charge. Scenario 1 represented a valuation of inhaled versus intravenous induction and scenario 2 represented a valuation of inhaled versus intravenous maintenance. An open-ended question was directed to test understanding of the exercise, and thus validity of the valuation given. A thematic framework approach was used to analyze these qualitative data. A second researcher checked the consistency of the coding of the themes in a sub-sample of the statements (inter-rater reliability).
RESULTS: 260 (81%) parents/guardians and 907 (85%) adults recruited onto the RCT were telephoned around day seven. 88% and 85% of parents/guardians' and adults' responses were classed as valid, respectively. 69% of adults preferred an injection for induction (mean CV: £237, SD: £370) and 31% preferred a mask (mean CV: £144, SD: £110, $p < .05$). 97% of adults selected the scenario with a lower nausea and vomiting rate (mean CV: £192, SD: £149). 57% of parent/guardians preferred a mask for induction (mean CV: £255, SD: £259) and 43% preferred an injection (mean CV: £221, SD: £177, ns). 99% of parents/guardians selected the scenario with a lower nausea and vomiting rate (mean CV: £238, SD: £194).
CONCLUSION: Contingent valuation was used successfully in this prospective study. Telephone interviewing produced a high response rate and respondent understanding of the exercise was high.

POD3

THE PSYCHOMETRIC TESTING OF THE HUNGARIAN VERSION OF THE SYSTEMIC LUPUS ERYTHEMATOSUS DISEASE-SPECIFIC QUALITY OF LIFE QUESTIONNAIRE

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OBJECTIVE: Quality of life (QoL) is a key parameter in describing the impact of Systemic Lupus Erythematosus (SLE). The reliability and validity of the Hungarian version of the SLEQoL were assessed with the intention of using it in clinical and health economic trials and burden-of-disease studies in Hungary.
METHODS: Data were collected through a postal survey of patients with SLE. Participants completed the SLEQoL and Nottingham Health Profile (NHP) on two occasions, two weeks apart. Test-retest reliability was assessed by correlating SLEQoL scores at the two time points. Internal consistency was assessed using Cronbach's alpha coefficients. Evidence of construct validity was gained by correlating SLEQoL scores with NHP section scores and by testing whether the measure was able to distinguish groups that differed according to self-perceived severity of condition.
RESULTS: Fifty-three patients participated in the survey. Mean age of the sample was 39.9 years (SD = 12.2), 49 patients (92.5%) were female and mean disease duration was 12.0 years (SD = 8.2). Test-retest reliability for patients who had no change in their condition between administrations was 0.94. Cronbach's alpha coefficients were 0.90 and 0.93 at times 1 and 2 respectively. The highest correlation was observed with the emotional reactions section of NHP and the lowest with pain and sleep disturbance. Patients who perceived the severity of their condition to be moderate or quite severe obtained higher SLEQoL scores (indicating poorer QoL) than those who perceived their condition to be mild ($p < .05$).
CONCLUSION: The Hungarian SLEQoL was shown to have good test-retest reliability, indicating that it produces little random measurement error. Evidence of validity was also good. The results provide preliminary evidence that the instrument will be able to detect changes in QoL occurring in routine clinical practice or in clinical trials or studies.

POD4

COST-CONSEQUENCES OF ORTHOPAEDIC SURGERY IN HAEMOPHILIA PATIENTS WITH INHIBITORS

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OBJECTIVES: To date, surgical interventions in people with haemophilia and high-titre, high-responding inhibitors have been largely restricted to life-threatening situations. This is to the detriment of patients who would benefit from surgery in terms of reduced pain, a reduction in the frequency of regular bleeding episodes and improved quality of life. However, with the development of recombinant FVIIa (rFVIIa: Novo Nordisk Ltd) elective surgery such as joint replacement can be carried out safely with effective haemostasis. This study examines the cost-consequences of surgical intervention in this patient group over time, to establish an estimate of the net cost of surgery.
METHODS: A modeling framework has been used to estimate costs associated with haemostasis (rFVIIa treatment) in patients for nine surgical procedures, and to consider the cost-consequences of the intervention over a five-year time horizon. Key parameters in the model have been obtained from available literature (i.e. assumption of reduction in bleeding episodes) and expert opinion from a leading Haemophilia Comprehensive Care Centre (i.e., protocols for haemostasis required during orthopaedic surgery, physiotherapy and rehabilitation).
RESULTS: For a typical person with haemophilia with inhibitors, weighing 75kg, experiencing one regular bleed per month in the affected joint, the costs for haemostasis associated with total hip replacement are an estimated £322,911. However, the net cost, when considering the reduced costs of treatment for regular minor bleeds over the following 5 years, are −£298,401 (cost-saving) when treating first line with rFVIIa.
CONCLUSIONS: In addition to improved quality of life, orthopaedic surgery in people with haemophilia and inhibitors may be cost-saving when the reduction in regular

minor bleeds is taken into account, and the subsequent cost consequences over time offset the surgical costs.

