usage would be needed to identify the reasons and desired outcomes for the use of these agents. This would also potentially derive initiatives that might help rationalise the prescription of these agents.

PCV33

COST ANALYSIS OF A PRIOR AUTHORIZATION PROGRAM FOR ANTI-OBESITY THERAPY IN A MEDICAID POPULATION

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OBJECTIVE: Clinical trials have demonstrated moderate therapeutic efficacy for orlistat and sibutramine, with patients losing between 5–10% of initial body weight. Due to the cost of orlistat and sibutramine and moderate efficacy, Kansas Medicaid chose to use prior authorization to control expenditures on obesity agents. The objective of this study was to determine if differences exist in cost and effect between patients who received PA approval for anti-obesity therapy and those who did not.

METHODS: A retrospective, cohort study was designed in which patients were divided into those that received PA approval for sibutramine or orlistat and those that did not. The payer perspective was used in this study. Cost data included the total direct costs incurred by the Medicaid program including medications, physician office visits, hospital admissions, and administrative costs of the PA program. Effectiveness therapy was measured by the probability of patients achieving greater than 5% loss of initial weight. Independent sample t-tests were used to determine if differences exist between mean costs and effectiveness between the alternatives. RESULTS: Patients who received PA approval for orlistat/sibutramine incurred $16,730 ± $20,185 in average total costs over the study time period compared to $12,527 ± $18,702 for patients who did not (p = 0.02). Average initial weights and BMIs for patients who received drug therapy were 286 pounds and 43.4 kg/m² respectively, while patients who didn’t had average initial weights of 255 pounds and BMI of 38.9 kg/m². Patients who received anti-obesity therapy met the effectiveness goal 33% of the time, compared to 5% of the time for a patient who didn’t (p < 0.001). CONCLUSION: The average cost per Medicaid beneficiary was $4203 higher for those patients who received prior authorization approval for anti-obesity therapy compared to those who did not. However, patients also had a significantly higher probability of losing weight.

CARDIOVASCULAR DISEASE (including Obesity)

CARDIOVASCULAR DISEASE (including Obesity)—Quality Of Life/Patient Preference/Adherence Studies

PCV34

QUALITY OF LIFE FROM THE MINNESOTA LIVING WITH HEART FAILURE QUESTIONNAIRE FOLLOWING AORTIC VALVE REPLACEMENT SURGERY

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OBJECTIVE: Quality of life instruments may be generic or more disease specific. We were interested in disease specific quality of life in patients following aortic valve replacement.

METHODS: We surveyed 743 patients following aortic valve replacement surgery. The survey instruments were the SF-36 and the Minnesota Living with Heart Failure Questionnaires. MLwHF scores are computed by adding scores ranging from 0 to 5 on 21 questions, yielding total summary scores of 0 to 105 with higher scores indicating poorer quality of life. All patients were also part of an adult cardiac database that included prospectively collected information on demographics, diagnosis and surgical course. One-way analysis of variance (ANOVA) tests were used to compare continuous demographic, pre-operative, operative, and post-operative variables, and MLwHF scores across different valve types. RESULTS: Three hundred twenty-nine patients (43%) returned surveys. There were no differences in age, gender or valve type received between responders and non-responders. Of the respondents, 226 were male and 103 were female. The average age was 61.8 (standard deviation = 13.9, range 15 to 90). The majority of patients [222 (67.48%)] received the Medtronic Freestyle stentless bioprosthetic valve, 16 (4.86%) received stented bioprosthetic valves, 56 (17.02%) received mechanical valves, and 13 (3.95%) received homografts. The MLwHF found homograft recipients to have on average poorer QoL (as reflected by higher MLwHF scores), but these differences were not significant. No significant differences were seen in MLwHF scores across valve types. Patient Mean & Standard Deviation scores for respective categories: Physical 10.45, 10.43; Emotional 5.04, 6.23; Total 23.28, 22.71. CONCLUSIONS: Our study suggests that 5 to 10 years after AVR no single valve type has a clear QoL advantage and confirms previous reports that age-matched population QoL norms can be achieved in many domains. Postulated advantages and disadvantages of stentless valves did not seem to have any net effect on QoL.

