rates: 1.15 and 1.51 for 1A and 1B respectively, p < 0.01). Mean (SD) costs of care at one year of follow-up also were reduced among GA patients ($9,522 [$9,706] vs. $9,957 [$9,083] and $10,185 [$9,526] for 1A and 1B respectively). Findings persisted in multivariate analyses controlling for differences in demographic characteristics and propensity scores for immunomodulatory therapy. CONCLUSIONS: Glatiramer acetate is associated with reductions in the incidence of relapse and costs of care relative to the beta interferons among this large group of managed-care patients with MS.

NEUROLOGICAL DISEASES/DISORDERS & PAIN—Quality of Life

USE OF THE TOPS AS A PAIN-SPECIFIC HRQOL INSTRUMENT
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The Total Outcome of Pain Scale, TOPS, is a fully validated disease-specific outcome measurement tool for use in patients with chronic pain. The TOPS provides much greater sensitivity and specificity for measuring outcomes. The 60-V-item TOPS questionnaire contains the SF-36 and information on Pain Symptom, Functional Limitations, Perceived Family/Social Disability, Real Family/Social Disability and Formal Work Disability. Unlike the SF-36, TOPS is precise enough to monitor outcome over time in individual patients. All patients at the University of Utah Pain Management Center complete TOPS at evaluation, three months, six months, and then every six months for the duration of therapy. Paper forms are scanned into an Access database. This produces a report that summarizes current and prior TOPS scores for the patient and which is put into the patient's medical record. From July 1, 1997 through August 2, 2001, 3454 TOPS instruments were completed and entered. This represented 2692 individual patients. Most (80.5%) of patients completed one TOPS; the remainder had 2 or more. This population was 62.2% female and had the following characteristics (median values): age (40–44), years of education (13), income $30,000–$39,999. The 6 most common diagnoses and ICD 9 codes were: myalgia and myositis, unspecified (729.11), low back pain, low back syndrome (724.2), pain in limb (729.5), neuralgia, neuritis, and radiculitis, unspecified (729.2), pain in neck (723.1) and headache (784.0). Mean responses were as follows: ICD 9 Code PCS MCS Pain Symptom Score Work Disability 729.1 28.9 39.7 72.2 37.7 724.2 27.1 40.1 72.9 47.4 729.5 27.9 40.4 75.3 38.7 729.2 28.9 40.1 73.0 46.8 723.1 30.5 37.6 73.2 40.1 784.0 31.6 37.6 71.2 31.8. Data collection is ongoing, with 20–30 surveys completed weekly. By the end of 2002, data on approximately 5000 TOPS administrations will be available and will be included in the presentation. Querying the database may provide valuable data on relative outcomes by intervention and clinician.

PHYSICIAN PREFERENCE FOR ANTIEPILEPTIC DRUG CONCENTRATION TESTING
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OBJECTIVES: To determine rate of adoption of saliva concentrations as a monitoring method for antiepileptic drugs (AEDs). To determine whether child neurologists would prefer saliva testing to serum testing to obtain AED concentrations for clinical practice. METHODS: A survey asked participants about use, availability, and value to the physician of saliva AED concentrations. Respondents chose between the following four responses when considering value: 1) Very valuable, willing to spend $1/2 hour of time per patient to arrange; 2) Moderately valuable, willing to spend 10 minutes of time per patient to arrange; 3) Not very valuable, might use test but would not spend extra time to arrange; and 4) Of no special value, I doubt that I would use such a test. All members of the Child Neurology Society were surveyed. Surveys were re-mailed to non-responders after one- and two-month intervals. RESULTS: We mailed 1006 surveys and received 546 responses (54%) and 57 surveys were returned undelivered. Less than 1% of respondents had obtained a saliva AED concentration in the last year. Seven percent stated there was an available laboratory to perform saliva AED concentration determinations. Fifty-three percent of individuals indicated that having a pain-free method of AED concentration determination was very or moderately valuable to them and 68% stated that the ability to obtain real-time samples outside of the clinical environment was very or moderately valuable. CONCLUSIONS: Most child neurologists have not obtained saliva AED concentrations and perceive they do not have this technology available to them. The majority of respondents would be willing to spend 10–30 minutes of time to arrange for saliva AED concentrations to prevent patient discomfort and obtain real-time concentrations.

QUALITY OF LIFE (QOL) AND PHARMACOECONOMICAL ASPECTS IN PATIENTS WITH SYMPTOMATIC LOCALIZATION-RELATED EPILEPSIES (SLE) IN MOSCOW
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OBJECTIVES: The growing attention to the social aspect of epilepsy and the necessity to improve the system of care require knowledge of QOL and pharmacoeconomic