the CE of OAB treatments isn't this simple, however, and further research is needed to assess changes in resource consumption due to treatment.

PRK6

EVALUATING THE COST OF LONG-ACTING TREATMENTS FOR OVERACTIVE BLADDER

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OBJECTIVES: To compare the estimated first-line treatment costs of extended-release tolterodine versus controlled-release oxybutynin in patients with overactive bladder patients (OAB). **METHODS:** Data from a randomized clinical trial (Curr Med Res Opin 2002; 18:177–184), showing greater improvement in bladder condition for patients taking extended-release tolterodine compared to controlled-release oxybutynin (70% vs. 60% in all patients, 75% vs. 54% in patients with prior therapy, and 69% vs. 61% in treatment naïve patients), was used to conduct the analyses. The analysis input trial outcomes into an existing decision analysis model that had shown extended-release tolterodine was 6.3% less expensive than controlled-release oxybutynin in terms of the cost of treatment. Analyses were constructed from the payer perspective; all costs are given in 2000 U.S. dollars. **RESULTS:** The decision analysis model yielded results that ranged between a 5.7% and 7.0% total cost of treatment advantage for extended-release tolterodine in the treatment of all patients. This cost advantage was 5.1%–6.3% for treatment-naïve patients and 8.9%–10.8% for previously treated patients. The variation in the results depended on the model timeframe chosen (12, 14, or 16 weeks). Sensitivity analyses showed these results to be stable. **CONCLUSIONS:** Results from these analyses confirm earlier studies that, for patients with OAB and initiating long-acting pharmacologic therapy in the primary care setting, treatment with extended-release tolterodine is less costly than treatment with controlled-release oxybutynin. Additional studies directly comparing these treatment alternatives are needed to further confirm these results.

URINARY & KIDNEY DISEASES/DISORDERS—Quality of Life

PRK7

PATIENTS ARE SATISFIED WITH TELEMEDICINE (HOME-CARE)

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OBJECTIVES: Since satisfaction for telemedicine is ill-defined (Mair, 2000) and no standard measurement tool is available, we developed a self-administered Questionnaire of the Satisfaction for Telemedicine (QueST). **METHODS:** Domains of satisfaction were: 1) global satisfaction; 2) user-friendliness; 3) relationship with the medical center; 4) coping; 5) everyday life; 6) expectations about telemedicine; and 7) detailed judgment. Answers were provided through a 4–5 degrees Likert scale; the overall score was standardized to a maximum value of 100. After a probe technique, the final QueST was administered to 26 patients on telemonitoring (transmission of subjective/objective data to an automatic call center or web server) for peritoneal dialysis or heart failure. **RESULTS:** Mean age of the patients was 57.3 years (range 43–74); 81% were males. Electronic devices (cellular phone or teletext) were daily used by 73% of the patients, but computer by only 34% of them. Mean satisfaction score was 72 (48–91): 29% of the patients were highly satisfied with telemedicine either by considering those with an overall score >= 80 or by assessing the answer in the first domain. However, a detailed elicitation of patients judgement on telemedicine showed that 60% of them were very satisfied with it. Some users (24%) declared to have some practical difficulties with telemedicine but 88% of them expected a future benefit from telemedicine. Both the relations with the referral center, quality of daily life and coping ability improved during the period on telemedicine in 73%, 77%, 81% of the patients, respectively. Willingness to pay for one year of telemedicine was on average €81: 22% of the patients were willing to pay for more than €90. **CONCLUSIONS:** Acceptability of telemedicine is high and its impact over the perceived quality of care is relevant. Nevertheless, patients are willing to have this service included into their usual health care with no or little extra costs. From the patients perspective, telemedicine should be implemented by the National Health Care System.

PRK8

HEALTH RELATED QUALITY OF LIFE (HRQOL) IN CHRONIC DIALYSIS PATIENTS: A CRITICAL COMPARISON OF CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) AND CENTRE HEMODIALYSIS (CHD)

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OBJECTIVE: To evaluate the role of treatment approach (CHD or CAPD) on the self-perception of QoL in uremic patients. Cross-sectional matched pair study of CHD and CAPD subjects. **METHODS:** Sixty-two matched pairs of patients (30 M and 32 F), median age 59 years were studied. The CHD and CAPD groups were similar for demographic and social variables. Higher percentage of patients with diuresis >500 ml/die and hypertension were registred in CAPD patients. Nutritional Status was

