Psoriasis, quality of life and depressive symptomatology: French results
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OBJECTIVE: To evaluate the effect of psoriasis on quality of life of patients and DS in France. To highlight a relation between DS and quality of life for patients suffering from psoriasis.

METHOD: Seven hundred fifty anonymous questionnaires (composed of two scales: the Psoriasis Disability Index [PDI] and the Center for Epidemiologic Studies—Depression scale [CES-D]) were sent, via a Psoriasis Patient Support Group (APLCP). The CES-D, a short self-report scale composed of 20 items, is a questionnaire designed to measure DS in the general population. The PDI is widely used in epidemiological surveys on large populations. The PDI is a questionnaire specific for psoriasis patients.

RESULTS: 297 questionnaires were returned (June 2002): response rate 39.6%. The sex ratio Men (M)/Women (W) was 47/53. Mean age: 48.8 years. Mean age of diagnosis: 26.3 years. The average to the total PDI score was 10.3 (s.d.: 7.7 rank 0 to 39) i.e 22.8 (sd: 17.10) when reported to a scale of 0 to 100. Significant difference was observed between W and M for the global handicap score 24.53 vs 19.87 p < 0.002. Two groups were identified: flare-up of psoriasis (49.5%), psoriasis not in flare-up (50.5%); no answers (4%). Psoriasis had a greater affect on patients with episode: PDI score = 20.24 (sd 17.52) than the patient without episode PDI score = 8.98 (sd 11.34). This difference was significant (p < 0.00001). CONCLUSION: These results highlight the value of appropriate and relevant psychological and medical environment for patient suffering from psoriasis.

Assessment of the dermatologic life quality index (DLQI) in chronic idiopathic urticaria
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The Dermatology Life Quality Index (DLQI) was designed to be used with different types of dermatologic pathologies instead of being directed at a single condition such as psoriasis or acne. Although a reasonable approach, this broader measurement model may not be appropriate for conditions such as chronic idiopathic urticaria (CIU) that, unlike some other chronic skin conditions, are subject to daily or weekly fluctuations.

OBJECTIVES: This validation study tested the reliability, structural validity, and construct validity of the DLQI in two samples of CIU patients obtained from two large identical multicenter, double-blind, randomized, placebo-controlled, parallel studies. METHODS: Patients recorded daily signs and symptoms (# of wheals and pruritus severity) on a daily basis, and completed the DLQI during three clinic visits (approximately 2 weeks apart); investigators also assessed CIU severity. RESULTS: The DLQI means and standard deviations indicated relatively symmetrical distributions free from serious ceiling or floor effects, and alpha coefficients indicated an acceptable level of reliability in the two samples. The exploratory factor analysis suggested that the six categories of items did not define different factors and supported the unidimensionality of the scale. In a formal test of the structural validity for a single-factor model, confirmatory factor analysis supported either a one or two-factor model, with the correlations from the two-factor model indicating that the total score of all items is interpretable as a global score. Item response analyses showed that most items were able to distinguish people with low versus high impairment at the appropriate ends of the continuum demonstrating content validity. Finally, changes in DLQI scores were related to changes in investigator and patient-assessed symptoms of urticaria, providing evidence of construct validity. CONCLUSION: These results support the DLQI as a valid instrument for the measurement of CIU related quality of life.

Health state utilities in patients with dermatological problems—a population study
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OBJECTIVES: In spite of the common occurrence of dermatological problems there are virtually no population-based studies on the impact of skin diseases in the
population. The aim of the study was to evaluate the impact of skin diseases on health state utilities in the population. METHODS: A postal survey was carried out on a sample of the population 20–84 years of age (n = 8000) of the county of Uppland, Sweden. Information on dermatological problems was obtained by self-report. Rating Scale was used to measure health state utilities. RESULTS: The response rate was 68% (5404 individuals). A large proportion (20.5%) reported dermatological problems and/or use of topical dermatological drugs. Skin disease was evenly distributed over age but was more frequent among women (23.3%) than among men (17.3%). Persons reporting dermatological problems also reported lower health state utility than others, 0.807 as compared to 0.836 (p < 0.001). Dermatological problems had an independent and statistically significant (p < 0.01) effect on utility when age, gender, somatic and psychiatric comorbidity were included in a multivariate analysis. CONCLUSIONS: The study shows that skin disorders are a considerable problem in the population, and that they do cause a decrease in health state utility as measured by the Rating Scale (RS). The result of this study emphasizes the need for further epidemiological studies analysing health state utilities in relation to severity and type of skin disease.