POD5

THE COST EFFECTIVENESS OF AN EXTRA-CORPOREAL LIVER ASSIST DEVICE FOR PATIENTS WITH FULMINANT HEPATIC FAILURE

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OBJECTIVES: Emergency liver transplantation represents the only effective and recognized therapy for fulminant hepatic failure (FHF). However, many patients die while waiting for a donor liver. Bioartificial liver devices such as the Extracorporeal Liver Assist Device (ELAD) could allow for sufficient support until a donor liver becomes available or until the patient's own liver can recover. The objective of this study was to assess the cost-effectiveness of ELAD in FHF patients.
METHODS: We performed a cost-effectiveness analysis from a payer perspective using clinical data from 19 patients who received either ELAD or usual care in a Phase II randomized clinical trial. A statistically significant improvement in bridging to transplant with the use of ELAD was found, with 67% ELAD patients surviving 30 days, compared to 43% of patients in the usual care group. A decision-analytic model was used to determine the incremental cost per additional year of life gained with ELAD versus usual care. Costs were derived from liver transplant literature.
RESULTS: The incremental cost per additional year of life gained for ELAD compared with usual care ranged from $49,200 to $71,500. Among those patients requiring liver transplant, the cost per additional year of life gained was $52,600 compared to individuals not receiving a transplant. The model was sensitive to assumptions regarding the cost of ELAD and the proportion of patients successfully bridged to transplant.
CONCLUSIONS: ELAD bioartificial liver device may offer both survival and economic benefits to FHF patients. ELAD appears to be a reasonable and cost-effective alternative to usual care in the treatment of FHF. In addition to its value as a bridge to transplant, ELAD may offer even more health and cost benefits as a bridge to recovery. Future studies will continue to examine this effect across larger populations.

POD6

ECONOMIC EVALUATION OF TREATING ERECTILE DYSFUNCTION IN SPAIN: THE PRIMARY CARE APPROACH VERSUS SPECIALIZED CARE

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OBJECTIVE: To perform economic evaluations both of cost-effectiveness (C/E) and cost-utility (C/U) analysis of erectile dysfunction treatments, sildenafil and intracavernous alprostadil, depending on whether they are prescribed in primary (PC) or specialized (SC) care.
METHODS: The costs include diagnosis, treatment and clinical follow-up, have been obtained from Spanish official Administration and Hospitals data. The cost of the treatment was the wholesale price in year 2000. Utility units were assessed using time trade-off and efficacy rates obtained from the scientific literature.
RESULTS: The annual costs of the treatments for four monthly drug administrations, vary between €421,02 (sildenafil in PC); €608,42 (sildenafil in SC) and €715,28 (alprostadil IC) for the first year and €370,89 (sildenafil PC), €404,67 (sildenafil SC) and €465,92 (alprostadil) for each of the following years. The C/E and C/U values lie between €568,18 and €3,465.19, respectively for sildenafil in PC and €821,07 and €5.007,54 respectively for sildenafil in PC for the first year of treatment. For alprostadil, the values during the first year are €1.027,71 (C/E) and €5.431,5 (C/U). For the following years they are €500,53 (C/E) and €3053,60 (C/U) for sildenafil in PC, €546,11 (C/E) and €3330,60 (C/U) for sildenafil in SC and €669,43 (C/E) and €3537,76 (C/U) for alprostadil.
CONCLUSIONS: Treatment with sildenafil is cheaper than with alprostadil. Sildenafil has a better pharmacoeconomic profile than alprostadil, both in terms of C/U and C/E analyses. Sildenafil is the best therapeutic option in terms of C/E and C/U ratios for the treatment of erectile dysfunction when it is prescribed in primary care.

POD7

THE EF-VAS: A PREFERENCE-BASED SELF-ADMINISTRATION INSTRUMENT FOR ASSESSING THE IMPACT OF ERECTILE DYSFUNCTION (ED) AND ED TREATMENT

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OBJECTIVE: To develop a generalizable, responsive and sensitive self-administered instrument by combining disease-specific and preference-based approaches in an ED-specific HRQL instrument.
METHODS: Literature review provided structure for expert panel discussion. Consensus regarding content produced eight domains and five levels within each domain describing a continuum of dysfunction-function. This content formed the foundation for a preference-based self-administration HRQL instrument, consisting of two visual analog scales (VAS). Scale 1 allows the rating of the patient's self-state along with three 'marker' health