measurements like waist circumference (WC) may define obesity and explain its health consequences. The objective of this study was to determine if utility (EQ5Dindex) varied by BMI category, as WC varied. METHODS: This retrospective study used the latest data from the England Health Survey (2003). A general linear model (GLM) was developed that included factors associated with utility, standardising for age and sex to generate estimates of utility with relation to obesity (obesity categories: normal [NI, BMI 18.5–24.9 kg/m^2], overweight [OV, 25.0–29.9 kg/m^2], obese [OB, ≥30 kg/m^2], and thirties of WC, L = low, M = medium, and H = high). RESULTS: The standardised mean utility by BMI category for men was: NI = 0.877, OV = 0.894, OB = 0.858. Standardised mean utility by BMI category for women was: NI = 0.879, OV = 0.871, OB = 0.812. Standardised mean utility by WC category for men was: L = 0.887, M = 0.877, H = 0.866. Standardised mean utility by WC category for women was: L = 0.872, M = 0.857, H = 0.833. BMI and WC were dependent and interacting determinants of utility. For females in the nine obesity groups, the standardised mean utility was as follows: NI/L = 0.878, NI/M = 0.877, NI/H = 0.882, OB/L = 0.896, OB/M = 0.873, OB/H = 0.844, OB/L = 0.842, OB/M = 0.822, OB/H = 0.774. For men: NI/L = 0.862, NI/M = 0.882, NI/H = 0.888, OV/L = 0.907, OV/M = 0.893, OV/H = 0.883, OB/L = 0.892, OB/M = 0.856, OB/H = 0.828. CONCLUSIONS: In both women and men, the highest EQ5Dindex, values (best QoL) was evident in overweight people with a low WC. A reduction in WC in obese people resulted in a greater gain in utility than the same change in normal or overweight people. Use of both BMI and WC, rather than a single measure of obesity, provided a more precise prediction of health-related utility. Utility varied more widely as a function of waist circumference in higher BMI categories.

**PBO10**

**VALIDATION OF A PATIENT-REPORTED OUTCOMES QUESTIONNAIRE FOR ASSESSING POSITIVE WELL-BEING ASSOCIATED WITH BEHAVIORAL CHANGES**

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Based on 31 concept-elicitation interviews of former smokers and individuals who wanted to lose weight, a questionnaire was developed simultaneously in three languages (French, US-English and US-Spanish). Draft items were generated in each language and culturally adapted into Spain-Spanish and UK-English. Face validity was assessed through 30 cognitive debriefing interviews; resulting in a 27-item questionnaire. OBJECTIVE: To validate a questionnaire that investigates the positive well-being associated with behavioral changes in adults. METHODS: The psychometric properties of the questionnaire were examined in US-English, US-Spanish and French through a stand-alone study in former smokers and individuals who wanted to lose weight. RESULTS: Based on an initial Principal Component Analysis (PCA) and item-item correlation analysis, 18 items were retained. A final PCA indicated that the questionnaire encompassed five dimensions: Serenity; Healthy Lifestyle, Support from Others, Self-Confidence, and Social LIfe. The questionnaire surpassed the threshold for internal consistency reliability for all dimensions and globally (Cronbach’s alpha > 0.8) in both behavioral changes and in all languages. All items surpassed the criterion for item-convergent validity and item-discriminant validity was satisfactory for 17/18 items. Correlations between the questionnaire and the Psychological General Well-Being index (PGWBi) scores confirmed its validity and indicated that it supplements information obtained through the PGWBi. Known-groups validity was satisfactory in individuals who wanted to lose weight based on the amount of weight lost, BMI reduction and number of weight loss attempts, but was inconclusive in former smokers because the abstinence status and the discontinuation of smoking cessation aids were not confirmed. CONCLUSION: Results support the reliability and validity of this questionnaire making it a useful tool for determining the positive well-being associated with behavioral changes. The questionnaire is currently undergoing additional validity testing in a population where smoking status is assessed.

**URINARY/KIDNEY**

**PUK1**

**THE TIMELY CONSTRUCTION OF AN ARTERIOVENOUS FISTULAE: A KEY FACTOR IN REDUCING MORBIDITY AND MORTALITY AND IMPROVING ECONOMIC EFFECTIVENESS**

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OBJECTIVE: To analyze morbidity, mortality and the impact on cost-effectiveness caused by the delay in having adequate arteriovenous fistulae (AVF) at start of periodic hemodialysis (PHD).

METHODS: Prospective study of 110 patients who started PHD between January 1st 2002 and July 31 2004 with creatinine clearance of 5–10 mL/minute/1.73 m^2. Data: sociodemographic, Charlson Comorbidity Index (CCI), type and duration of the vascular access (VA), “de novo” morbidity and hospitalisations. Patients were separated into three groups according to the VA at start PHD (AVFgroup): Group 1(G1) having an adequate functioning AVF before initiating HD; group 2(G2) not having an AVF at the start of HD, but having it before three months; group 3(G3) using catheters during the first three months. Patients who had a delayed nephrology referral, those who suddenly started PHD and those with Diabetes mellitus were excluded because these are mortality risk factors. RESULTS: There were no significant differences between the three groups with respect to initial variables of patients: age (p = 0.10), sex (p = 0.45), diagnostic of renal disease (p = 0.24) and CCI (p = 0.76). G1 patients had lower “de novo” morbidity and less hospitalisations (p = 0.000). A logistic regression was applied with morbidity and hospitalisations as dependent variables and age, sex, CCI and AVF-group as co-variables: G2 and G3 were independently associated with higher morbidity and hospitalisations (p < 0.01). Kaplan-Meier analysis showed that G1 had better survival than G2 and G3 (33 months vs. 27 and 24); and patients without morbidity had better survival than those with. The Cox Regression (time dependent model) analysis showed that not having an adequate AVF at start of PHD (G2 and G3) reduced survival (RR:11.32; CI:1.06–120.6). Cost-effectiveness analysis showed that G1 patients with respect to G2 and G3 had better survival and lower cost per live gained month. CONCLUSIONS: “De novo” morbidity caused by not having a adequate AVF at start of PHD considerably decreases survival and implies higher cost.