

9.1% had at least 14 urine losses per week. Level of symptoms was closely related quality of life. Comparing the two groups, we observed some relationships between level of symptoms and socio-demographics. **CONCLUSIONS:** Prevalence of SUI in French women was high. Women with SUI had a marked decrease in their quality of life. There was an inverse relation between level of urinary symptoms and quality of life: as the intensity of symptoms increased, the quality of life decreased.

## URINARY/KIDNEY DISEASES/DISORDERS

### URINARY/KIDNEY DISEASES/DISORDERS—Health Policy

PUK20

#### IMPLICATIONS OF OVERACTIVE BLADDER ICD-9 CODE CHANGES AND USE OF CODES IN A MANAGED CARE POPULATION

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**OBJECTIVES:** In October 2000, the ICD-9 diagnosis code 596.51 “Hypertonicity of Bladder” was updated to include “Overactive Bladder” (OAB). Previously, no specific code identified OAB. To determine implications for outcomes estimates, this study examined correspondence between suggested ICD-9 coding for OAB before the update and use of codes in claims data. **METHODS:** Data were drawn from medical claims of enrollees aged  $\geq 18$  years of a large US health plan. Fifteen ICD-9 diagnosis codes that might indicate OAB were identified through literature review and clinical consultation, and examined for agreement between sources. Possible OAB patients were identified if an OAB ICD-9 code appeared in claims from August 31, 1999–March 1, 2000. **RESULTS:** Sources agreed completely on five of 15 suggested ICD-9 codes. Of 33,290 patients with suggested codes, 86% had 1 of the 5 codes, and only 1% had 596.51 “Hypertonicity of Bladder” before the added OAB description. Most commonly used were “Urinary Frequency” (788.41; 48% of possible patients), “Unspecified Urinary Incontinence” (788.30; 19%), “Nocturia” (788.43; 15%), “Urge Incontinence” (788.31; 8%), and “Mixed Incontinence, Urge and Stress” (788.33; 5%). Proportion of subjects with the 5 codes differed by geographic region ( $p < 0.0001$ ), but not by gender ( $\chi^2 = 3.30$ ,  $p = 0.07$ ). Of 15 codes, “Nocturia” (788.43) was the only code with a greater proportion (74%) of men. Use of the five primary codes showed a linear trend ( $p < 0.0001$ ) increasing from 81% in ages 18–35 to 91% in ages  $\geq 75$ . **CONCLUSIONS:** Before the ICD-9 code update, five codes accounted for most possible OAB patients and few were coded with 596.51. We expect claims data following the October 2000 implementation will gradually shift to the updated OAB code. Research should include 596.51 and the other five codes because coding practices may change and demographic coding differences could have an impact on outcomes estimates.

PUK21

#### AN ANALYSIS OF PATIENTS ON WAITING LISTS TO RECEIVE SURGERY FOR STRESS URINARY INCONTINENCE (SUI) IN ENGLAND AND SCOTLAND

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**OBJECTIVES:** To analyse waiting lists and waiting times for female patients with SUI in order to determine their burden on Gynaecology and Urology National Health Service (NHS)

waiting lists waiting for SUI procedures. **METHODS:** The CHKS hospital database in the UK was analysed over a two year period for patients admitted for surgery between April, 2001 and March, 2003. Specific SUI procedures were identified within Gynaecology and Urology specialties and the number of cases waiting for these procedures at specific time points was derived. Results are presented as an average across the financial year 2001–2002 as this data was considered most complete. Results were stratified by England, Scotland and specialty. **RESULTS:** England: 3.38% of patients on the Gynaecology waiting list and 2.90% of patients on the Urology waiting list are waiting for SUI procedures. The mean and median wait times for Gynaecology were 313 and 309 days respectively and for Urology 343 and 350 days respectively. The mean age of patients admitted to Gynaecology was 54.76 and Urology was 56.98. Scotland: 4.25% of patients on the Gynaecology waiting list and 3.30% of patients on the Urology waiting list are waiting for an SUI procedure. The mean and median wait times for Gynaecology were 175 and 142 days respectively and for Urology 268 and 275 days respectively. The mean age of patients admitted to Gynaecology was 51.64 and Urology was 54. **CONCLUSIONS:** The percentage of patients waiting for an SUI procedure represents a significant burden on the NHS where, in England, there is an average of 2866 patients on the gynaecology waiting list and 2080 on the Urology waiting list in any one quarter between 2001–2002 waiting for SUI procedures. Any new treatment reducing the need for SUI procedures could potentially have a noticeable impact on waiting lists in the NHS.

## URINARY/KIDNEY DISEASES/DISORDERS

### URINARY/KIDNEY DISEASES/DISORDERS—Methods and Concepts

PUK22

#### DERIVING UNIT COSTS FOR RESOURCE UTILISATION IN PROSPECTIVE URINARY INCONTINENCE RESEARCH (PURE)—AN OBSERVATIONAL STUDY IN 14 EUROPEAN COUNTRIES

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**OBJECTIVES:** To collect and compare unit costs for resource use data in PURE, an observational study with the primary objective to determine the direct cost of urinary incontinence (UI) treatment in Europe. **METHODS:** Resource use data include medication, conservative treatment, diagnostic and surgical procedures, incontinence products and visits to health care providers. Unit costs by country and type were collected using a standardized data collection form. OECD consumer price indices and purchasing power parity figures were used to convert prices into 2003/2004 values and US dollars respectively. Prices were then converted into Euros using an exchange rate of 1\$ = 0.84€ (June 2004). **RESULTS:** Unit costs were derived from standard national pricelists for medications, retail prices for incontinence products, DRG (Diagnosis-related Groups) data for surgical interventions where applicable, or costs of procedures and overnight stays derived from hospitals in the remaining countries. The costs of conservative therapy, incontinence products and health care visits varied between countries within reasonable