depression (3.5%) was mostly unchanged (Baseline-Wk8; P = 0.059). Clinical depression (patient-reported) was associated with increased bothersomeness of other symptoms (fatigue, loss of appetite, nervousness) at Baseline & Wk8 (P < 0.05). CONCLUSIONS: Patient-reported depression outcomes should be valued during HIV treatment, as more patients who were virologically controlled but experiencing Grade 2 PI/NNRTI-associated side effects self-reported signs of clinical depression than were diagnosed by physicians. Prevalence of clinical depression was reduced following substitution to LPV/r.

PIN25

ASSESSMENT OF HEALTH-RELATED QUALITY OF LIFE MEASURES IN HIV AND AIDS
Clayson DJ1, Wild DJ2, Quarterman P3, Coons SJ4, Duprat-Lomon I5, Kubin M6
1Oxford Outcomes Ltd, Oxford, Oxon, UK; 2The University of Arizona College of Pharmacy, Tucson, AZ, USA; 3Bayer Pharma, Puteaux Cedex, Paris, France; 4Bayer HealthCare, Wuppertal, Elberfeld, Germany

OBJECTIVES: The widespread use of highly active antiretroviral therapy (HAART) has greatly prolonged life expectancy in patients with HIV. Therefore, health-related quality of life (HRQoL) has become an increasingly important endpoint in clinical trials to assess interventions for people with HIV. We reviewed the HRQoL measures that have been used in HIV/AIDS since 1990 to establish the most appropriate measures to use in future research and clinical trials. METHODS: A comprehensive, unbiased review of generic and HIV-specific HRQoL measures was conducted using predefined selection criteria. Generic and HIV-specific measures were assessed for practicality (length, administration time and mode), Generic measures were also assessed for their ability to elicit utility data and provide normative values. Measures of HRQoL that were considered practical and were capable of producing utility data and normative values (generic measures) were assessed in detail in terms of their psychometric properties, patient derived content (HIV-specific measures), and use in clinical trials. RESULTS: Two generic measures (EuroQol five Dimension [EQ-5D] and Medical Outcomes Study [MOS] Short Form 36 [SF-36]) and six HIV-specific measures met the initial selection criteria and were reviewed in full. EQ-5D and SF-36 were very similar in terms of the selection criteria and two HIV-specific measures (Functional Assessment of HIV Infection [FAHI] and MOS-HIV) were selected on the basis of their superior psychometric properties. CONCLUSIONS: We recommend using either the EQ-5D with the MOS-HIV, or the SF-36 with the FAHI to assess HRQoL in HIV/AIDS patients when planning future research. Administration of these measures in combination would enable utility scores to be calculated, patient scores to be compared with normative data, and disease-specific HRQoL to be assessed. Future research should concentrate on the sensitivity of the different measures at each stage of infection in patients on HAART.

PIN26

VALIDATION OF 5-ITEM INSTRUMENT FOR ASSESSING SYMPTOM SEVERITY IN PATIENTS WITH ACUTE BACTERIAL SINUSITIS
Taylor DC1, Norman GR2, Torrance G3, Thompson D4, Amorosi SL5, Asche CV6, Patel M7, Lavin B8, Ferguson B9
1Innovus Research, Inc, Medford, MA, USA; 2McMaster University, Hamilton, ON, Canada; 3Innovus Research, Inc, Burlington, ON, Canada; 4Aventis Pharmaceuticals, Bridgewater, NJ, USA; 5University ENT Specialists, Inc, Pittsburgh, PA, USA

OBJECTIVES: To validate a symptom assessment instrument for patients with acute bacterial sinusitis (ABS). METHODS: Data were obtained from a randomized, double-blind, equivalency study of adults with radiographic evidence of ABS treated with telithromycin 800mg od for 5 days (n = 159) or moxifloxacin 400mg od for 10 days (n = 163). A 5-item Acute Sinusitis Daily Symptom Survey (ASDSS) was developed for use in the trial. The five items of the ASDS (nasal congestion, runny nose, postnasal discharge, thick nasal discharge, and facial pain/pressure) used a six-point adjectival scale ranging from zero (“no problem”) to five (“problem as bad as it can be”). Overall ASDSS score was the sum of item responses. Subjects completed the ASDSS daily for the first 17 days of the study. At Visits 1 (Day 1) 2 (Day 3–5), and 4 (Day 17–24), subjects were assessed for quality of life (SF-36, acute form), treatment outcomes (success/failure), and infection-related signs/symptoms. Data were pooled across treatment groups. RESULTS: Survey completion rates ranged from 100% (Day 3) to 79.8% (Day 17). Pearson correlations between the ASDSS items ranged from 0.258 to 0.639. Test-retest intraclass correlation coefficients (ICC) measured over a 5 day interval (Day 1–5) were: nasal congestion (0.681), runny nose (0.612), postnasal discharge (0.689), thick nasal discharge (0.669), and facial pain/pressure (0.679). Cronbach’s alpha was 0.788 and test-retest reliability (ICC) of the total score was 0.694. Pearson correlations between the ASDS and the SF-36 scales at Visit 4 ranged from −0.293 (mental health) to 0.496 (vitality). Pearson correlations with the ASDSS at Visit four were 0.599 for major and 0.634 for minor symptoms of infection. Mean ASDSS scores at Visit four were 3.34 for subjects deemed treatment successes and 10.35 for treatment failures (F = 2.60, p < 0.0001). CONCLUSIONS: The ASDSS appears to be a valid symptom assessment instrument for patients with ABS.

PIN27

WILLINGNESS TO PAY FOR PREVENTION AND TREATMENT OF TUBERCULOSIS (TB) IN RURAL NEPAL: A CONTINGENT VALUATION STUDY
Paudel L1, Adhikari M1, Devkota N2
1The University of Georgia, Athens, GA, USA; 2Louisiana State University, Baton Rouge, LA, USA

OBJECTIVES: In the mountain kingdom of Nepal, nearly 44,000 new cases of the tuberculosis (TB) appear every year. This study explores community valuation of TB prevention by estimating household and community willingness to pay (WTP) for the prevention of transmission and treatment of TB in the rural areas of mid-Nepal. METHODS: A contingent valuation survey was used to assess individual WTP for specific prevention and treatment interventions for TB. In order to estimate confidence limits in mean WTP and to generate a distribution of WTP for the community, accounting for uncertainty in regression coefficients and variability within the population, a two-dimensional Monte Carlo simulation was also developed. RESULTS: The study results show a mean WTP of $0.81 per month per household (90% CL: $0.43, $1.61) to prevent transmission of TB. However, the mean WTP for TB treatment was estimated to be $2.31 per month (90% CL: $1.32, $3.47) per household. Nearly 22% and 47% of household were not willing to pay for prevention and treatment of TB, respectively. As expected, income positively affected estimates of mean WTP for both TB treatment and prevention. An individual’s familiarity with TB and superstitions significantly negatively influenced WTP for treatment and prevention. Contrary to expectation, WTP for TB treatment and prevention was not influenced by religion and ethnicity in the rural villages of Nepal. In our study, sex and health education do not show any significant affects on WTP for transmission prevention and treatment interventions of TB. CONCLUSIONS: These results show that the majority of the community places a positive value on both prevention and treatment of TB. Mean