PCV35

VALIDATION OF THE EQ-5D QUESTIONNAIRE IN PATIENTS WITH A HISTORY OF ACUTE CORONARY SYNDROME

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OBJECTIVE: To analyze the construct validity, criterion validity, and the acceptance and understanding of the EQ-5D in patients with acute coronary syndromes (ACS).

METHODS: All ACS-diagnosed patients discharged from a university-affiliated hospital during a 3-year period were mailed a questionnaire that included the EQ-5D and the SF-8. The EQ-5D includes a 100-point visual analogue scale (VAS) to measure self-reported current health-state and five items measuring mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Also included were disease severity measures [Duke Activity Status Index (DASI), cardiac symptom count (SC), patient-perceived cardiac disease severity], comorbidity measures (Charlson comorbidity index, total medication count), and other demographic and disease-related items. RESULTS: Of 1217 patients, 490 (40.3%) responded. Patients averaged 65.2 (± 11.3) years of age; 71.0% male; 91.9% Caucasian; 64.3% history of MI. Acceptance and understanding appeared high with only 0.2%–0.4% of EQ-5D items and 8% of the VAS unanswered. Correlations between the VAS score and DASI/SC/patient perceived severity were $r_1 = 0.741 (p < 0.0001). Levels of responses to EQ-5D items and the VAS score were significantly better for patients with very mild/mild perceived disease severity compared to severe/very severe, and for patients with a DASI ≥ 18 compared to a DASI ≤ 18. VAS score and SF-8 subscale score correlation coefficients ranged from 0.526–0.764 (all p < 0.0001). Significant differences were observed between the response level of individual EQ-5D items and scores of comparable SF-8 subscales. The nine most common health states were identified based on the five EQ-5D item scores. As health status diminished there was a decline in the VAS, DASI and satisfaction with current health state, and an increase in the perceived severity, comorbidity score, SC, and medication count.
Abstracts

PCV36

THE IMPACT OF ACEI RELATED COUGH: A SURVEY OF AUSTRALIAN PATIENTS

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OBJECTIVES: Cough is a widely recognised adverse effect of Angiotensin-converting enzyme inhibitors (ACEI) and has been linked to poor medication compliance and potentially poorer quality of life (QoL). Clinically, AIIIRAs (Angiotensin II receptor antagonists) have been shown to reduce the occurrence of cough relative to ACEIs. This study was designed to determine the impact of cough on patients’ QoL by using generic and cough-specific QoL measures and contingent valuation (CV) methodology. METHODS: Ninety-one patients currently on ACEIs and 48 patients switched from ACEIs to AIIIRAs were recruited from across Australia. Both groups were asked to complete the World Health Organisation Quality of Life questionnaire (brief version) (WHOQoL-Bref) and to answer general questions on smoking cessation, health and demographics. Those on ACEIs also completed the Cough-specific Quality of Life Questionnaire (CQLQ). A CV question, which gave the participants the choice between an ACEI and an AIIRA was asked. The CV health states were based on clinical trial data. RESULTS: Respondents ranged in age from 38–81 years (mean = 58.4 years) in the ACEI group, and 31–82 years (mean = 55.6 years) in the AIIRA group. A significant relationship between cough severity and QoL existed for the CQLQ (p = 0.003) and the WHOQoL-Bref (p = 0.025) in the ACEI group. Cough severity was significantly related to difficulty of sleeping (p = 0.009), being self-conscious (p = 0.015), and exhaustion (p = 0.002). The CV analysis for the AIIRA scenario yielded a mean willingness-to-pay of AUS$16.80 per month for those on ACEIs and AUS$16.20 per month for those on AIIIRAs. CONCLUSION: Overall, the results from this study illustrate the impact that ACEI-induced cough has on quality of life. Both patient groups were willing to pay over AUS$16 per month to experience effective hypertension control associated with a lower risk of experiencing cough. This suggests that the impact of cough on QoL may be more than previously considered and should be considered when selecting anti-hypertensive treatment.

