cantly. HighBAI/highBDI was significantly different than the other groups (p < 0.01). This pattern was similar for social functioning, role emotion, mental health. Physical-related SF-36 domains were generally not different between groups. The difference in work-performance scale scores followed the same general pattern of less impairment with lowBAI/lowBDI (for example, WPAI-Percent Impairment While Working score 0.22 ± 0.3) and highBAI/highBDI (WPAI Percent Impairment While Working 0.77 ± 0.2), p < 0.01. Other work scales followed a similar pattern. BDI routinely was more significant in regression models compared to BAI. CONCLUSION: Comorbid anxiety and depression greatly impair patients. Clinicians and researchers should measure the presence and severity of both mental illnesses when assessing their influence on health-related quality of life and work-performance.

PMH61

PATIENT PREFERENCES IN THE THERAPY OF ADHD—A DISCRETE CHOICE EXPERIMENT

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OBJECTIVE: While the clinical efficacy of drugs for ADHD is widely studied in clinical trials (usually randomised controlled trials, RCTs), patient preferences with regard to their treatments are not well understood and therefore considered to a lesser extent. Aim of this study therefore was to explore the patients’ perceptions of an “ideal treatment” for ADHD. METHODS: Examination of the state of the art as reported in the literature was followed by a qualitative study with four focus groups consisting of 6–8 parents of ADHD-patients each. In a subsequent quantitative study phase, data was collected in an online or paper-pencil self-fill-in questionnaire for parents of patients and patient (age >14 years) themselves. It included sociodemographic data, treatment history and actual treatment and patients’ preferences of therapy characteristics using direct measurement (23 items on a 5-point Likert-scale) as well as a discrete-choice-experiment (DCE, 8 pairs with 6 characteristics). RESULTS: N = 215 questionnaires were filled; most of them by the parents of patients (79% by the mothers, 9% by the fathers). Most of the patients were male (83%) and most of them (83%) had actual medical treatment of ADHD. Direct measurement showed “good emotional quality of life”, “no addiction on medication”, “improvement of concentration capability,” and “few side effects” in the first places. In the DCE, alternatives with “better social quality of life (friendships etc. possible)”, “better emotional quality of life (disease not all of the time mentally present)”, and “longer duration of medication effect” were more likely chosen, giving thus similar results. CONCLUSION: This unique study demonstrates that it is possible to obtain valid and robust information from patients on what constitutes relevant patient outcomes. Such information should play a critical role in appraisal of treatment alternatives by HTA bodies.

PMH62

ASSESSING THE VALIDITY OF DERIVING CLINICAL DEMENTIA RATING (CDR) GLOBAL SCORES FROM INDEPENDENTLY OBTAINED FUNCTIONAL RATING SCALE (FRS) SCORES IN VASCULAR DEMENTIA AND MIXED VASCULAR DEMENTIA PATIENTS

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OBJECTIVE: The functional rating scale (FRS) and clinical dementia rating (CDR) scale are two different tests used to assess the severity and progression of dementia. Although the FRS covers more domains and requires less time to administer than the CDR, the CDR categorizes severity of dementia while the FRS does not. The purpose of this research was to calculate the agreement between the FRS and CDR scales and to determine if they could be used interchangeably for diagnosis of disease severity in vascular dementia (VaD). METHODS: Inpatients and outpatients diagnosed with VaD/mixed VaD were evaluated using the FRS and CDR scales. The tests were administered independently by two separate raters. Since the FRS contains all of the domains that are rated in the CDR, CDR scores were extracted from the corresponding FRS domains and used to derive global scores of severity. FRS-derived global scores were then compared to original CDR global scores by a weighted kappa analysis to measure concordance. RESULTS: A total of 28 VaD/mixed VaD patients were involved in the study. In the patient population, 60.7% were males and average age was 78.6 ± 7.7 years. Average MMSE score was 19.9 ± 4.8 while mean Hachinski score was 8.1 ± 2.8. The modal value obtained for both the FRS-derived CDR scores and original CDR scores was 2; in both groups scores ranged from 0.5–3 with 43% of patients diagnosed in category 2 (moderate dementia). The weighted kappa analysis showed substantial concordance (kappa = 0.75) between FRS-derived CDR and original CDR-global scores. CONCLUSION: These results suggest that FRS scores can be used to derive global scores that are in agreement with those produced by the validated CDR method. This serves as a powerful tool since it allows for easy comparison of the diagnostic distribution, natural history and treatment outcomes of individuals with dementia.

PMH63

PATIENT REPORTED MEASURES AS QUALITY ASSURANCE TOOLS IN CNS CLINICAL TRIALS

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OBJECTIVE: Signal detection and, ultimately, regulatory approval depend on high-quality, valid and reliable data. The subjective rating scales utilized in CNS clinical trials may be vulnerable to spurious ratings and intentional or unintentional manipulation of ratings by investigators at screening or baseline visits. The objective of this study was to evaluate the feasibility of utilizing a patient reported outcome as a quality assurance measure for evaluation of the quality of a clinician rated primary efficacy measure in a CNS clinical trial. METHODS: A proprietary ratings surveillance system was utilized in a multi-center, double blind, randomized, placebo-controlled clinical trial in which the Hamilton Anxiety Rating Scale (HARS) was the primary efficacy measure. The patient rated Beck Anxiety Inventory (BAI) was added to the baseline visit for quality assurance purposes. Based on published guidelines of the expected relationship between HARS and BAI scores, a computer program flagged aberrant ratings and three flags with the same rater triggered a teaching intervention. The ratings surveillance system was intended both to detect aberrant rating patterns and to deter intentional inflation of ratings in order to qualify subjects. RESULTS: The clinical trial is ongoing. 91 pairs of HARS and BAI ratings have been examined from the randomization visit. 61/91 (67%) pairs were flagged for discordance, in most cases (79%) due to disproportionately high HARS scores compared to the BAI. In 8 cases, the BAI was under 10 with the HARS 22 or greater. In 11 cases, there were at least 3 flags for the same rater and the pattern of discordance was considered to be of sufficient clinical significance to warrant a teaching intervention. CONCLUSION: Use of