after a first episode of SAH. Screening may prevent new episodes of SAH but might also lead to higher morbidity rates because of diagnosis and treatment related complications. Further clinical studies are required to fill the gaps detected, and costs should be balanced against effects.

OBJECTIVES: Stenting of the arteria carotis interna (CAS) is becoming an increasingly popular means of treating carotid stenosis. At present however costs of stents are high and conclusive trials to prove the (equal) effectiveness of CAS as compared to carotid endarterectomy (CEA) are not finalized yet. The primary goal of the current study is to assess the uncertainties concerning long- and short-term clinical outcomes on the cost-effectiveness analysis of CAS verses CAE. METHODS: A Markov model was constructed to assess the cost-effectiveness for carotid treatment for the Dutch setting based on clinical data published in literature and in-house collected cost data. RESULTS: The procedural costs for the CAS procedure are 15% higher than costs for a CEA. Major stroke is a dominating factor in both quality of life and in follow-up costs. Therefore the short- and long-term results of the cost-benefit analysis will be highly influenced by the perioperative and post-operative incidence rates for major stroke. This idea is supported by model sensitivity analyses who show that the sensitivity to the long-term incidence rate is two times higher than the short-term incidence rate. As the level of uncertainty of the long-term major stroke rates are higher than those of the perioperative stroke rates, these will clearly dominate the level of uncertainty regarding the decision on the cost-effectiveness of the CAS procedure. CONCLUSIONS: The results show that the uncertainties concerning the long-term major stroke risks have a predominant influence on the outcome of the evaluation of the cost-effectiveness of CAS over CEA. Therefore, long-term effects need to be assessed and considered before a balanced decision on the cost-effectiveness of the CAS over the CEA procedure can be taken.

OBJECTIVES: Patients with Heart Failure (HF) are known to be noncompliant and can also suffer from poor HRQoL. We wanted to determine whether compliance influenced HRQoL scores. We used the SF-36 and compliance scores of patients with HF to examine this question. METHODS: These data are from a RCT of patients with HF (n = 134) who were assigned to a usual care arm (U) or an enhanced intervention arm (I) and followed for one year. Improvement in HRQoL was considered as an increase in 10 points in the PCS or MCS summary scales of the SF-36, which we considered to be reflective of a minimal clinically important difference (MCID) for patients. Patients who had an overall compliance score between 0.8 and 1.2 were considered compliant. Patients who had an overall compliance <0.8 or >1.2 were deemed non-compliant. Using a logistic regression model with compliance as the dependent variable we entered HRQoL data and ARM allocation. RESULTS: The odds ratio of associated with a 10-point increase in PCS was 1.63 for compliance relative to non-compliance (CI 1.06–2.51) p = 0.026. The odds ratio associated with a 10-point increase in MCS was 1.26 (CI 0.868–1.83) p (ns). When we include the ARM in the model the odds ratio is 1.58 (CI > 1.02–2.45), p = 0.040. CONCLUSIONS: There is a statistically significant relationship (p < 0.05) between HRQoL and compliance, where 1.63 can be interpreted as the change in odds of compliance relative to non-compliance that is associated with a 10-point change in the PCS score of the SF-36. These findings help us interpret HRQoL data by including HRQoL as a mediating variable that affects outcomes such as compliance that are known to have a significant impact on patients with HF.

THE IMPACT OF AN EDUCATIONAL INTERVENTION ON MULTIPLE HEALTH RELATED QUALITY OF LIFE MEASURES IN PATIENTS WITH HEART FAILURE (HF)

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OBJECTIVES: Patients with HF suffer from poor health related quality of life (HRQoL). In this randomized controlled trial we used both generic (SF-36, HUI Mark 2/3) and disease specific (MLHFQ) measures of HRQoL to determine whether our educational intervention had any impact on these outcomes. METHODS: Patients with HF were stratified by reason for admission and then randomized to receive either usual care (U) or an educational intervention (I). HRQoL was a secondary outcome measure in this trial. All patients were measured at baseline and every three months to one year. RESULTS: In the SF-36 there was a trend at certain visit numbers in physical functioning (p = 0.081), role limitation due to physical problems (p = 0.032), role limitation due to emotional problems (p = 0.068) and energy vitality (p = 0.068). There were no differences over time between each