

rates: 1.15 and 1.51 for 1A and 1B respectively,  $p < 0.01$ ). Mean (SD) costs of care at one year of follow-up also were reduced among GA patients (\$9,522 [\$9,706] vs. \$9,957 [\$9,083] and \$10,185 [\$9,526] for 1A and 1B respectively). Findings persisted in multivariate analyses controlling for differences in demographic characteristics and propensity scores for immunomodulatory therapy. **CONCLUSIONS:** Glatiramer acetate is associated with reductions in the incidence of relapse and costs of care relative to the beta interferons among this large group of managed-care patients with MS.

## NEUROLOGICAL DISEASES/DISORDERS & PAIN—Quality of Life

### PNP 11

#### USE OF THE TOPS AS A PAIN-SPECIFIC HRQOL INSTRUMENT

Oderda GM, Lipman AG, Ashburn MA, Stockdale W  
University of Utah, Salt Lake City, UT, USA

The Total Outcome of Pain Scale, TOPS, is a fully validated disease-specific outcome measurement tool for use in patients with chronic pain. The TOPS provides much greater sensitivity and specificity for measuring outcomes. The 60°V-item TOPS questionnaire contains the SF-36 and information on Pain Symptom, Functional Limitations, Perceived Family/Social Disability, Real Family/Social Disability and Formal Work Disability. Unlike the SF-36, TOPS is precise enough to monitor outcome over time in individual patients. All patients at the University of Utah Pain Management Center complete TOPS at evaluation, three months, six months, and then every six months for the duration of therapy. Paper forms are scanned into an Access database. This produces a report that summarizes current and prior TOPS scores for the patient and which is put into the patient's medical record. From July 1, 1997 through August 2, 2001, 3454 TOPS instruments were completed and entered. This represented 2692 individual patients. Most (80.5%) of patients completed one TOPS; the remainder had 2 or more. This population was 62.2% female and had the following characteristics (median values): age (40–44), years of education (13), income \$30,000–\$39,999. The 6 most common diagnoses and ICD 9 codes were: myalgia and myositis, unspecified (729.11), low back pain, low back syndrome (724.2), pain in limb (729.5), neuralgia, neuritis, and radiculitis, unspecified (729.2), cervicgia, pain in neck (723.1) and headache (784.0). Mean responses were as follows: ICD 9 Code PCS MCS Pain Symptom Score Work Disability 729.1 28.9 39.7 72.2 37.7 724.2 27.1 40.1 72.9 47.4 729.5 27.9 40.4 75.3 38.7 729.2 28.9 40.1 73.0 46.8 723.1 30.5 37.6 73.2 40.1 784.0 31.6 37.6 71.2 31.8. Data collection is ongoing, with 20–30 surveys completed weekly. By the end of 2002, data on approximately 5000 TOPS administrations will be available and will be included in the presentation.

Querying the database may provide valuable data on relative outcomes by intervention and clinician.

### PNP 12

#### PHYSICIAN PREFERENCE FOR ANTIEPILEPTIC DRUG CONCENTRATION TESTING

Baumann RJ, Ryan M, Yellowitz AS  
University of Kentucky, Lexington, KY, USA

**OBJECTIVES:** To determine rate of adoption of saliva concentrations as a monitoring method for antiepileptic drugs (AEDs). To determine whether child neurologists would prefer saliva testing to serum testing to obtain AED concentrations for clinical practice. **METHODS:** A survey asked participants about use, availability, and value to the physician of saliva AED concentrations. Respondents chose between the following four responses when considering value: 1) Very valuable, willing to spend ½ hour of time per patient to arrange; 2) Moderately valuable, willing to spend 10 minutes of time per patient to arrange; 3) Not very valuable, might use test but would not spend extra time to arrange; and 4) Of no special value, I doubt that I would use such a test. All members of the Child Neurology Society were surveyed. Surveys were re-mailed to non-responders after one- and two-month intervals. **RESULTS:** We mailed 1006 surveys and received 546 responses (54%) and 57 surveys were returned undelivered. Less than 1% of respondents had obtained a saliva AED concentration in the last year. Seven percent stated there was an available laboratory to perform saliva AED concentration determinations. Fifty-three percent of individuals indicated that having a pain-free method of AED concentration determination was very or moderately valuable to them and 68% stated that the ability to obtain real-time samples outside of the clinical environment was very or moderately valuable. **CONCLUSIONS:** Most child neurologists have not obtained saliva AED concentrations and perceive they do not have this technology available to them. The majority of respondents would be willing to spend 10–30 minutes of time to arrange for saliva AED concentrations to prevent patient discomfort and obtain real-time concentrations.

