with patients with forms of hand-foot syndrome of varying severity, which yielded a detailed and rigorous collection ofverbatim transcripts. RESULTS: Thirty-one items were identified, and 14 items were selected as being relevant and non-overlapping after initial evaluation. The first question in the HFS14 addresses which member is affected (hand, foot or both). The second question addresses the pain with three possible responses (very, moderate or not painful). The 14 items can be organised in 2 modules: the first module more specifically assesses the handicap generated by involvement of the “feet” and the second assesses the handicap generated by involvement of the “hands”. Six (6) items are considered common to both modules, 4 are hand-specific and 4 are foot-specific. Psychometric validation confirmed the internal consist- ency and very high reproducibility of the questionnaire. CONCLUSIONS: The hand-foot syndrome-specific HFS14 scale is easy to use and meets the requirements of a quality of life scale. This scale now needs to be tested in longitudinal studies (for example in clinical trials) to confirm its ability to measure a change in status.

PMCS4 ESTIMATING SOCIAL PREFERENCES FOR EQ-SD IN TURKEY: A NOVEL METHOD BASED ON A VALUATION EXCHANGE-RATE MECHANISM
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OBJECTIVES: To estimate a set of Turkish social preference weights for EQ-SD health states in a 2-stage process that (a) establishes the relationship between VAS ratings for real (self-reported) health states in the UK and Turkey, and (b) applies this functional relationship to adjust UK utilities for hypothetical EQ-SD health states for use in Turkey as proxy social preferences. METHODS: A stratified sample of the general population of Turkey was drawn, based on 7 geographical provinces and adjusting for rurality. 7000 individuals aged 18 and above were randomly selected from district registers in 14 cities and invited to participate in a face-to-face interviews conducted at home or in the workplace. Of the 3676 (81%) who were contacted, 2,990 (71%) completed the interview which included the Turkish language version of EQ-SD. RESULTS: The mean age of the sample was 39.5 (range 18 to 70) of whom 57% were female. The sample was deemed to be broadly representative of the general population in Turkey. Mean VAS ratings for self-assessed health status was 70.1 (range 5–100). A total of 49 self-reported EQ-SD health states identified in the Turkish survey were also found present in a UK database containing corresponding EQ-SD data (n=23,000). Although non-linear functional forms were tested, an OLS regression model proved to be the most efficient function linking the mean VAS values for these states in the Turkish survey and the UK samples. The items of preference and utility were able to use a variety of measurement scales, for countries without their own domestic value set appears feasible.

PMCS5 AGREEMENT BETWEEN PATIENT AND PROXY ASSESSMENT OF HEALTH-RELATED QUALITY OF LIFE BEFORE INTENSIVE CARE UNIT ADMISSION
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OBJECTIVES: To determine the agreement between patient and proxies’ responses for the SF-36 questionnaire was greatest in aspects concerning the physical function (0.91), mental health (0.87), vitality (0.85), and anxiety/depression (0.82). The level of agreement between patients’ and the proxies’ responses for the SF-36 questionnaire was greatest in aspects concerning the physical function (0.91), mental health (0.87), vitality (0.85), and anxiety/depression (0.82). The level of agreement, according the Spearman’s correlation coefficients for EQ-5D sub- dimensions of the “feet” and the second assesses the handicap generated by involvement of the “hands”. Six (6) items are considered common to both modules, 4 are hand-specific and 4 are foot-specific. Psychometric validation confirmed the internal consistency and very high reproducibility of the questionnaire. CONCLUSIONS: The hand-foot syndrome-specific HFS14 scale is easy to use and meets the requirements of a quality of life scale. This scale now needs to be tested in longitudinal studies (for example in clinical trials) to confirm its ability to measure a change in status.