PCV37

HEALTH-RELATED QUALITY OF LIFE OF PATIENTS MAKING AN ATTEMPT AT SMOKING CESSION

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OBJECTIVE: To assess the acute effects of smoking cessation on health-related quality of life (HQL). METHODS: Questionnaires were mailed to patients enrolled in a smoking-cessation program just prior to quit date (T1) and 1-week post-quit (T2). HQL was assessed by the Smoking Cessation Quality of Life Questionnaire (SCQoLQ). It contains 5 cessation-targeted scales: social interactions, self-control, sleep, cognitive-functioning, and anxiety. The SF-36 is included as a generic core. Other data included patient demographics, duration of smoking, Fagerstrom scale, and smoking status at T2. Student’s t-test for paired data was used to compare the T1–T2 HQL scores. Student’s t-test for independent samples compared the HQL of a higher addiction (HA) group (Fagerstrom > 6) to a lower addiction (LA) group (Fagerstrom < 6). RESULTS: Respondents (n = 34, 12 in HA-group, 22 in LA-group) averaged 48.6 (±12.0) years of age and were primarily Caucasian (97%) and female (72.2%). The mean Fagerstrom score was 5.0 (±2.3). Overall, one week into cessation (T1 to T2) there was significant worsening in SCQoLQ anxiety (71.5 ± 25.1 to 61.1 ± 26.0, p = 0.04) and cognitive-functioning (72.2 ± 20.4 to 61.3 ± 23.9, p = 0.02) scores and improved self-control (46.5 ± 22.2 to 51.1 ± 18.5, p = 0.001) and SF-36 general health (65.2 ± 18.4 to 70.5±16.9, p = 0.01). At T1, all LA-group HQL scores were higher than HA-group scores, significantly for sleep, cognitive-functioning, anxiety, and SF-36 role-emotional and mental-health. Between T1 and T2 there was significant decline in sleep, cognitive-functioning, and anxiety and improved self-control in the LA-group; the HA-group had significant improvement in self-control and SF-36 general health, but no significant changes in other scores. All SCQoLQ scores at T2 for LA were higher than either the T1 or T2 SCQoLQ scores for the HA. CONCLUSIONS: Generally, HQL changes one-week into a smoking cessation attempt. Smokers with higher addiction have lower HQL when they begin their cessation attempt, while smokers with lower addiction have greater change in their HQL.

PCV38

HEALTH-RELATED QUALITY OF LIFE IN AN ACUTE CORONARY SYNDROME POPULATION IS AFFECTED BY DEPRESSION TREATMENT ADEQUACY

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OBJECTIVES: 1) To determine the prevalence of depression symptoms and to describe antidepressant treatment in a population with a history of ACS, and 2) To describe the relationship of depression treatment adequacy and health-related quality of life (HRQL) controlling for patient, treatment and disease characteristics. METHODS: All ACS-diagnosed patients discharged from a university-affiliated hospital during a 3-year period were mailed a survey that included the SF-8, EQ-5D and other self-reported measures of disease and treatment (e.g. physical functioning, comorbidity, medication compliance, perceived cardiac severity). Patients were categorized based on self-report of depressive symptoms and antidepressant medication. Adjusted mean HRQL measures were determined by least square mean analysis controlling for independent variables. RESULTS: Of 1217 patients, 490 (40.3%) responded. Respondents averaged 65.2 (± 11.3) years of age; 71% male; 92% Caucasian; 64% with MI history; 17% had their most recent cardiac event within 6 months. No depressive symptoms and no depression treatment (without depression) were reported by 59.8%; 27.6% reported untreated depressive symptoms (untreated); 8.6% reported depressive symptoms and antidepressant medication (under-treated); and 4.1% reported no symptoms and antidepressant medication (adequately treated). Adjusted mean SF-8 Mental Component Summary (MCS-8) scores were 52.8, 52.5, 42.8, and 40.2 for patients without depression, adequately treated, untreated, and undertreated respectively (p < 0.0001 for all pairwise comparisons except for patients without depression vs. adequately treated and untreated vs. undertreated). The only other significant pairwise HRQL comparison was between the adjusted mean general health VAS scores for nondepressed and