In Response to Stephen McKenna and John Brodersen’s Letter to Editor —
Application of the Disease-Specific Quality of Life Assessment of Growth
Hormone Deficiency in Adults (QoL-AGHDA) Questionnaire in a General
Population: Results from a French Panel Study

We are grateful for having the opportunity to reply to the letter
from Stephen McKenna and John Brodersen [1], in which the
authors discuss several issues related to our work. Our study
was intended to pursue the work begun by others to provide normative
data on the quality of life assessment of growth hormone de-
ciency in adults (QoL-AGHDA) questionnaire to help interpret QoL-
AGHDA data collected in growth hormone deicient (GHD) pa-
tients. In this context, we aimed to complete previous studies
that enabled reference values for the QoL-AGHDA question-
naire to be collected in general populations in European coun-
tries [2–6]. Therefore, we would like to provide some clariication
as it seems that the objective of our work has not been fully un-
derstood by the authors of the letter to editor.

The QoL-AGHDA questionnaire was developed according to
the needs-based approach of QoL, and is indeed intended to be
used in GHD patients and not in healthy individuals. Thus, the
questionnaire was psychometrically validated in GHD patients
in the UK, Sweden, Germany, Italy, and Spain [7]. The translation
and psychometric validation of the French version of the QoL-AGHDA
questionnaire in GHD patients was undertaken and published by
aiming to validate the QoL-AGHDA questionnaire in Sweden using
Rasch analysis and to compare the QoL of GHD patients to that of
a random sample of the Swedish population. Reference values
were collected in other European countries [2–5], but without mea-
suring the scaling properties of the QoL-AGHDA questionnaire in
general populations. The main purpose of our study was to collect
reference QoL-AGHDA data for the French general population. To
ensure scientiically sound results to be produced, we also as-
cessed the psychometric properties of the French QoL-AGHDA
questionnaire in our study sample.

Contrary to the study conducted by Wiren et al. [6], our study
was not designed to directly compare a patient sample to a ran-
dom sample of the general population using Rasch analysis. In
order to focus our article on the main objective (that was to pro-
vide additional reference values for the QoL-AGHDA question-
naire), we deliberately did not develop on technical aspects of the
Rasch analysis in the article. Nevertheless, in order to clarify some
doubts from the authors of the letter, we would like to state that
the overall fi of our Rasch model was good (item-trait interaction
p [ 2 ] = 1000; separation index = 0.88). We appreciate that it would
have been interesting to explore the issue of differential item func-
tioning (DIF) between males and females as regards the results
observed on the mean QoL-AGHDA total score. The objective of the
study, however, was to establish reference values on the observed
score to make easy comparison with GHD patients. Correcting the
score by gender for DIF would have prevented this simple and
direct comparison, which, for example, may be conducted by cli-
nicians to compare with QoL of their patients.

One major concern when using QoL instruments is the inter-
pretation of data collected with such measures, and reference val-
ues represent a simple and direct way for clinicians to convert a
QoL score given by a patient into interpretable and worthwhile
information. Such reference data have been collected for many
years, for both generic and specifi questionnaires, including the
QoL-AGHDA questionnaire [9–12]. In particular, Wiren [6] com-
pared QoL-AGHDA data between GHD patients and a random sam-
ple of the Swedish population, with no reference to the potential
irrelevance of using such a population as comparator. We are thus
surprised by the statement made by the authors of the letter about
the irrelevance of comparison with healthy individuals, as Ste-
phen McKenna contributed to the Swedish study.

As explained in the article, the issue of which population
should be used to compare QoL-AGHDA data in GHD patients re-
mains an open question. Both general and other disease popula-
tions present advantages and disadvantages, and it seems obvious
that the comparator should be chosen depending on the research
question to be addressed [13,14]. In the context of choosing the
appropriate comparator, it is important to collect as much infor-
mation as possible to enable a comparison that is as accurate and
relevant as possible to be conducted. Our study falls within this
framework as we chose to collect reference values in the French
general population to complete previous studies. Moreover, refer-
ce values collected in general populations have a major addi-
tional interest compared to reference values collected in disease
populations: they may enable utility values to be derived for use in
economic evaluation [15].

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REFERENCES

[1] McKenna S, Brodersen J. The chimera of population norms. Value
Health 2011;14:618.

ERRATUM

In Value in Health, Volume 14, Issue 1, the article, “Exact Method for Computing Absolute Percent Change in a Dichotomous Outcome from Meta-Analytic Effect Size: Improving Impact and Cost-Outcome Estimates,” denotes that Delia Hendrie is with the School of Population Health, University of Western Australia, Perth, Australia. Her correct affiliation is Curtin Health Innovation Research Institute (CHIRI), Population Health Research, Curtin University, Perth, Western Australia.

ERRATUM

In Value in Health, Volume 13, Issue 8, the article, “Use of a Disease-Specific Instrument in Economic Evaluations: Mapping WOMAC onto the EQ-SD Utility Index,” Table 1 was published with some incorrect numbers. This table has been corrected and is available here.

Table 1 - Demographic characteristics and quality of life scores for the study samples.

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Total sample (n=257)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>66.5 (7.6)</td>
</tr>
<tr>
<td>Female, N (%)</td>
<td>213 (82.9)</td>
</tr>
<tr>
<td>Ethnicity, N (%)</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>230 (89.5)</td>
</tr>
<tr>
<td>Malay</td>
<td>10 (3.9)</td>
</tr>
<tr>
<td>Indian</td>
<td>14 (5.4)</td>
</tr>
<tr>
<td>Others</td>
<td>3 (1.2)</td>
</tr>
<tr>
<td>Formal education, N (%)</td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>107 (41.6)</td>
</tr>
<tr>
<td>1-6 years</td>
<td>85 (33.1)</td>
</tr>
<tr>
<td>7-10 years</td>
<td>46 (17.9)</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>14 (5.4)</td>
</tr>
<tr>
<td>Married, N (%)</td>
<td>235 (91.4)</td>
</tr>
<tr>
<td>Retirees/homemaker, N (%)</td>
<td>222 (86.4)</td>
</tr>
<tr>
<td>BMI, mean (SD)</td>
<td>28.2 (4.7)</td>
</tr>
<tr>
<td>Years with OA, mean (SD)</td>
<td>6 (5.2)</td>
</tr>
<tr>
<td>EQ-SD scores, mean (SD)</td>
<td>0.62 (0.13)</td>
</tr>
<tr>
<td>WOMAC scores, mean (SD)</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>6.64 (3.38)</td>
</tr>
<tr>
<td>Stiffness</td>
<td>3.12 (2.03)</td>
</tr>
<tr>
<td>Function</td>
<td>26.24 (10.18)</td>
</tr>
</tbody>
</table>

BMI, body mass index; SD, standard deviation; OA, osteoarthritis; WOMAC, Western Ontario and McMaster Universities Osteoarthritis Index.