PMCS6 PREFERENCES FOR PREFERENCES
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OBJECTIVES: We assessed the most commonly-used measurement scales for utility weights elicitation in published cost-utility analyses (CUAs) and examined changes in elicitation methods over time. METHODS: Our study is based on data on CUAs in the Tufts Medical Center Cost-Effectiveness Analysis Registry (www.crearegistry.org). For each study, we extracted data on the reported utility weight used to construct QALY estimates, including whether it was based on primary or published/secondary data, and the measurement scale used (e.g., EQ-5D, HUI, SF-6D). RESULTS: We reviewed 1,149 original CUAs published from 2002 to 2007. A total of 3860 utility weights were reported, of which 2848 (74%) were based on published sources, 832 (22%) came from a primary source, and 122 (3%) weights were based on both primary and secondary data. For 58 weights (1.5%), the data source was not stated or could not be determined. Of weights for which a measurement scale was identified (n = 483), the EQ-SD was used for 341 (71%) of cases, the HUI for 28 (6%), the SF-36/6D for 27 (6%), and the QWB for 23 (5%). Use of the EQ-SD increased substantially, from 59% of weights in 2002-2003, to 75% in 2006-2007 (p = 0.0034), whereas use of the SF-6D algorithm to estimate utilities increased from 1% in 2002-2003 to 9% in 2007-2008 (p = 0.0014). The use of the HUI has not changed sub- stantially over time. The EQ-SD dominated all other scales in the UK, The Netherlands, and Sweden (>90% use), while studies from the United States and Canada tended to use a variety of measurement scales. CONCLUSIONS: Only one fifth of utility weights reported in CUAs are based on primary data elicitation. There is a strong preference for using the EQ-SD for elicitation of primary utility values.

PMCS7 TO MAP OR NOT TO MAP? THE OXFORD HIP SCORE AND EQ-SD COMPARED
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OBJECTIVES: Disease specific measures (DSM) and generic utility measures (GUM) both provide information about the health status of patients. Generally, a DSM tends to provide more descriptive information than a GUM but does not permit the calculation of cost-utility ratios. The primary aim of this study was to estimate the comparability of the information captured by both types of instruments. The aim of this study was to assess the comparability of the information captured by a DSM and a GUM and the validity of obtaining utilities for the DSM via mapping. METHODS: We compared the Oxford Hip Score (OHS) and the EQ-SD in patients undergoing total hip replacement using data from the UK PROMs study. The comparability of the type of information was assessed using factor analysis and analysis of the correlation matrix. RESULTS: Comparing the instruments showed clear differences in the conceptualisation of the two measures. Factor analyses showed that the OHS data can be associated with 3 distinct constructs: one relating to pain, one to movement, one to daily activities. The 12 items of the OHS load on the 5 dimensions of EQ-SD (no OHS items loaded onto the “anxiety/depression” factor). Also, the results of the exploratory and confirmatory factor analyses describe system- atically that—compared to EQ-SD—the OHS items are multidimensional by nature and that the same phenomenon is picked up repeatedly by different items. CONCLU- SIONS: The differences we found between the two types of instruments do not impede the merits of either when used for their own purposes. However, the conceptual dif- ferences between the two types of instruments will have a major impact on the way utility values for a DSM are obtained via mapping.

PMCS8 EVALUATING THE INFLUENCE OF PHYSICAL ACTIVITY ON THE SOCIAL AND ENVIRONMENTAL DOMAINS OF QUALITY OF LIFE Lin WL, Yao G
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OBJECTIVES: Many researches indicate that physical activity can increase well-being and quality of life, specifically three domains of quality of life. The purpose of this study attempts to investigate whether physical activity also has the influence on social and environmental domains of quality of life. METHODS: A total of 412 students at National Taiwan University participated in this study. Two questionnaires concerning the physical activity and quality of life (WHOQOL-BREF) were used. Structural equation modeling was conducted to indicate any relationships between physical activity and the social or environmental domains of quality of life. RESULTS: The results showed that the two models of predicting social and environ- mental domains of quality of life from physical activity did not fit the real data well if the standard items of the WHOQOL were used. However, after deleting some inappropriate items from both (social and environmental) domains of quality of life, significant relationships between physical activity and the two domains of quality of life were noted respectively. CONCLUSIONS: The study expects the impact of indi- vidual physical activity to his/her social and environmental domains of quality of life. Furthermore, physical activity can enhance not only individual physical and psycho- logical domains of quality of life but also their social and environmental domains of quality of life by deleting some inappropriate items of the WHOQOL-BREF.

