

multidimensionality of QoL can be assessed properly this way; especially in this specific situation where the owners are proxy reporters but also responsible for the well-being of the animal and therefore likely to be biased.

## HEALTH CARE INTERVENTIONS—Health Care Use & Policy Studies

PHC12

### STARR PROCEDURE FOR OBSTRUCTED DEFAECATION SYNDROME (ODS): 12-MONTH FOLLOW-UP

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**OBJECTIVE:** A European STARR registry was set-up to determine the short-term safety and effectiveness of the STARR procedure for obstructed defaecation syndrome. **METHODS:** STARR registries in Italy, Germany and the UK were designed with a web-based interface to allow pooling of results for combined analysis. Recruitment commenced in January 2006. Data collection included a symptom severity score (SSS), obstructed defaecation score (ODS), Cleveland clinic incontinence score, symptom-specific (PAC-QoL) and generic (ED-5Q utility and VAS) QoL score. All complications were recorded. Data collection was performed at baseline, 6 weeks, and 6 and 12 months. **RESULTS:** A total of 1456 patients were recruited and eligible for analysis. There were 214 (14.7%) male patients. The mean age was 54 yrs (range: 17–92). Mean operative time was 44mins (range: 15–210). Average length of stay was 3 days (range:1–36). By September 2007, 698 (48%) and 422 (29%) were eligible for analysis at 6 and 12 months, respectively. A significant symptomatic improvement was seen between baseline and 6 months and maintained at 12 months (SSS: baseline 24.1 (95%CI: 23.8,24.4) v's 12 months 12.5 (95%CI: 12.1,12.9),  $p < 0.001$ ; ODS: baseline 15.3 (95%CI: 14.9,15.6) v's 12 months 5.8 (95%CI: 4.8,6.7),  $p < 0.001$ . This was reflected in a significant improvement in both PAC-QoL and ED-5Q QoL scores at both 6 and 12 months. Incontinence scores improved from 3.1 (95%CI: 2.9,3.3) at baseline to 2.9 (95%CI: 2.1,2.7) at 6 months and 1.9 (95%CI: 1.5,2.2) at 12 months ( $p < 0.001$ ). 457 minor and major complications were reported, of which the most frequent were: unexpected pain (7.7%), urinary retention (6.8%), bleeding (4.5%), stapled line complications (3.2%), sepsis (1.4%), incontinence (1.3%). Postoperative defaecatory urgency was reported in 17% of patients. There was no mortality. **CONCLUSION:** STARR for ODS is safe, effective and significant improvement in QoL.

## INDIVIDUAL'S HEALTH—Clinical Outcomes Studies

PIH1

### PREVENTION OF FALLS AND FALL-RELATED INJURIES IN THE COMMUNITY-DWELLING ELDERLY: A REVIEW

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**OBJECTIVE:** As part of a broader analysis on aging in the community, the purpose is to perform a literature review to assess the effectiveness of interventions designed to prevent falls and fall-related injuries in community-dwelling elderly individuals. **METHODS:** A search was performed in OVID MEDLINE, MEDLINE In-Process and Other Non-Indexed Citations,

EMBASE, CINAHL, Cochrane Library, and INAHTA/NHS EED between January 2000 and September 2007. Furthermore, all studies included in a Cochrane review published in 2003 were considered for inclusion. Studies were included if they were controlled trials in a population of community dwelling elderly and examined falls or fall-related injuries as an outcome. **RESULTS:** Fifty-nine studies were identified investigating the effectiveness of nine interventions. A meta-analysis found that exercise programs effectively reduced falls if they were 6 months or longer in duration (RR = 0.84 [95% CI: 0.76–0.93]) or were offered to the general population and not a high risk group (RR = 0.79 [0.70–0.90]). Environmental modifications were effective in individuals with a history of falls (RR = 0.66 [0.54–0.81]), and a gait stabilizing device for outdoor winter use effectively reduced falls (RR = 0.43 [0.29–0.64]) and injurious falls (RR = 0.10 [0.01–0.74]). Although neither hormone replacement therapy or vitamin D alone reduced falls or injuries, vitamin D plus calcium supplementation resulted in a reduction in the number of falls (RR = 0.83 [0.73–0.95]) and fractures (RR = 0.60 [0.39, 0.94]). Multifactorial interventions were only marginally effective in reducing falls in a high risk population (RR = 0.87 [0.76–1.01]), and there was no evidence that vision interventions or hip protectors were effective. **CONCLUSION:** Several interventions were identified which reduce the risk of falls and fall-related injuries in community-dwelling elderly, however special consideration must be given to the intervention duration and population risk profile when determining the most appropriate interventions to implement. An economic analysis that informs investment decisions to maximize the impact of reducing falls is currently underway.

PIH2

### CONTRACEPTIVE FAILURE RATES AMONG MEDICAID AND NON-MEDICAID ENROLLEES

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**OBJECTIVE:** Contraceptive efficacy depends both on patient compliance and the characteristics of the method used. Efficacy rates can thus vary across different populations, particularly in women employing user-dependent methods (i.e., oral, condoms). This study measured the contraceptive failure rates in a Medicaid and a non-Medicaid population and evaluated the efficacy variance between the two groups. **METHODS:** Monthly contraceptive-use histories were constructed for all women using data from the 2002 National Survey of Family Growth (NSFG VI). Contraceptive use was defined by first contraception method mentioned in the survey. Poly-modal use was not defined. Women were classified as Medicaid enrollees if they reported having Medicaid coverage in the 12 months prior to the survey, or reported Medicaid payment for services. The final dataset included 1208 Medicaid-enrolled women and 6435 non-Medicaid enrolled women. Pregnancy rates were calculated each month and then annualized for women using user-dependent methods (oral contraceptives [OC], condom) or non-daily methods (IUD, injected, implanted birth control). **RESULTS:** Average annual contraceptive failure rates for Medicaid vs. non-Medicaid women were: oral pill—1.15% vs 0.13% ( $p = 0.0051$ ); condom—2.05% vs. 0.55% ( $p = 0.0015$ ); IUD—0.52% vs. 0.16% ( $p = 0.5156$ ); injected or implanted—0.27% vs. 0.13% ( $p = 0.3940$ ). OC failure rate was nearly 9-times higher in the Medicaid population than in the non-Medicaid population. Failures rates for IUD, injectables and implants were also higher but