range from 5 to 45 with domains ranging from 2 to 8. Quality of life was assessed by most instruments on the basis of physical disability such as the MIDAS and MIGSEV. However, instruments such as HDI and MSQOL have also included emotional disability in the assessment of quality of life. Cronbach’s alpha of reported ranged from 0.77 to 0.9 and one or more validities was established in all instruments. CONCLUSION: Although all instruments claim to assess the quality of life of patients, not all include physical and emotional functions. The MSQ seems most complete in this aspect, considering the psychometric properties that are reported. In the future, instruments assessing response to therapy should include domains measuring emotional and physical disability to improve treatment schedules.

**PND30**

**PERFORMANCE OF THE EURO QOL 5D (EQ-5D) IN PRIMARY CARE PATIENTS WITH CO-MORBID INSOMNIA**

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**OBJECTIVE:** Use of the EQ-5D in an insomnia population has not been reported before. METHODS: Primary care patients (18 to 64 years of age) in a large hospital outpatient clinic were mailed a survey packet containing EQ-5D, Insomnia Severity Index (ISI), and MOS Short Form 36 (SF-36). Patients were selected based on visit(s) to the clinic in the past six months and grouped into one of the following five groups: cardiovascular (CVD), diabetes (D), gastrointestinal (GI), musculoskeletal (MS), and obstructive airways diseases (OAD) based on presence of diagnostic codes related to these chronic conditions in their medical records. RESULTS: Of 2,190 surveys mailed, 1,020 responses were received. After controlling for the relevant potential confounders, mean EQ-5D scores (i.e., average health state utilities) for patients with insomnia were 0.68 in cardiovascular group, 0.69 in diabetes group, 0.54 in musculoskeletal group, 0.75 in obstructive airways diseases group, and 0.61 in patients with gastrointestinal disorders. Utilities in patients, who did not screen positive for insomnia in the above groups, were 0.81, 0.82, 0.72, 0.83, and 0.83, respectively. Utilities for health states experienced by patients with severe insomnia were the lowest, with progressively higher scores in patients with milder insomnia, and no insomnia. Correlations between EQ-5D mobility and SF-36 physical function domains, and SF-36 social functioning domains were −0.64 and −0.49, respectively; between EQ-5D pain/discomfort and bodily pain and physical functioning domains of the SF-36 were −0.70 and −0.57, respectively; between EQ-5D anxiety/depression and the SF-36 mental health and vitality domains were −0.71 and −0.58, and between EQ-5D fatigue and the SF-36 general health domain was 0.74. CONCLUSION: EQ-5D utilities in the insomnia and no-insomnia groups, and the direction and strength of correlations with the SF-36 domains were as hypothesized thereby assuring satisfactory psychometric performance of the EQ-5D and confirming its usefulness for studying utilities in an insomnia population.

**PND31**

**CO-MORBID INSOMNIA IN PRIMARY CARE PATIENTS AFFECTS HEALTH-RELATED QUALITY OF LIFE (HRQL) INDEPENDENT OF OTHER FACTORS**

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**OBJECTIVE:** To understand the association between insomnia and HRQL after statistically controlling for socio-demographic characteristics, health habits, BMI, a number of medical conditions, and the presence of depressive symptoms. METHODS: A sample of primary care patients (18 to 64 years of age) in a large hospital outpatient clinic was mailed a survey packet that contained the MOS Short Form 36 (SF-36), and Insomnia Severity Index (ISI). These patients were selected based on their visit(s) to the clinic in the past six months and grouped into one of the following five groups: cardiovascular (CVD), diabetes (D), gastrointestinal (GI), musculoskeletal (MS), and obstructive airways diseases (OAD) based on presence of diagnostic codes related to these chronic conditions in their medical records. Group differences in SF-36 domain scores were analyzed using ANOVA techniques. RESULTS: Based on 1,020 responses (46.58% response rate), in patients with insomnia, mean SF-36 Physical Component Summary (PCS) scores were: CVD: 37.8 ± 2.9; D: 37.6 ± 3.9; GI: 45.3 ± 2.9; MS: 32.4 ± 3.2; OAD: 44.6 ± 3.2. Mean Mental Component Summary (MCS) scores were: CVD: 39.2 ± 2.6; D: 42.7 ± 4.0; GI: 33.9 ± 3.8; MS: 41.1 ± 3.6; OAD: 41.1 ± 3.8. In patients without insomnia, PCS scores were: CVD: 47.0 ± 2.4; D: 46.4 ± 3.3; GI: 49.2 ± 2.2; MS: 39.9 ± 3.0; OAD: 51.7 ± 2.9. In the same patients MCS scores were CVD: 47.5 ± 2.1; D: 47.0 ± 3.3; GI: 50.0 ± 2.9; MS: 50.0 ± 3.4; OAD: 45.0 ± 3.4. In addition, SF-36 scores for all individual domains in patients with insomnia were lower than those of patients without insomnia across all disease groups. CONCLUSION: A significant independent relationship between insomnia and HRQL remained even after controlling for all relevant potential confounders. No domain of HRQL was disproportionately influenced by insomnia.