PMCS9 CULTURAL AND LINGUISTIC ISSUES ASSOCIATED WITH THE TRANSLATION AND LINGUISTIC VALIDATION OF QUESTIONNAIRES FOR USE IN CHINA Houshin C, Wild D
Oxford Outcomes Ltd, Oxford, UK
OBJECTIVES: An increasing number of clinical trials are taking place in China. This research aimed to identify some of the issues that may arise as a result of cultural and
linguistic differences between China and North America or Western Europe where PROs tend to develop. The objective of this study was to identify some of the linguistic and cultural differences between English and Mandarin as well as cultural differences between North America and Western Europe and China. METHODS: Five questionnaires based on the health state classification system were reviewed and the cultural and linguistic issues arising during different stages of the translation process were examined. RESULTS: Numerous cultural and linguistic issues became apparent throughout the review, including: 1) Mandarin does not employ superlatives so “the worst” was translated as “extremely bad”; 2) some patients did not understand how to complete a VAS although the words themselves were clear; 3) there is no specific benefit of “disability compensation” in China—this is a general benefit which can include pensions; 4) Private clinics where respondents receive acupuncture and massage are very common in China so additional categories had to be added to a resource utilisation measure; 5) in Mandarin questions cannot begin with “how often;” instead they are phrased “does it often;” 6) with response options such as “never,” “sometimes,” appropriate responses can still be chosen; and 6) Low levels of obesity in China made recruitment for the linguistic validation of an obesity measure difficult. CONCLUSIONS: An increasing number of clinical trials take place in China. The issues raised above show some of the linguistic differences between English and Mandarin, and cultural differences between Western Europe / North America and China. These and other issues are important to consider when selecting, developing and translating measures for use in China.

OBJECTIVES: The National Institute for Health and Clinical Excellence (NICE) has expressed a preference for the EQ-5D in cost-effectiveness analyses. Directly eliciting ICER threshold based on the author’s conclusion about cost-effectiveness. The value ranged after abstract review and/or full text review. Two independent reviewers worked to select relevant articles and extract data. Mean incremental cost per Quality-adjusted life-years-gained or Life-years-gained were US$13,514, US$25,446, US$30,448, US$70,420 for cancer, cardiovascular diseases, endocrine disease, and musculoskeletal disease, respectively. The ICER according to countries were also vary a lot in a lot of cases, the author’s judgment on cost-effectiveness, some interventions were recommended as cost-effective even in the case ICER were approximately US$80,000, US$75,000, US$200,000 for UK, Canada, and USA. CONCLUSIONS: The judgment on cost-effectiveness interventions could be different according to countries and disease. It tends to have higher ICER in severe disease and in developed countries.

CATEGORICAL OF EQ-5D SCORES FOR THE UK

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RESULTS: A total of 3662 articles were originally identified from the planned searching strategy. 1466 among them were finally included to calculate ICER range after abstract review and full text review. Two independent reviewers worked to select relevant articles and extract data. Mean incremental cost per Quality-adjusted life-years-gained or Life-years-gained were US$13,514, US$25,446, US$30,448, US$70,420 for cancer, cardiovascular diseases, endocrine disease, and musculoskeletal disease, respectively. The ICER according to countries were also vary a lot in a lot of cases, the author’s judgment on cost-effectiveness, some interventions were recommended as cost-effective even in the case ICER were approximately US$80,000, US$75,000, US$200,000 for UK, Canada, and USA. CONCLUSIONS: The judgment on cost-effectiveness interventions could be different according to countries and disease. It tends to have higher ICER in severe disease and in developed countries.

DIFFICULTIES WITH THE APPLICATION OF PRO MEASURES TO CULTURES OUTSIDE OF WESTERN EUROPE AND NORTH AMERICA IN MULTI-NATIONAL TRIALS

Parisi T, Meehan C, Wild D

OBJECTIVES: The majority of PRO measures are developed using a sequential rather than a cross-cultural approach and have been developed in the US and/or UK. When using these measures in multi-national trials, the assumption is made that the translated measure is acceptable for use in a multi-national trial, providing the translation general population survey. Scores and marginal disutilities for a wide variety of chronic ICD-9 and CCC codes can be used to estimate QALYs in cost-effectiveness analyses in the UK. Although the preference function was derived from a UK population sample, there are limitations associated with using a US survey to develop the condition-specific questionnaire responses.