evaluated by Subjective Global Assessment (SGA). The comorbidity of each patient was stratified by Index of Co-Existent Disease (ICED). The MOS-Short Form 36 questionnaire was filled at home by patients to evaluate their HRQoL. The eight multi-items scales, General Health (GH), Role Physical (RP), Physical Function (PF), Role Emotional (RE), Social Function (SF), Bodily Pain (BP), Emotional Well-Being (EW-B), Energy/Fatigue (EF) were summarized into two scores: Physical Component Score (PCS), Mental Component Score (MCS).The scores were expressed as median value. U-Mann Withney test was used to compare the scores of the eight domains measured by SF-36. QoL correlates were investigated with a series of logistic regression analyses, where questionnaire scores, dychotomised using the median value as cut-off, were the depend variables. Results are thus expressed in terms of Odds Ratio. **RESULTS:** The patients on CAPD had a better, but not statistically significant, self-perception of GH, SFand BP. The scores of the other domains were significantly better in CAPD than in CHD patients (RP: 37vs37p < 0.02; PF: 75vs20p < 0.001; RE: 83vs20p < 0.0002; EWB: 50vs45p < 0.0001; EF: 64vs52p < 0.01; PCS: 40vs36p < 0.05; MCS: 43vs39 p < 0.05). Among clinical correlates, female sex (OR: 3.34–95% CI: 1.12–9.03 p < 0.002), age > 58 years (OR: 3.81–95% CI –1.33–10.9 p < 0.01), SGA ≥ 1 (OR: 5.6–95% CI: 1.8–17.5 p < 0.001) high comorbidity (OR: 2.25–95% CI: 1.5–13.4 p < 0.005) were significantly associated to lower values of PCS. MCS was lower in patients with diuresis <500 ml/die. **CONCLUSIONS:** Patients on CAPD had a better self-perception of QoL until significant diuresis was manteined.

PRK9

PATIENTS TREATED WITH SERENOA REPENS: EVOLUTION OF THE IPSS SCORES IN TERMS OF IRRITATION AND OBSTRUCTION

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OBJECTIVE: The degree of severity of the undesirable mictional problems caused by BPH is assessed according to the scores obtained in the acknowledged and validated IPSS questionnaire. **METHOD:** In accordance with the WHO recommendations, the IPSS was proposed to patients (n = 189) in the form of a self-questionnaire with the aim of analyzing the obstruction and irritation scores for the patients suffering from a recently diagnosed BPH and treated with Serenoa Repens. **RESULTS:** The IPSS obstruction score was respectively 6.7 (3.8) and 5.9 (3.5) upon patient inclusion and after six months. This noted difference is statistically significant (p < 0.0001). The IPSS irritation score was respectively 5.5 (2.6) and 4.5 (2.3) upon patient inclusion and after six months. This difference is here statistically significant with p < 0.0001. **CONCLUSION:** Treatment by first intention with Serenoa Repens thus showed a significant improvement as demonstrated by both the obstruction and irritation scores.

PRK10

PATIENTS TREATED WITH SERENOA REPENS: EVOLUTION OF THE SCORES SPI AND SF12

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OBJECTIVE: Undesirable mictional problems caused by a BPH have been found in 20 to 25% of the male population over 50 years old. This condition can thus be considered as a public health problem that offers many aspects in terms of diagnosis, therapeutics or economics. **METHOD:** Within the framework of a follow-up cohort study, a patient population suffering from a recently diagnosed BPH and treated with Serenoa repens (n = 158) was asked to fill in questionnaires SF12 and SPI upon inclusion and 6 months later. **RESULTS:** When looking at the SF-12, the results were organized in 2 types of scores: psychological (MCS-12) and physical (PCS-12). The SF12 scores upon patient inclusion were: PCS-12 = 41.7 and MCS-12 = 46.5. The SF12 scores after 6 months were: PCS-12 = 45.4 and MCS-12 = 46.9. These results bring out a significant improvement in the physical dimension of the SF-12 (p < 0.0001). The SPI score upon patient inclusion was 12.6 and reached 10.8 after 6 months of treatment. This improvement is statistically significant (p < 0.0001). **CONCLUSION:** Treatment by first intention with Serenoa repens thus showed a significant improvement as demonstrated by the 2 validated scales, SF12 and SPI.

PRK11

BPH AND IPSS SCORES EVALUATED AFTER SIX MONTHS ACCORDING TO THE TYPE OF DISEASE MANAGEMENT

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OBJECTIVE: Undesirable mictional problems caused by a BPH—benign prostatic hypertrophy—have been found in 20 to 25% of the male population over 50 years old. This condition can thus be considered as a public health problem that offers many aspects in terms of diagnosis, therapeutics or economics. **METHOD:** Using a follow-up cohort study, we isolated two groups presenting a recently diagnosed BPH: the first patient population was kept under medical supervision (n = 101) versus a second patient population undergoing treatment with Serenoa Repens (n = 112). **RESULTS:** For the patients under medical supervision, the IPSS score was respectively 11.8 (5.7) and 10.9 (6.7) upon patient inclusion and after 6 months. This difference is not statistically significant. However, for the patients treated with Serenoa Repens,