INFECTION—Economic Outcomes

THE COSTS OF SEVERE SEPSIS—THE NETHERLANDS, 2000

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OBJECTIVES: New therapies for the treatment of severe sepsis are in development and estimates are required of treatment costs, annual incidence and the national burden-of-illness. This study concerns the Netherlands. METHODS: Cost data were collected for 100 patients consecutively admitted to a general hospital ICU from 1998 to 2000 for treatment of a first episode of severe sepsis. Costs were limited to direct medical ICU costs from a societal perspective and collected with an activity based information system. Annual incidence was estimated with a point-prevalence survey in Dutch ICU’s, collecting the clinical information concerning all patients at the ICU on a single day. Patients were regarded as severely septic if infection was present, two or more SIRS criteria were fulfilled and when there was at least one dysfunctional organ system. RESULTS: Daily costs were estimated to be log-normally distributed with a mean of €1,244 ± 404. ICU length of stay was estimated to be geometrically distributed with a mean of 15.3 ± 15.8 days. Total treatment costs were estimated at €19,509 ± 26,966 (log-normal). Main cost items were fixed costs (43%), nursing costs (28%), diagnostic tests (7%), medication (5%), renal replacement therapy (5%) and blood (4%). The presence of shock and/or renal failure was significantly associated with higher treatment costs, whereas ICU survival only showed a trend towards increase. Forty-seven ICU’s participated in the prevalence survey and 143 patients were found to meet the criteria for severe sepsis. The national incidence was estimated at 8,643 ± 929 patients per year. CONCLUSIONS: Costs of severe sepsis treatment within the ICU are estimated at €168.6 ± €29.5 million per year. This equals 1.7% of the national hospital budget and 0.51% of all healthcare expenses in 2000 in the Netherlands.

SEVERE SEPSIS: CLINICAL TRIAL VERSUS DAILY PRACTICE. A COST ANALYSIS IN BELGIUM

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OBJECTIVES: To determine and compare costs and cost driving factors in the management of severe sepsis either within a clinical trial setting or in daily practice. METHODS: One hundred fifty-two patients (from 4 Belgian centres) fulfilling criteria for severe sepsis between 1998 and 2000 were included in a chart review. Ninety-one were clinical trial patients (rhAPC, TFPI or ATI1); 61 were non-trial patients. All healthcare costs (payers perspective) between sepsis diagnosis and discharge were collected from patient invoices by independent researchers. RESULTS: Trial and non-trial patients were comparable with regard to age, status (medical or surgical), underlying conditions including COPD, alcohol or tobacco abuse and immunosuppression. Differences were observed in mortality (45% versus 50%, trial versus non-trial patients respectively), positive blood cultures (39% versus 75%), renal replacement therapy (22% versus 31%), hypertension (41% versus 31%) cardiomyopathy (16% versus 29%) cerebrovascular disease (5% versus 13%) and malignancy (19.8% versus 8%). There was no difference (trial versus non-trial) in hospital (28 versus 27 days) or ICU length of stay (16 days both) after sepsis diagnosis. Overall costs were similar in trial and non-trial patients: €19,292 (St E:1,574) versus €16,314 (St E: 1,684) respectively. Multivariate regression (OLS on log-transformed cost) revealed the following explaining factors for total cost: death (neg. p = 0.003), pos. blood culture (pos. p = 0.009), university hospital (pos. p = 0.035), mechanical ventilation (pos. p = 0.002) and renal replacement therapy (pos. p = 0.002). The variable “trial patient or not” revealed a p-value of 0.624. CONCLUSIONS: Factors influencing costs in severe sepsis include death, pos. blood culture, university hospital setting, renal replacement therapy and ventilation. Trial and non-trial patients appear to be comparable with regard to