discontinued medication. The most commonly cited reason for discontinuation was the medication(s) did not work well (35%); side effects was the second most common reason (20%). Additional reasons included lack of need for frequent use (17%), cost of treatments (11%), and dislike of taking pills all the time (12%). When asked about medication-taking behaviors, 155 (21%) out of 752 patients taking oral medications reported skipping doses. Reasons for skipping doses included forgetting to take medication (68%), dislike of taking pills all the time (14%), and cost of medication (10%). Of those reporting skipping doses of medications, 41% reported this occurs every couple of weeks; 30% and 25% reported it occurs weekly and monthly respectively. Only 4% reported daily skipping of doses. CONCLUSIONS: A significant portion of BPH patients using oral treatments reported discontinuing therapy due to lack of efficacy and a variety of other reasons. Skipping doses was also a problem for over 20% of patients taking oral medications.

PIH13

COMPLIANCE WITH PRESCRIBED ONCE A DAY PLACEBO IN ADOLESCENT HEALTHY VOLUNTEERS

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OBJECTIVES: The objective of the present study is to describe the compliance observed with a prescribed once a day placebo over a 28 days period in adolescent healthy volunteers, in school-dwelling youngsters in Belgium. METHODS: Eighty students were asked to take a placebo once a day during 28 days. Tablets supply was dispensed by sequences of 14 days either in an electronic pill box (MEMS®) or in an electronic blister pack (Cerepak®) according to a crossover design. Both devices allowed real time electronic compilation of dosing histories. At the end of the study, students were asked to assess their own compliance with a structured questionnaire. RESULTS: Compliance data were available for 78 students. We observed no difference in compliance between the two monitoring devices (p = 0.682), nor between periods (p = 0.462), and no carry-over effects (p = 0.599). 46% of the students took most of their doses in the morning (before 10:00 AM) and 49% in the evening (after 04:00 PM). Compliance was higher (p = 0.016) among the students who took their pills in the morning (92% vs 85%). Only 9 (11%) students took all of the 28 prescribed doses and 36 (46%) missed more than 5 doses. There was a strong weekend effect. The probability to take a tablet on a Friday or a Saturday was reduced by 30% (p < 0.0001). Only 58% of the subjects were able to estimate reasonably well their compliance with the prescribed regimen. CONCLUSIONS: To be compliant with drug therapy is a burden for the majority of adolescents, most of whom are in good health and have little experience with taking medicines. Evening and weekend discipline seems to be problematic. No differences in compliance by measuring device were observed. When precise assessment of compliance is crucial for the interpretation of study results, electronic monitoring should be used, especially in adolescent populations.

PIH14

RECALL PERIODS FOR SATISFACTION WITH SEXUAL INTERCOURSE: TWO APPROACHES FOR ASSESSING OUTCOMES

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OBJECTIVES: The recall period associated with any patient-reported outcome (PRO) measure is critical to the interpretation of the measure. However, the most appropriate recall period is often unclear. The objective of this analysis was to compare responses to two satisfaction with sexual intercourse (SSI) measures with different recall periods. METHODS: Sexual health data and intravaginal ejaculatory latency time (IELT) were collected from 1115 men and their female partners as a part of a two-month observational study of men with and without premature ejaculation (PE) from five European countries. Data from men diagnosed with PE are included in this analysis (n = 196). IELT was measured by a female-operated stopwatch and recorded by the male subject on an event log. Two single-item measures of SSI were collected: 1) “Over the past month, was your satisfaction with sexual intercourse: 0 = very poor, 1 = poor, 2 = fair, 3 = good, or 4 = very good?” and 2) “Were you satisfied overall with this sexual experience?” (yes/no). Responses to the first item were recorded by the male subjects at the study site. The second measure was assessed following each sexual intercourse and recorded on the event log along with the IELT. For this per-event item, a mean percentage SSI was computed for each subject over a one-month period so that the recall periods for the two measures were comparable. RESULTS: There was a strong association between SSI measures based on one-month recall and the percentage of satisfactory sexual experiences based on the event log data: Very poor (Mean = 12.6%, SD = 29.4%, n = 11), Poor (Mean = 24.0%, SD = 19.0%, n = 49), Fair (Mean = 63.7%, SD = 25.0%, n = 66), Good (Mean = 85.6%, SD = 16.8%, n = 52) and Very good (Mean = 95.6%, SD = 7.3%, n = 18). CONCLUSIONS: Measures of SSI assessed on a per-event basis and using a one-month recall period are highly associated suggesting that either measure could be used to assess outcomes related to SSI among men with PE.

PIH15

BARRIERS TO COMMUNICATION ABOUT ERECTILE DYSFUNCTION IN PATIENTS TAKING ANTIHYPERTENSIVE MEDICATIONS

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OBJECTIVES: To evaluate barriers to communication about erectile dysfunction (ED) and their impact on patient-reported outcomes. METHODS: Male participants in the May 2004 internet-based National Health and Wellness Survey (NHWS) who reported being married/living with a partner, difficulty achieving/maintaining an erection but had not spoken with a physician about ED, and taking medication for blood pressure were recontacted in December 2004. Patients were asked whether they had spoken with a physician about ED since the May 2004 survey and barriers to communication about ED. ED status and severity were confirmed with the Erectile Function (EF) domain of the International Index of Erectile Function. Data were also collected from the SF-8, Erectile Distress Scale (EDS), and the 2004 NHWFS. RESULTS: Of the 233 ED patients who were recontacted and completed the questionnaire, 31% reported speaking with their physician about ED. Patients who spoke (vs did not speak) with their physician were younger (63 vs 67 y, P = 0.008), had less severe ED (EF domain score, 12.1 vs 7.7, P < 0.001), and were more distressed about ED (EDS scores, 4.1 vs 4.7, P = 0.002). Among those who spoke with their physician, 83% initiated the discussion, and the most common motivator was their spouse; 32% reported currently taking a phosphodiesterase type 5 inhibitor. Fifty-seven percent of these patients waited ≥ 1 year before discussing ED with their physician, most commonly because of a belief that ED was a natural part of aging (42%). Of those who did not speak with their