and their combination are medicines of choice for treatment of glaucoma in Russia. CONCLUSIONS: More attention is being paid to prostaglandins and CAIs. The information of ophthalmologist and their patients about the cost of therapy is a very important component for pharmacoeconomical decisions together with medical effectiveness of treatment. But it is rather low in Russia in whole.

EYE/EAR/SKIN DISEASES/DISORDERS

EYE/EAR/SKIN DISEASES/DISORDERS—Quality of Life/Utility/Preference Studies

RESPONSIVENESS OF SELF-REPORTED VISUAL FUNCTIONING IN AGE-RELATED MACULAR DEGENERATION (AMD) PATIENTS TO GENERAL HEALTH AND CHANGES IN VISUAL ACUITY IN A PHASE III RANDOMIZED CONTROLLED TRIAL OF LUCENTIS™ (RANIBIZUMAB; RHUFAB V2) Globé D1, Tonnu IQ1, Chang TS1, Fine J2
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OBJECTIVES: Evaluate association of National Eye Institute Visual Functioning Questionnaire-25 (VFQ-25) score changes with systemic comorbidities and visual acuity (VA) changes in neovascular AMD patients in a phase IIII randomized controlled trial of Lucentis™ (ranibizumab; rhFab V2). METHODS: At baseline and three months, 57 patients completed the VFQ-25 (self-reported visual function) and VA was measured. The presence of seven comorbidities was recorded at baseline. VA score (number of lines read) was converted to a weighted log of the minimum angle of resolution (0.25 worse eye logMAR + 0.75 better eye logMAR). To estimate the relative association of changes in VA and comorbidities with changes in VFQ-25 scores, separate regression models of three-month change in each subscale score on the logMAR scores were developed for each comorbidity. RESULTS: Mean number of comorbidities was 3, including: 25 (44%) hypertension, 24 (42%) arthritis, 14 (23%) hearing loss, 12 (21%) diabetes, 12 (21%) psychiatric disease, 12 (21%) back pain, 11 (19%) cancer. Due to small sample size, only VA estimates in the regression were significant after controlling, individually, for the comorbidities. For all models, a one-line (0.1 logMAR) worsening in VA was significantly associated with decreased subscale scores, particularly those related to central vision (Near Activities, Distance Activities). VA alone explained 11% of the variation in the VFQ-25 change between baseline and 3 months in the Near Activities subscale. Inclusion of an individual comorbidity improved the explanatory power of the models slightly (r2): to 12% for hypertension, hearing loss, diabetes, psychiatric disease, cancer, and back pain, 13% for arthritis subjects, and 14% when summing all comorbidities a patient had. CONCLUSIONS: Some selected VFQ-25 subscale scores were decreased with the presence of visual impairment and comorbidities. Systemic diseases should be included in VFQ-25 assessments to control for differences between patients and samples.

SCALING PROPERTIES OF THE DERMATOLOGY LIFE QUALITY INDEX (DLQI)

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OBJECTIVES: The Dermatology Life Quality Index (DLQI) is a widely-used HRQL measure. The instrument is intended for use by patients with any skin disease. The aim of this study was to assess the scaling properties of the DLQI and whether it is free from differential item functioning (DIF). METHODS: DLQI data collected in atopic dermatitis (AD) and psoriasis studies in the UK were subjected to Rasch (one-parameter logistic item response theory) analysis. Fit to the Rasch model was examined via Chi2 statistics and assessments of DIF related to gender, age and type of skin disease were made. RESULTS: Sample: Psoriasis study: n = 148 (49.7% male; mean age 45.1 +/- 14.9; mean illness duration 20.9 +/- 13.5; mean DLQI score 8.7 +/- 6.7); AD study: n = 286 (29.4% male; mean age 44.9 +/- 16.4; mean illness duration 29.0 +/- 16.7; mean DLQI score 7.0 +/-5.1). The DLQI showed significant misfit to the Rasch model in psoriasis and AD—indicating that the instrument is not unidimensional. Several DLQI items exhibited DIF by age and gender. Four of the ten items in the measure exhibited DIF by disease. CONCLUSIONS: The DLQI was found to misfit the Rasch model in both patient samples, indicating that it is unsafe to use the total score on the measure. Its validity is further compromised by items associated with age and gender which indicates that items work differently with different subgroups of patients. For example, “How much has your skin influenced the

EY/EAR/SKIN DISEASES/DISORDERS

IMPACT OF ATOPIC DERMATITIS ON PARENT/PATIENT QUALITY OF LIFE AND USE OF DIRECT RESOURCES IN PATIENTS BETWEEN 2 AND 12 YEARS OLD. DAES STUDY

