Safety was characterized by ADR reporting and discontinuation of treatment. Medication effectiveness was determined by persistence on the subsequent alternative α1-antagonist.

RESULTS: Of 226 patient requests submitted, 55 (24.3%) were denied. Patients averaged 17.9 months (±12.4) on tamsulosin prior to denial. After 90-days, 67.3% remained on the recommended alternative α1-antagonist, 14.5% had no alternative ordered and no tamsulosin dispensed, 9.1% remained on tamsulosin from VASDHS, 5.5% continued tamsulosin from non-VASDHS sources, 3.6% required changing to a second non-tamsulosin alternative, and adverse events occurred in 9.1%. The cost of a prescriber entering a reauthorization request was $8.19/patient while adjudication by a pharmacist was $11.61/patient. Few telephone contacts (10), unscheduled clinic visits (1), and urgent care visits (0) occurred adding $5.29 per patient per month (PPPM). Prescription costs were $9.82 PPPM for patients denied versus an estimated $43.87 for those approved. The total cost of 226 requests, excluding scheduled clinic visits, was $128.94/patient versus an estimated $131.58/patient if the program had not been implemented.

CONCLUSION: Overall outcomes and associated costs incurred in a tamsulosin reauthorization program eliminated much of the anticipated cost savings in the 90-days following a denial.

FACTORS INFLUENCING EARLY NEPHROLOGY CARE PRIOR TO HEMODIALYSIS INITIATION AMONG ELDERLY PATIENTS WITH END-STAGE RENAL DISEASE
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OBJECTIVE: Early care provided by nephrologists before initiating dialysis may improve treatment outcomes for patients who later progress to end-stage renal disease (ESRD) and start hemodialysis. The objective is to identify factors influencing early nephrology care, defined as visiting a nephrologist from 4 to 12 months prior to hemodialysis initiation among elderly ESRD patients.

METHODS: The study population consists of patients initiating hemodialysis in the years 1996–1999, aged 67+ years and having Medicare Part B coverage in the fee-for-service system in the 2nd year prior to dialysis initiation. Patients’ characteristics were obtained from Centers for Medicare & Medicaid Services form 2728 files. Comorbidities and hospital utilization were generated from Medicare Part A and/or Part B claims. Physician visits including early nephrology care and access to non-nephrologist physicians and nephrologists practicing in a local area, defined as an area 30 miles within a patient’s residence ZIP code, were computed with Medicare Part B physician/supplier files and US 2000 Census data.

RESULTS: About 33.79% of 91,189 elderly patients received early nephrology care before starting hemodialysis. Logistic regressions indicated that patients who were male, had hypertension, anemia, more hospital admissions in the year before initiating dialysis, lived in an area with more nephrologists per 1000 prevalent elderly ESRD patients were more likely to obtain early nephrology care. Patients older than 76 years, having diabetes, living in an area with more non-nephrologist physicians per 10,000 population had a lower likelihood of getting early nephrology care. Patients residing in areas 12 miles or more away from the nearest nephrologist had a smaller odds ratio of receiving early nephrology care compared to patients living in an area less than 4 miles away.

CONCLUSIONS: Elderly ESRD patients’ characteristics and access to local non-nephrologist physicians and nephrologists affect the use of early nephrology care prior to hemodialysis initiation.
with OAB was collected. Baseline mean health state values ranged from 0.92 to 0.994. Post 12 weeks treatment mean health state values ranged from 0.936 to 0.991. The observed improvements in health state values are consistent with results obtained during validation of the model. CONCLUSIONS: Although modest, these improvements may be expected to be significant and are consistent with observed reductions in KHQ scores.

URINARY/KIDNEY—Patient Reported Outcomes

PSYCHOMETRIC PROPERTIES OF THE KING'S HEALTH QUESTIONNAIRE: A SYSTEMATIC CRITICAL APPRAISAL OF THE LITERATURE
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OBJECTIVE: King's Health Questionnaire (KHQ) is a self-administered, 32-item, 8-domain, urinary incontinence-specific quality of life (QOL) instrument. A critical appraisal of the literature was conducted to assess its psychometric properties across all available language versions. METHODS: Computer searches limited to English language and Humans were conducted using PubMed with keywords “KHQ” or “king’s health questionnaire”. When articles ascertained through these searches referenced additional citations, we retrieved them. Exclusion criteria were: review articles, no information on psychometric properties, related to short-form KHQ, or KHQ was used to validate other QOL measures. RESULTS: We found 11 articles that met the inclusion criteria. Item generation included data from over 1,100 patients, inputs from clinicians, and items from existing instruments. Eight articles were on English version-KHQ, and 3 were on Portuguese-, German-, and Japanese-KHQ (one article per language). Cronbach’s = 0.70 for English- and German-KHQ. The range was wider for Portuguese-, and Japanese-KHQ (0.47–0.88 and 0.63–0.90, respectively). English-KHQ had a high test-retest reliability across all 8 domains (Spearman’s ρ = 0.80–0.96). KHQ had face and content validity. KHQ was used in multiple clinical trials and it underwent a systematic translation process involving forward translation, backward translation, and cultural adaptation. Correlation coefficients between KHQ and SF-36 domains were (−0.32 to −0.73) and (−0.26 to −0.63) for English- and German-KHQ. Internal responsiveness was shown in Portuguese-KHQ with the mean standardized response mean ranging −0.54 to −1.61. Using both distribution- and anchor-based methods, a change from baseline of at least 5 points on KHQ domains meant a minimal important difference. CONCLUSION: The KHQ is reliable and has good face and content validity, responsiveness, and interpretability. Construct validity was variable across different language versions and KHQ domains. Thus, we recommend additional research on construct validity, especially in European populations.

QUALITY OF LIFE IN YOUNG MEN AFTER RADICAL PROSTATECTOMY FOR CLINICALLY LOCALIZED PROSTATE CANCER: RESULTS FROM THE CAPSURE REGISTRY
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OBJECTIVE: Literature on quality of life (QOL) following local treatment for prostate cancer has primarily focused on comparing treatment modalities rather than specific age groups. This analysis explored QOL outcomes in younger men following primary curative treatment for localized prostate cancer. METHODS: Using the CaPSURE (Cancer of the Prostate Strategic Urologic Endeavor) registry, men who underwent radical prostatectomy (RP) for localized disease and completed the UCLA Prostate Cancer Index (PCI) pre- and one-year post-surgery were identified. Men were grouped by age (<55, 55–64, >65 years). A decline in PCI domains from pre- to post-RP was defined as a decrease of one standard deviation from the pre-RP score. Logistic regression was used to analyze predictors of severe declines. RESULTS: A total of 1143 men were identified, with 190, 526, and 427 men in the 3 age groups, respectively. Younger men had significantly higher mean scores one-year after RP in the urinary function (UF), urinary bother (UB) and sexual function (SF) domains. A severe decline in UB was more common in the youngest age group than in the oldest (54% vs. 36%, p < 0.01). With the youngest men as the reference group in the multivariate model, the oldest age group was 40% less likely to have a severe decline of SB (OR = 0.60, 95% CI 0.41–0.90, p = 0.04) but trended toward a higher risk of severe decline in UB (OR = 1.27, 95% CI 0.85–1.89, p = 0.08). CONCLUSIONS: Age predicts disease-specific QOL changes at one-year following RP.