### PNP 13

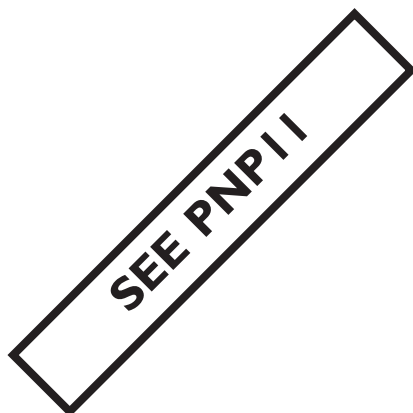
#### QUALITY OF LIFE (QOL) AND PHARMACOECONOMICAL ASPECTS IN PATIENTS WITH SYMPTOMATIC LOCALIZATION-RELATED EPILEPSIES (SLE) IN MOSCOW

Guekht AB<sup>1</sup>, Gusev EI<sup>1</sup>, Belousov JB<sup>1</sup>, Bykov AV<sup>2</sup>, Dzugaeva FK<sup>1</sup>, Milchakova LE<sup>1</sup>, Mitrokhina TV<sup>1</sup>

<sup>1</sup>Russian State Medical University, Moscow, Russia; <sup>2</sup>Russian Society for Pharmacoeconomics Research, Moscow, Russia

**OBJECTIVES:** The growing attention to the social aspect of epilepsy and the necessity to improve the system of care require knowledge of QOL and pharmacoeconomic

aspects. The purpose of the study was to evaluate the QOL in 223 patients (age 18–70 years old) with SLE and to estimate the cost-effectiveness of the optimization of treatment (OT). **METHODS:** After appropriate investigation, patients received the optimized treatment with adequate carbamazepine or valproate monotherapy. (Previously 139 patients were on inadequate treatment with low-dose polytherapy, 84 patients were untreated). Frequency, severity (NHS3 scale, M.F. Donoghue et al., 1996) of seizures and QOL (QOLIE-31 scale, J. Cramer 1998) were analyzed as effectiveness parameters before and 1 year after the OT. **RESULTS:** After OT complete control of seizures (CCS) was achieved in 122 patients (54.7%). Before OT the significant ( $p < 0,01$ ) negative correlation was found between the QOLIE-31 overall score (OS) and the duration of disease ( $r = -0,34$ ), severity ( $r = -0,33$ ) and frequency of seizure. In patients with CCS the improvement of QOL was the most significant. QOL in patients with remaining rare seizures was significantly lower than in CCS group. Clinical efficacy/tolerability, QOL improvement, cost-effectiveness parameters were similar on carbamazepine or valproate, that supports the use of valproate as adequate first-line drugs in patients with SLE. In patients with initial inadequate polytherapy the cost of 100% remission (CCS) after OT (valproate monotherapy) was 125 USD per year. **CONCLUSIONS:** Duration of epilepsy, severity, frequency of seizures have the main impact on QOL. Complete control of seizures is essential for improvement of QOL. Results of pharmacoeconomical analysis support the necessity of OT in epilepsy patients.

**PNP14****PNP15**
**EVALUATION OF THE RELATIONSHIP  
BETWEEN EPILEPSY SEVERITY AND UTILITY**

 Selai C<sup>1</sup>, Kaiser S<sup>2</sup>, Trimble M<sup>1</sup>, Price M<sup>3</sup>
<sup>1</sup>UCL Institute of Neurology, London, Middlesex, United Kingdom; <sup>2</sup>University of Heidelberg, Heidelberg, Germany; <sup>3</sup>Janssen-Cilag, High Wycombe, Bucks, United Kingdom

**OBJECTIVES:** Epilepsy has a significant impact on the patient, with higher frequency of seizures being associated with lower quality of life. The association between utility and epilepsy clinical status is less well defined. In this analysis, we present utility values that were collected during a prospective study of patients with intractable epilepsy and describe the association between utility scores and clinical status. **METHODS:** One hundred twenty-five patients with intractable epilepsy were recruited at a tertiary referral centre in London, UK. At recruitment, each patient was about to start treatment with a new adjunctive anti-epileptic drug (AEDs). Patients were interviewed at baseline, three months and six months. At each visit patients completed a semi-structured interview, the National Hospital seizure severity and frequency scale and the EuroQol EQ-5D. Results are presented for both the EQ-5D tariff and VAS (visual analogue) scores. Clinical response was determined as a 50% or greater reduction in baseline median seizure frequency. **RESULTS:** At baseline, mean EQ utility score was 0.850, (VAS = 65.08). Mean values were lower in patients with higher seizure frequency, with utility scores of 0.798, 0.902 and 0.934 in patients with >10, 2–9 and ≤1 seizure per month, respectively. VAS scores were 62.85, 66.96 and 70.71 for these groups. At 6 months, 20/125 patients had become seizure-free, with a mean utility value of 0.923 (VAS = 77.63), compared with 0.824 (VAS = 66.56) in patients who did not achieve a