we calculated Pearson correlations between changes in KCCQ and Peak VO2 at 3 and 12 months. Confidence intervals of r’s were estimated via bootstrapping.

RESULTS: The SIMPLE method produced a wider distribution of change scores than the other two methods. However, compared to BLUP-1 and BLUP-2, the SIMPLE approach resulted in lower correlations between changes in KCCQ and Peak VO2 at both 3 and 12 months: At 3 months, SIMPLE r (95% CI) = 16 (11.21), BLUP-1 r = .28 (1.18, .38), and BLUP-2 r = .29 (.22, .40). At 12 months, SIMPLE r = .22 (.13, .27), BLUP-1 r = .27 (.21, .35), and BLUP-2 r = .31 (.25, .40). CONClUSIONS: Compared to the SIMPLE approach, the BLUP approach has the following advantages: 1) uses all of the longitudinal data available; 2) estimates with reasonable assumptions about missing data; 3) accommodates nonlinear and differing longitudinal trajectories for the PRO and clinical measures; and 4) minimizes the influence of noisy data.

OBJECTIVES: To review studies assessing the quality of life associated with thoracic aortic diseases (TADs) and their treatment with Open Aortic Repair (OAR), Thoracic Endovascular Aortic Repair (TEVAR) or medical management (MM). METHODS: PubMed and EMBASE were searched covering terms related to TADs and patient outcomes. Two with two interventions and two with one of the TADs; all of them were based on assessment of quality of life after treatment rather than on the disease itself. Only one study covered emergency versus elective surgery. The percentage of patients was small in all studies, ranging from 7 to 11 months. The most commonly used instrument was the SF-12. The SF-36 was used to study the Hospital Anxiety and Depression Scale (HADS) in addition to the SF-16. One study adopted the SEDQUAL questionnaire; another study had recourse to the Illness Intrusiveness Rating Scale (IIRS) and the Karnofsky Activity Scale (KAS), which lacked information on proper validation for this target population. All in all, none of the studies reported utility assessment, particularly with regard to the follow-up period, the lack of pre-operative assessment and lack of direct comparison between interventions. Lastly, there were no utility assessments to be found, which would be essential to arrive at QALY values and thus take the process of economic analysis forward. CONCLUSIONS: The studies available so far do not provide evidence of the quality of life associated with TADs, as well as conclusive evidence of the quality of life associated with OAR, TEVAR and MM.

Health-related quality of life among diabetic patients with and without macrovascular comorbidities in the United States

Zhu L, Fu AZ, Radican L

Medtronic International SA, Toluochen, Vaud, Switzerland; LSE, London, UK

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