cantly improves OAB symptoms and is associated with less office visit utilization. Thus, initiating patients on medica-
tion, rather than trying a step-wise care approach, may be a cost-effective means to manage symptoms of OAB.

THE RELIABILITY AND VALIDITY OF A NEW OAB-SPECIFIC HRQL QUESTIONNAIRE (OAB-Q)
Coyne K1, Abrams P2, Revicki D3, Herzog R1, Hunt T*
1MEDTAP International Inc, Bethesda, MD, USA; 2Bristol
Urological Institute, Bristol, UK; 3University of Michigan, Ann
Arbor, MI, USA; 4Pharmacia, Peapack, NJ, USA

OBJECTIVES: Most health-related quality-of-life (HRQL)
bladder questionnaires address the impact of incontinence;
however, OAB includes frequency and urgency symp-
toms without incontinence. Thus, a questionnaire was
developed to assess the impact of OAB on HRQL in pa-
tients with and without incontinence. METHODS: The
61-item self-administered OAB-q contains a symptom
and HRQL scale. Both the OAB-q and the SF-36 were
completed by participants recruited from: 1) a community
sample who screened positive for OAB in a tele-
phone survey and participated in a clinical validation
study (n = 254); 2) a clinical study for those seeking
 treatment for OAB symptoms (baseline)(n = 736). Item
analysis and exploratory factor analysis (EFA) were
performed to assess factor structure. Psychometric evalu-
ation was conducted to assess internal reliability and va-

didity. RESULTS: Of the 911 participants, the clinical
diagnoses were; normal = 130, OAB with incontinence
(OAB-I) = 552, OAB without incontinence (OAB-C) =
229. Mean age = 59.5; 74.4% were women. EFA re-
vealed 1 domain for symptom distress and 4 domains for
HRQL: coping, concern/emotional, sleep and social in-
teractions. Both OAB-I and OAB-C participants reported
significantly greater symptom distress and HRQL impact
than normals. Significant differences between OAB-I and
OAB-C participants were present in all OAB-q subscales
except sleep where both groups were highly affected. In-
ternal consistency reliability of the symptom distress scale
was 0.86 and the HRQL subscales ranged from 0.88–
0.94. The OAB-q subscales correlated moderately well
with the SF-36 subscales (r = 0.17–0.52) providing valid-
ity evidence. The OAB-q was reduced to 34 items: 8
symptom distress and 26 HRQL items. CONCLUSIONS:
The OAB-q is a reliable and valid instrument that can
discriminate between clinically-diagnosed normal, OAB-I
and OAB-C participants. As the first OAB-specific
HRQL questionnaire, the OAB-q demonstrates that OAB
with and without incontinence causes significant symp-
tom distress and has a negative impact on HRQL.

CLINICAL CORRELATES WITH
HEALTH-RELATED QUALITY OF LIFE SCORES
AND SUBSCALES AMONG CONSULTING AND
NON-CONSULTING INDIVIDUALS WITH
STRESS URINARY INCONTINENCE
Rao S, Bowman L, Buesching D
Eli Lilly and Company, Indianapolis, IN, USA

OBJECTIVES: To measure clinical parameters and
health-related quality of life using the incontinence qual-
ity of life (I-QOL) instrument among consulting and
non-consulting stress urinary incontinence (SUI) patients.

METHODS: The I-QOL is a self-administered instru-
ment that contains 22 items yielding a total score as well
as three subscale scores (avoidance and limiting behav-
iors, psychosocial and social embarrassment). Physicians
and consulting patients were identified in the UK, Ger-
many, France, Italy, Netherlands and the US. Study par-
ticipants completed questionnaires to obtain diagnostic
treatment and information for patients and to also gather
details on demographics, symptoms and quality of life.
The non-consulting patients (those who did not consult a
doctor) were also asked to complete questionnaires re-
garding their symptoms and quality of life. Statistical
analysis included t-tests and multiple regressions, adjusting
for multiple comparisons using Hochberg's method.
The analysis consisted of associations between I-QOL
measures and treatment variables, diagnostic tests and se-
verity of symptoms among consulting and non-consulting
SUI patients. RESULTS: A sample of 2174 SUI consult-
ing patients and 809 SUI non-consulting patients partici-
pated. Multivariate analysis showed that pad use among
consulting patients was a predictor of the psychosocial
subscale score (t = -3.52, p < 0.01) whereas leakage
during exercise predicted the avoidance and limiting behav-
ors subscale scores among non-consulting SUI pa-
tients (t = -4.47, p < 0.05). The non-consulting SUI pa-
tients were younger than the consulting SUI patients (t =
-8.99, p < 0.0001). There were no statistically signifi-
cant differences in employment and marital status be-
tween the two groups. CONCLUSIONS: There were dif-
fences in association between the I-QOL subscores and
symptom severity among consulting and non-consulting
SUI patients. There was a significant age difference be-
tween the non-consulting and consulting SUI patients.
Evaluation of I-QOL differences between consulting and
non-consulting patients will require additional study.

