and/or from an employed person (33.0% versus 20.9%) and consumed more antidepressant drugs than patients with mild psoriasis (20.1% versus 7.8%). Mean individual cost of the disease was estimated to be £543/year/patient. CONCLUSIONS: This study is the first in France to explore the impact of psoriasis on different perspectives. Our results show that psoriasis, particularly severe psoriasis, is a true burden for patients and impacts significantly everyday life and patient economical resources.

**OBJECTIVES:** The Dermatology Life Quality Index (DLQI); 10 items is a generic dermatology health-related quality of Life (HRQoL) measure that is the most commonly used in dermatology. Despite its popularity little research has been conducted into the dimensionality of the questionnaire. The purpose of this study was to examine its scaling properties and establish whether it is unidimensional.

**METHODS:** DLQI data were combined from two studies; one involving people with psoriasis and the other patients with atopic dermatitis. Item Response Theory was used to determine; overall fit to the Rasch model, individual item fit, targeting of scale to severity of response categories, and the presence of Differential Item Functioning (DIF) by disease, age or gender. RESULTS: The sample included 146 psoriasis patients (male 50%, mean age = 44.2 range = 17–83 years) and 146 atopic dermatitis patients (male 50%, mean age = 45.3, range = 20–82 years). The DLQI misfit the Rasch model (Chi2 = 63.38, df = 40, p = 0.01). Item 2 misfit the Rasch model and items 5 and 7 showed borderline misfit. Items 4, 6, 7, 8 and 9 had disordered response thresholds indicating that these did not work in a logical way. Results showed a lack of spread in the measurement of HRQoL with too few items covering either milder or more severe levels of HRQoL. DIF by disease was shown in items 6 and 7 and DIF by age in item 10. After removal of item 2 and rescoring the response categories the DLQI still misfit the Rasch model (Chi2 = 54.92, df = 36, p = 0.02). CONCLUSIONS: The results of the Rasch analysis showed there were several problems with the scaling properties of the DLQI and that little confidence can be placed in the raw scores generated from the scale. These problems need to be addressed before the QLDS can be considered a valid and useful outcome measure.

**OBJECTIVES:** The aim of this study was to develop such an instrument and to test its acceptability and responsiveness across a broad spectrum of cultures. The BeautyQol is a multidimensional, self-administered QOL questionnaire specific to cosmetics and physical appearance.

**METHODS:** Semi directive interviews were conducted by clinical psychologists simultaneously to develop such an instrument and to test its acceptability across a broad spectrum of cultures. The BeautyQol is a multidimensional, self-administered QOL questionnaire specific to cosmetics and physical appearance.

**RESULTS:** From the item generation phase, 62 questions were selected in describing major domains such as well being, self esteem, social life, love life, sexual life, confidence, happiness, image, status, emotion, seduction, success, vitality, charisma, motivation, joy, fun, dignity, etc. General acceptability was very good according to the very low rate of no answer. Mean time duration was 11 minutes to complete the 62 questions and 3 open questions (median: 9 min). Item reduction analysis led to a 48 questions. The next study currently underway is a global validation study involving a minimum of 3200 subjects worldwide. CONCLUSIONS: BeautyQol is the first user-centered instrument specific in physical appearance that is effective therapy in these refractory patients. Review of this aspect of NICE guidance may indicate a reluctance of both patients and clinicians to withdraw an at least partly effective therapy in these refractory patients. Review of this aspect of NICE guidance may be warranted.

**OBJECTIVES:** To check clinical compliance with guidance specified by NICE Technology Appraisals 103 (etanercept & efalizumab), 134 (infliximab) and 146 (adalimumab), METHODS: A retrospective audit of medical records of patients treated with biologics for psoriasis, since issue of relevant NICE guidance in 6 UK Dermatology centres. The audit was conducted between December 2008 and February 2009 in accordance with a standardised protocol and data collection form, with local management approval to release anonymised data for pooled analysis. RESULTS: A total of 173 courses of biologic treatment (in 149 patients) were included in the audit. PASI and DLQI were recorded at initiation of 96% (n = 166) of treatments. Biologics were initiated for appropriately severe disease in 92% of cases (n = 155) and only after failure, intolerance or contra-indication to standard systemic therapies in 99% (n = 170) of cases. In 69% (n = 120) of cases, PASI and DLQI were recorded at the appropriate review dates (10, 12 or 16 weeks, depending on biologic). Etanercept was prescribed at the licensed dose of 50 mg weekly in 92% of cases (n = 120) but was discontinued appropriately in responders before week 24 in only 6.5% (n = 3 of 45). Only 37% of cases with an inadequate response to biologics at the appropriate review date (n = 50 of 135), had therapy withdrawn. CONCLUSIONS: In the 6 sites audited, compliance with national guidance was entirely appropriate for the commencement and dosing of biology therapy. However, the requirement to discontinue etanercept in responders was rarely followed. Similarly, discontinuation of biologics in non-responders was not routine practice. These results indicate that despite guidance to the contrary etanercept is used continuously in practice in these specialist centres. This may indicate a reluctance of both patients and clinicians to withdraw an at least partly effective therapy in these refractory patients. Review of this aspect of NICE guidance may be warranted.