reason for anticonvulsant discontinuation was lack of efficacy. Patients had PDN for 34 months on average prior to starting topiramate. Mean duration of topiramate therapy was 17 months; mean total daily dose was 127 mg. A total of 57% used topiramate monotherapy. According to physician assessment, 46% (95% CI 28, 64) were “very much improved” or “much improved” for pain, 36% (95% CI 18, 54) for physical activity, and 39% (95% CI 21, 57) for sleep. None had worsening of symptoms. A total of 32% experienced topiramate-related adverse effects (AEs). In 67% no action was taken for AEs. There were no discontinuations due to AEs or lack of efficacy. CONCLUSIONS: Topiramate was effective and well-tolerated for the treatment of PDN, even in a group of difficult to treat patients for whom other anticonvulsants had failed.

PAIN—Cost Studies

PPN3

A UK MULTI-CENTRE TRIAL-BASED COST-UTILITY ANALYSIS OF SURGICAL STABILISATION OF THE SPINE VERSUS INTENSIVE REHABILITATION FOR TREATMENT OF CHRONIC LOW BACK PAIN PATIENTS

Rivero-Arias O¹, Campbell H¹, Gray A¹, Stabilisation Trial S²
¹Oxford University, Oxford, United Kingdom; ²Nuffield Orthopaedic Centre, Oxford, United Kingdom

The management of back pain is controversial. Despite a high incidence (between 15% and 40% in most Western countries) and associated economic burden, considerable uncertainty exists as to the effectiveness and cost-effectiveness of alternative interventions for the condition. OBJECTIVES: To determine whether, from a UK National Health Service (NHS) perspective, surgical stabilisation of the spine is cost-effective when compared to an intensive rehabilitation programme for the treatment of patients with chronic low back pain. STUDY DESIGN: Three hundred forty-nine patients (349) assessed as having chronic low back pain were randomised to surgery (176 patients) or rehabilitation (173 patients) at centres across the UK. Patients were followed-up at 6, 12, and 24 months post randomisation. METHODS: Costs to the NHS of initial treatment (surgery or rehabilitation), medications, and all primary and secondary sector health care contacts were collected for each patient out to 24 months. Patient utility measured using the EuroQol EQ-5D questionnaire was combined with 24 month survival data to calculate quality adjusted life years (QALYs). Results were expressed using an incremental cost per QALY. Statistical techniques were used to examine stochastic uncertainty surrounding cost, QALY, and cost per QALY results. RESULTS: Preliminary analysis shows surgery to be more costly than rehabilitation at 24 months following randomisation. The main cost drivers appear to be the initial surgical procedure and a higher proportion of surgery patients receiving subsequent outpatient and community care. No difference in QALYs was detected between the two modes of treatment and the baseline incremental cost per QALY exceeded £30,000. Examination of uncertainty surrounding key parameters did not alter these results greatly. CONCLUSION: Preliminary results from this trial, one of very few in orthopaedic surgery in the UK, suggest that surgical stabilisation of the spine for patients with chronic low back pain may be more costly than alternative treatments with no clear advantage in successful outcomes.

PAIN—Quality of Life

PPN4

EPIDEMIOLOGY, CO-MORBIDITY, AND IMPACT ON HEALTH-RELATED QUALITY OF LIFE OF SELF-REPORTED HEADACHE AND MUSCULOSKELETAL PAIN—A GENDER PERSPECTIVE

Bingefors C, Isacson D
Uppsala University, Uppsala, Sweden

OBJECTIVES: Epidemiological studies have consistently shown that the prevalence of most pain conditions is higher in women than in men. METHODS: Cross-sectional survey in the county of Uppland, Sweden, 1995. The questionnaire was completed by 5404 people (response rate = 68%); this analysis of those aged 20–64 years included 4506 of the responders. RESULTS: Back pain (22.7%) and shoulder pain (21.0%) were the most commonly reported medical problems in the population, while pain in arms/legs (15.7%) was fifth and headache (12.5%) was eighth in ranked order of prevalence. Major gender differences were found. The prevalence of pain conditions, especially headache, was higher among women, who also reported more severe pain. Co-morbidity between pain conditions and psychiatric and somatic problems was higher among women. Health-related quality of life (HRQoL; SF-36) also differed with gender and type of pain. Headache affected the physical dimensions of the HRQoL more in men than in women, and affected the psychological dimensions more in women than in men. Although pain conditions were associated with poorer socioeconomic conditions and lifestyle factors in both men and women, there were gender differences. Education and unemployment were associated with pain only among men, while economic difficulties, part-time work and being married were associated with pain among women. Obesity, early disability retirement, long term sick-leave and lack of exercise were associated with pain conditions in both genders. Factors associated with pain conditions were unevenly distributed between genders. CONCLUSION: There are major differences between men and women in the prevalence and severity of self-reported pain in the population. Biological factors may explain some of the differences but it is suggested that the main explanation is the result of gender disparities in work, economic situation, daily living,