THE INFLUENCE OF RACE ON SF-36 SCORES OF
DIALYSIS PATIENTS
Boening AJ1, Chapman MM1, Brown RH2, Zager PG1, Meyer KB1
1New England Medical Center; Boston, MA, USA; 2Dialysis
Clinics Inc, Albuquerque, NM, USA

OBJECTIVES: African-Americans represent one-third of
dialysis patients and are known to live longer than Cau-
African-American dialysis patients. Previous reports suggest they also have better health status. The health status of African-Americans and Caucasians has not been compared using the SF-36. We hypothesize that SF-36 scores for African-Americans will be better than for Caucasians. METHODS: This retrospective analysis compares 6,509 African-Americans (mean age 55 years, 48% male, 34% diabetes as primary diagnosis) to 7,715 white patients (mean age 60 years, 56% male, 37% diabetes as primary diagnosis) from one dialysis chain. Health status is measured by a single administration of the SF-36 between 10/30/90 and 10/30/00. Clinical variables are assessed. RESULTS: For all domains except Role Emotional, African-Americans report better health status, despite univariate analysis showing significantly worse hematocrit, dialysis adequacy (Kt/V), creatinine, hypertension, and socioeconomic status (all: p < .01). CONCLUSIONS: Despite worse results on clinical parameters and lower socioeconomic status, African-American dialysis patients report better SF-36 scores than Caucasians. Health status has been shown to be an independent predictor of dialysis patient survival. Our results may partially explain the increase in survival observed for African-American dialysis patients. Further investigation is necessary to determine if these differences remain after case-mix adjustment. (See table below.)

WOMEN'S & MEN'S HEALTH

PREMATURE BIRTH AND RESOURCE UTILIZATION IN A LARGE EMPLOYMENT BASED INDEPENDENT PRACTICE ASSOCIATION (IPA)
Harley CR1, Leader S2
1Ingenix Pharmaceutical Services, Eden Prairie, MN, USA;
2MedImmune Inc, Gaithersburg, MD, USA

OBJECTIVES: While premature birth is one of the costliest hospital events, the total direct medical cost of care associated with the birth of a premature infant has not been documented from a societal perspective. METHODS: Retrospective analysis of administrative claims data from a large, employment based IPA covering a total of 3 million members in 1998 was conducted. All infants born in calendar year 1998 with a birth diagnosis of prematurity (<38 weeks gestation) and low birth weight (<2500 grams) [ICD 9-CM codes 765.0x and 765.1x] were identified. Eligible infants were required to be continuously enrolled in the plan during the birth hospitalization, have complete claims histories, and have prescription drug benefits. A secondary analysis of resource utilization during the first 30 days post-initial hospital discharge was conducted among surviving infants who were continuously enrolled during that 30 day period. Costs reflect payments by the plan, patient deductibles, and co-payments for all covered medical services. RESULTS: In 1998, 1,208 births to enrollees were premature and eligible for study; 28% were multiple births. Twenty-one infants (1.7%) died during the birth hospitalization. The total direct medical cost of the birth hospitalization was $35.5 million. During the first 30 days post discharge, 133 (12.4%) of the remaining eligible infants (n = 1,076) had claims for inpatient services. Total direct cost of all covered medical services during this period was an additional $1.2 million. CONCLUSION: Even in a relatively low risk population, the direct medical costs associated with premature birth were very high (nearly $37 million for about 1,000 infants) and need for acute medical care continued in the first month post-discharge. Appropriate medical management of this high risk population may be cost-effective.

Table for PUR8

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<th>Role Physical*</th>
<th>Bodily Pain*</th>
<th>General Health*</th>
<th>Vitality*</th>
<th>Social Function*</th>
<th>Role Emotional</th>
<th>Mental Health*</th>
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*p < .01