mixed treatment comparison (MTC). Triggers for treatment switches included poor compliance (MTC); lack of IOP control (MTC); or progression of visual field defects (3 long-term clinical trials). Treatment dropouts were from expert opinion and death rates from UK national data. Follow-up times are from NHS treatment pathways, drug costs from UK Drug Tariff December 2007, cost of follow-up visits and surgery from NHS National Tariff 2007/8, and cost of low vision from a published UK national study. Utilities were from published sources. RESULTS: Patients were stable on treatment for 64%, 56%, 55% and 54% of follow-ups for latanoprost, bimatoprost, travoprost and timolol respectively. As a result, for every 1000 clinic appointments, 716 patients can be followed-up for a year if treated with latanoprost compared to 605 for bimatoprost (similarly versus other strategies). The total cost of the latanoprost 1st line strategy is £16.3, compared to £6239, £6228 and £6083 for bimatoprost, travoprost or timolol respectively (including surgery costs and cost of low vision), with 5.87, 5.85, 5.85 and 5.84 QALYs. The reduction in time spent with low vision for latanoprost is approximately 2 months compared to the other strategies. CONCLUSIONS: The model demonstrates that stabilising a patient on treatment will lead to reduced disease progression and better outcomes in the long-term, and other benefits such as more efficient use of scheduled follow-up visits.

**COST UTILITY OF BILATERAL COCHLEAR IMPLANT**

Objetive: Unilateral cochlear implantation is generally accepted as a cost-effective intervention for hearing impaired patients. They gain understanding in quiet conditions, but report difficulties with sound localization and in noisy conditions. These can be solved with bilateral implants. Currently in Spain, there are estimated to be about 350 bilateral cochlear implanted patients. Our objective is to perform an economic evaluation of bilateral cochlear implantation in adults and children.

**METHODS:** We reviewed the published literature to find the effectiveness of bilateral cochlear implantation, and costs of the intervention, to estimate the incremental cost-effectiveness ratio. Our model only considers costs for public systems described by the literature. The time horizon considered is the remaining life of recipients. We use a discount rate of 3% in future costs and the literature. The time horizon considered is the remaining life of recipients. We use a discount rate of 3% in future costs and the literature.

**RESULTS:** Patients were treated for glaucoma or ocular hypertension with either Travatan® or DuoTrav®. Non compliant patients were identified with a computerized device (Travalert®) that collects daily instillation time and number of drops. The EDSQ was completed once patients used the device for 3 months. The EDSQ included six domains: Concern about treatment, Concern about disease, Satisfaction with patient-clinician relationship, Positive beliefs, Treatment convenience, and Declared compliance. Non compliant patients were over-sampled to reach a ratio 1 complier: 1 non complier. A Bayesian network was constructed to identify non compliers. The “Taboo order” algorithm was used to estimate associations. Missing data were inferred according to the EM structural method. EDSQ scores were dichotomised according to a decision tree aimed at maximising non complier identification.

**CONCLUSIONS:** To identify non compliant glaucoma patients with the EDSQ, the Eye Drop Satisfaction Questionnaire.

**TREATMENT**

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**OBJECTIVES:** To identify non compliant glaucoma patients with the EDSQ, a questionnaire measuring satisfaction and compliance of glaucoma treatment.

**METHODS:** Patients were treated for glaucoma or ocular hypertension with either Travatan® or DuoTrav®. Non compliant patients were identified with a computerized device (Travalert®) that collects daily instillation time and number of drops. The EDSQ was completed once patients used the device for 3 months. The EDSQ included six domains: Concern about treatment, Concern about disease, Satisfaction with patient-clinician relationship, Positive beliefs, Treatment convenience, and Declared compliance. Non compliant patients were over-sampled to reach a ratio 1 complier: 1 non complier. A Bayesian network was constructed to identify non compliers. The “Taboo order” algorithm was used to estimate associations. Missing data were inferred according to the EM structural method. EDSQ scores were dichotomised according to a decision tree aimed at maximising non complier identification.

**RESULTS:** Among the 176 patients who completed EDSQ, 113 patients used adequately Travalert®. 25 (22.1%) patients were identified as non complier. No difference between compliers and non compliers were found on demographics and baseline medical data. The 6 EDSQ dimensions were dichotomised according to a decision tree aimed at maximising non complier identification. The Bayesian network identified 3 populations whose posteriori probabilities were different from a priori. Patients declaring low compliance, aged <77.5, with a poor patient-clinician relationship and patients declaring good compliance, aged >77.5, with a poor patient-clinician relationship were at never been characterised previously in the UK.

**METHODS:** Routine hospital data from a large geographical area (population approx. 435,000) were record-linked using probability matching algorithms to mortality data from the Office of National Statistics (1991 to 2005). Relative survival was compared using Cox proportional hazards models. **RESULTS:** It was possible to identify 1935 hospital admissions from 1038 subjects; 49% male. The mean age at first admission was 44 years (sd 20). The minimum, crude prevalence of people hospitalised with psoriasis at some time was 0.23%. Coincidentally, these admissions represented 0.23% of all hospital admissions. The crude admission rate with a primary diagnosis of psoriasis was 2.9 per 10,000 population per year. The proportion of subjects who had only one admission ranged between 65% and 77%. The median time between the first admission and the second admission was 1.4 years (IQR 0.5 to 3.1). The mean length of hospital stay was 16.8 days (median 15; IQR 8 to 23). There were 55 deaths in total in this group. Ten year survival was between 94% and 95%. Following standardisation, people admitted more than once had increased risk of all cause mortality (hazard ratio 2.71; 95% CI 1.39 to 5.31). **CONCLUSIONS:** This study provides useful background intelligence on the most severe psoriasis patients. The proportion of psoriasis patients admitted was estimated to be about one in six people. Those with more than one admission with psoriasis—greater psoriasis severity—were associated with increased risk of all-cause mortality.

**SENSORY SYSTEMS DISORDERS—Patient-Reported Outcomes Studies**

**PSS36**

**THE DESCRIPTIVE EPIDEMIOLOGY AND OUTCOME OF HOSPITALISATIONS FOR PSORIASIS IN THE UNITED KINGDOM**

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**OBJECTIVES:** To characterise the epidemiology and outcome of people hospitalised with a primary diagnosis of psoriasis has never been characterised previously in the UK.