JUDGEMENT OF THE CLINICIANS THEMSELVES

Malignant testicular cancer can be cured in the majority of patients by chemotherapy. After chemotherapy, residual masses of the initial metastases may remain, which may effectively be resected by a second surgical resection. The resection rate between 25% and 80%. This variation is largely explained by differences in management of patients with minimal residual masses (0-20mm). In this analysis we therefore also investigated the expected resection rate on the basis of the size of the resected tumor and the size of the residual mass. A decision analysis model was constructed for the strategies ‘resection’ and ‘follow-up’. The outcome considered was the 5-year survival rate. With each strategy, one of three histologies may be found in the residual mass, namely seminoma, nonseminoma or mature teratoma. The probability of the occurrence of these histologies was estimated for each estimate. The result of this analysis was that resection of masses 11-20mm in size is expected to yield a 2.3% higher 5-year survival rate. For very small masses (0-10mm), the benefit of resection was rather robust when the estimates were varied over the sequence of health states. The minimum benefits according to the individual clinicians were 2.2% and 0.5% respectively.

In conclusion, the clinicians’ own judgements indicate a substantial benefit of resection, even in very small residual masses. Current surgical policies for residual masses therefore need to be reconsidered.

SEQUENCE EFFECTS IN TRADEOFFS: ARE GOOD YEARS AFTER BAD YEARS BETTER THAN THE REVERSE?

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Purpose. We studied whether a different sequence of health states in a health profile yields different valuations. Methods. The empirical task was part of a large standardized experiment involving 104 students. Thirteen health states were used in two different sets of 10. A sequence of health states was presented to students in such a way that they had to estimate the time in “best imaginable health state” and “worst imaginable health state” in order to estimate the lifetime health profile. The empirical task was part of a large standardized experiment involving 104 students. Thirteen health states were used in two different sets of 10. A sequence of health states was presented to students in such a way that they had to estimate the time in “best imaginable health state” and “worst imaginable health state” in order to estimate the lifetime health profile. The sequence effect in our study contradicts the commonly used “time trade-off” method, which is the conventional method for the respondents. On the other hand, performing evaluations based on Process-like descriptions demands without any doubt a considerable cognitive task of participants. Research into the causes of the differences in results between the “State” and the “Process” approach is required.

MEASURING STAKEHOLDER PREFERENCES FOR SCHIZOPHRENIA OUTCOMES

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Understanding stakeholder preferences is essential for identification of effective treatments for schizophrenia, a severe and chronic psychiatric disorder with multiple, conflicting outcomes. However, measuring preferences for schizophrenia outcomes poses particular challenges. First, personal stakeholder groups are involved in schizophrenia treatment, including patients, patient’s families, clinicians, and members of the general public. Second, patients’ preferences are often at odds with other stakeholders. Third, stakeholders demand without any doubt a considerable cognitive task of participants. Research into the causes of the differences in results between the “State” and the “Process” approach is required.

The McMaster Health Utility Index (MHS) and the EuroQol-5D assessed in patients with peripheral arterial disease in the United States and the Netherlands

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Purpose: To assess the relationship between the McMaster HUI (II) and the EQ-5D in the Netherlands, and to compare health profiles of patients with advantage (i.e., mild stage of peripheral arterial disease) and patients with severe disease (i.e., critical/interim stage of peripheral arterial disease) based on the McMaster HUI (II) and the EQ-5D.

Methods: The McMaster HUI (II) and the EQ-5D were completed by 112 patients with peripheral arterial disease (20% had severe disease, respectively). Values were transformed to a scale of 0.00-1.00 (1.00 being perfect health). The relationship between the two Indices was assessed with a correlation coefficient (r).

Results: Although the mean McMaster HUI (II) and EQ-5D values were significantly different (0.70 (SD 0.22) vs. 0.20 (SD 0.26) respectively), the relationship between the two Indices was 0.41. Since the McMaster HUI (II) formula is based on SQ utilities and the EQ-5D Index on RS values, we transformed the EQ-5D with Tarcov's transformation. This improved the relationship between the two Indices only slightly (r=0.44). No differences in outcomes or the correlation coefficients between the two countries were demonstrated. The mean McMaster HUI (II) and the mean EQ-5D were significantly different in the diabetic group, 0.76 (SD 0.15) vs. 0.51 (SD 0.31) respectively, and in the ambulation group 0.51 (SD 0.15) vs. 0.43 (SD 0.24) respectively (p<0.001). The mean values of the two Indices were also significantly different in the non-diabetic group (p<0.001) and in the amputation group (p<0.001).

Conclusions: Although the McMaster HUI (II) was developed in North America and the EQ-5D in Europe this influence affected neither the outcomes nor the relationship between the Indices across countries. The EQ-5D yielded lower values than the McMaster HUI (II), which was not explained by transforming the RS-based EQ-5D Index to a SQ Index. Finally, the McMaster HUI (II) was more discriminative between different stages of peripheral arterial disease than the EQ-5D.