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OBJECTIVES: Assess the impact of atopic dermatitis (AD) on parent’s quality of life (QoL) and use of health direct resources in patients between 2 and 12 years old. METHODS: An observational burden-disease study of nine months of follow-up in which AD patients 2 to 12 years old were included according to Hanifin&Rajka diagnostic criteria. Four visits were conducted per protocol (baseline, 3, 6, 9 months). Disease severity was assessed by Investigator’s Global Assessment(IGA). Parents’ QoL was assessed by Parents Index of Quality of Life Atopic Dermatit (PiQoL-AD) and by Visual Analogue Scale(VAS) of the EQ-5D questionnaire. Use of direct resources in the last three months were assessed retrospectively by medical files data or direct interviews to patients’ parents. RESULTS: Results are referred to baseline visit. A total of 240 children with AD were included in the analysis, with mean age (5D) 5.3 (2.7), 52% were boys. The most frequent careers were mothers (87.8%), 36.24 (4.9) years older (mean(SD)). 19.18% of patients had clear or almost clear AD (IGA < 2), 31.25% had mild disease (IGA = 2), 37.91% had moderate disease (IGA = 3) and 11.68% had severe or very severe disease (IGA = 4 or IGA = 5). Disease severity had a significant impact on parent’s QoL: mean scores of PiQoL-AD questionnaire increased 4.9 points and VAS score decrease 16.28 points (p < 0.5), indicating a worsening health state. In the last 3 months, 79.69% of patients required medical assistance, mainly from paediatricians or dermatologists; 81.84% pharmacological treatment and 24.11% laboratory tests, 17.61% unscheduled visits and 12.73% went to the Emergency Department. Use of direct resources increased with severity (p < 0.5). CONCLUSIONS: Parents’ QoL tends to reduce progressively from mild AD states while resource utilization increases progressively. Proper management of AD may help maintain patients in less severe disease states, reducing the negative impact on quality of life and on resource utilization.
Abstracts

LIVING WITH A DERMATOsis: A NATIONAL SURVEY OF QUALITY OF LIFE IN BELGIUM
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OBJECTIVES: To assess the consequences of dermatological diseases on the quality of life of the patients. METHODS: Every Belgian Dermatologist received a sample of 30 questionnaires including the DLQI and the SF-12 that they distributed during the “National Week of Dermatology” to the first 30 patients coming to the consulting room. The SF-12 is a generic measure of health status, composed of two dimensions, a Physical one (PCS-12) and a Mental one (MCS-12). The lower the score, the more the quality of life is affected. The DLQI is a questionnaire designed to measure and compare disability in different skin conditions. The higher the score, the more the quality of life is affected. RESULTS: The male/female ratio was 37%/63% and the mean age was 46.76 years. Concerning the patients’ state of health, MCS-12 and PCS-12 were respectively 43.8 (SD = 11.3) and 48.1 (SD = 9.4); with a significant difference in the mental dimension between Flemish (46.4, SD = 10.6) and Walloons (40.7, SD = 11.3) (p = 0.0001). The quality of life score, assessed by the DLQI, shows a quality of life’s impairment with a score of 6.1 (SD = 5.9). CONCLUSIONS: Our population reflect a QoL impairment comparable to the ranges obtained when initially validating the DLQI; i.e. for patients suffering psoriasis the DLQI mean score was 8.9, it was 4.3 for patients suffering from acne, and 6.7 for patients with viral warts. Concerning patients’ health status we observe for every patient, whatever his skin disease was, an important impairment in the mental dimension of the SF-12 compared to a standard population and a slight one for the physical dimension (except for patients with acne who are younger, mean age = 28 years old).

INTERPRETATION OF SCORES ON THE PSORIASis INDEX OF QOL (PSORIQoL)
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OBJECTIVES: The Psoriasis Index of Quality of Life (PSORIQoL) is a 25-item quality of life (QoL) scale specific to psoriasis. It has been shown to have excellent scaling properties and to be reproducible and valid. The aim of the present study was to assess the responsiveness of the PSORIQoL and provide data that will aid in the interpretation of scores on the measure. METHODS: Data from a 13-week, placebo-controlled clinical trial in psoriasis were analysed. PSORIQoL responsiveness was assessed using Effect Size (ES), Standardised Response Mean (SRM) and the Responsiveness Statistic (RS). The Standard Error of Measurement (SEM), a distribution-based method of interpreting scores was also calculated. An anchor-based Minimal Important Difference (MID; which provides an assessment of clinical meaningfulness) was derived by measuring QoL change accompanying changes in disease severity on a six-point Investigator’s Global Assessment (IGA). The IGA ranges from zero (clear) to five (very severe disease). RESULTS: A total of 69 psoriasis patients completed the PSORIQoL. (51/ 74% male; mean age 43.8 +/- 11.7; baseline mean PSORIQoL = 12.2 +/- 6.4; 13-week PSORIQoL = 9.8 +/- 7.1). Effect Sizes ranged from 0.37 for the placebo arm to 0.67 for the most potent treatment arm. Changes for the whole sample were significant over time (p = .007), with SRM = 0.40 and RS = 0.51. According to ES, changes of 1.3, 3.2, and 5.1 represent small, moderate and large changes in PSORIQoL scores respectively. One SEM = 1.91; 1.96 SEM = 3.75. A move from Severe to Moderate and from Moderate to Mild disease on the IGA requires a change of 1.8 and 2.7 points, respectively in PSORIQoL scores. CONCLUSIONS: The PSORIQoL was shown to be responsive to treatment effects. The MID for the measure is between two and three points.

SUNBURNs AND QUALITY OF LIFE
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OBJECTIVES: The ICARE programme's objective is to assess patients' knowledge of the consequences of sun exposure. Its specificity and relevance are based on the fact that patients will be asked to fill in the questionnaire after a sunburn. METHODS: Every patient coming to an outpatient pharmacy in order to obtain an advice or treatment following a sunburn was remitted a questionnaire assessing the consequences of sun exposure. The Dermatology Life Quality Index (DLQI) is a validated questionnaire to measure and compare disability in different skin conditions. RESULTS: First results showed evidence of a QoL...