individuals at greatest risk.

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LESS IS MORE

Computer-Aided Detection in Mammography: Downstream Effect on Diagnostic Testing, Ductal Carcinoma In Situ Treatment, and Costs

Since 2001, Medicare has reimbursed computer-aided detection (CAD) during screening mammography. The CAD software tool is used by radiologists to identify lesions suggestive of malignant disease. Research suggests that CAD use increases the rate of false-positive findings of screening mammography and the detection of ductal carcinoma in situ (DCIS).1 Increased DCIS detection could lead to overdiagnosis of breast cancer, particularly among older women at risk for competing causes of death. We estimated the fraction of diagnostic tests, DCIS treatments, and costs attributable to CAD dissemination within the Medicare population, among whom the risk for overdiagnosis may be elevated.

Methods | This study was approved by the institutional review board of the University of California, Davis. Informed consent was waived. Using Surveillance, Epidemiology, and End Results Medicare-linked data from January 1, 2001, through December 31, 2009, we identified screening mammograms performed on female Medicare enrollees aged 67 to 89 years,2 classified mammograms by CAD use, and computed the annual prevalence of CAD use. Using annual prevalences and CAD-associated incident rate ratios from a Medicare cohort study,3 we estimated annual attributable fractions for diagnostic mammography, ultrasonography of the breast, biopsy of the breast, and DCIS diagnoses. We also computed the attributable fraction assuming 100% CAD prevalence because nearly all US mammography units are now digital,3 and digital units typically have integrated CAD.

Extrapolating to the entire US fee-for-service Medicare population, we used incidence rate differences to estimate the