ations were the condition with the highest impact on OHRQoL. Women had poorer OHRQoL and higher GHQ-12 scores than males. There was a very strong correlation between questionnaires scores and PtGA, but none or very scarce between questionnaire scores and PhGA. The overall K between PtGA and PhGA was 0.14, i.e., only slight, and for some conditions it was even negative (e.g., −0.23 for non-malignant lesions). Patients whose condition was "underestimated" by the physicians (i.e., PtGA>PhGA) had the worst OHRQoL and psychological status among all patients in the study. **CONCLUSION:** The administration of specific and generic questionnaires provides a complete and clinically useful picture of the impact of oral diseases on quality of life and on psychological well-being. The combined use of PhGA and PtGA allows to define a group of patients with particularly high levels of quality of life impairment and psychological distress. This may be relevant since these patient characteristics have been linked to dissatisfaction with care, poorer treatment adherence, and possibly higher probability of legal litigation.

APPLES AND ORANGES? ASSESSING THE RELATIONSHIP BETWEEN HEALTH AND VISION RELATED QUALITY OF LIFE

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OBJECTIVE: Cost-utility analysis is the preferred method of economic evaluation to support health policy decision-making in most developed nations. Utility estimation is based upon the untested assumption that a single universal construct, "health related quality of life" (HRQoL), is measured. We hypothesize that this is the case with vision related diseases. We test whether vision-related quality of life (VRQoL) is a distinct construct from HRQoL using two instruments: the SF-36 to measure HRQoL, and the NEI Vision Function Questionnaire (NEI-VFQ) to measure VRQoL. **METHODS:** Over 16 months, 443 patients from 18 ophthalmic practices were interviewed. The relationship among item responses from the SF-36 and NEI-VFQ was assessed using exploratory factor analysis (EFA) and variable cluster analysis (VCA). **RESULTS:** The results suggest that vision and non-vision related quality of life are indeed two distinct constructs. In EFA, no items from the NEI-VFQ loaded on constructs formed by the SF-36 items, or vice-versa. Variable cluster analysis confirms the EFA, with the SF-36 and NEI-VFQ items showing moderate correlation with items from their "home" instrument, but weak correlation with items from the other instrument. **CONCLUSIONS:** Our preliminary results provide evidence that VRQoL and HRQoL are two distinct constructs that have modest association. While these analyses are based upon use of functional based measures as opposed to preference based measures such as the standard gamble (SG) or time trade-off (TTO), the results may have important implications for the validity of preference based measures for assessment of effectiveness. If the SG or TTO (or similar instruments) do not adequately measure all aspects of health, interventions addressing poorly measured problems (vision-related problems in this case) may be substantially underestimated. If this is the case, health policy makers relying on cost-effectiveness studies using these instruments might incorrectly reject health programs for treatment of important medical conditions.

MAPPING THE NATIONAL EYE INSTITUTE VISUAL FUNCTION QUESTIONNAIRE (NEI-VFQ 25) TO THE INDEX VALUES FOR THE EQ-5D: A COMPARISON OF MODELS

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OBJECTIVES: To date, no model has explained the relationship between the NEI-VFQ and health state utilities such as those measured by the EQ-5D. Ordinary Least Square (OLS) is most commonly used to identify association but it may not be appropriate in low vision. In this study, we evaluate different model specifications to identify which better predicts the relative importance of the NEI-VFQ 25 dimensions on the EQ-5D index. **METHODS:** We compare OLS and Tobit approach using cross-sectional data (n = 155) at screening from a phase I/II clinical trial in patients with neovascular age-related macular degeneration (NV-AMD). We validate the models using a split-sample technique and calculate each model's mean predicted error and standard error. Correlations between the predicted EQ-5D index values derived from the NEI-VFQ 25 dimensions and the observed EQ-5D index score are compared across models. **RESULTS:** Mean prediction error from the Tobit model is lower than the OLS approach (26 vs. 39 percent). The standard errors of prediction of the Tobit and OLS models are 0.0263 and 0.0234, respectively. The predicted EQ-5D index value from the Tobit model provides better correlation with the observed EQ-5D index score compared to the OLS approach [Pearson Correlation Coefficients are 0.57 and 0.47, respectively]. **CONCLUSION:** In this situation, the Tobit model provides better predictive accuracy than OLS for explaining the relationship between the EQ-5D index and the NEI-VFQ 25. Tobit produces consistent estimates of the relationship between the EQ-5D index and the dimensions of the NEI-VFQ 25 by accounting for censoring and ceiling effect problems. Although it is sensitive to model misspecification, adjusting for heteroscedasticity nevertheless allows it to perform better than OLS. Verification of these results using the model and a second dataset is warranted.

WORK RELATED LOST PRODUCTIVITY AND ITS ECONOMIC IMPACT IN CANADIAN PATIENTS WITH MODERATE TO SEVERE PSORIASIS

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OBJECTIVE: To determine the lost productivity of Canadian patients with moderate to severe psoriasis. **METHODS:** Seventy-nine consecutive Canadian dermatology patients were interviewed and completed the Work Productivity and Activity Impairment Questionnaire. The inclusion criteria were diagnosis with moderate to severe psoriasis by the treating dermatologist; 19 year of age or older and currently receiving treatment for psoriasis with either a biologic or alternative therapy such as phototherapy, systemic or topical treatments. Patient interviews and data collection occurred between September 21st, 2005 and November 8th, 2005. **RESULTS:** Eighty-one percent of patients reported working full-time. On average, 2.6 hours (±6.8) (about 6% of total work hours) were lost from work per week due to psoriasis-related events. When asked how much psoriasis affected their productivity while working, individuals on average