and/or from an employed person (33.0% versus 20.9%) and consumed more antide-
prescission drugs than patients with mild psoriasis (20.1% versus 7.8%). Mean individual
cost of the disease was estimated to be £543/year/patient. CONCLUSIONS: This study
is the first in France to explore the impact of psoriasis on different perspectives. Our
results show that psoriasis, particularly severe psoriasis, is a true burden for patients
and impacts significantly everyday life and patient economical resources.

OBJECTIVES: The Dermatology Life Quality Index (DLQI; 10 items) is a generic
 dermatology health-related quality of life (HRQoL) measure that is the most
commonly used in dermatology. Despite its popularity little research has been conducted
into the dimensionality of the questionnaire. The purpose of this study was to examine
its scaling properties and establish whether it is unidimensional.

METHODOLOGY: DLQI data were combined from two studies; one involving people with psoriasis and the
other patients with atopic dermatitis. Item Response Theory was used to determine;
overall fit to the Rasch model, individual item fit, targeting of scale to severity of
response categories and the presence of Differential Item Functioning (DIF) by disease, age or gender.

RESULTS: The sample included 146 psoriasis patients (male 50%, mean age = 44.2 range = 17–83 years) and 146 atopic
dermatitis patients (male 50%, mean age = 43.5, range = 20–82 years). The DLQI misfit to the Rasch model (Chi² = 63.38, df = 40, p = 0.011). Item 2 misfit the Rasch model and items 5 and 7 showed borderline misfit. Items 4, 6, 7, 8 and 9 had disor-
dered response thresholds indicating that these did not work in a logical way. Results showed
a lack of spread in the measurement of HRQol with too few items covering either milder or more severe levels of HRQol. DIF by disease was shown in items 3, 5 and 7 and DIF by age in item 10. After removal of item 2 and rescoring the response
categories the DLQI still misfit the Rasch model (Chi² = 54.92, df = 36, p = 0.02).

CONCLUSIONS: The results of the Rasch analysis showed there were several prob-
Leeds present in the scale of the DLQI and that little confidence can be placed in
raw scores generated from the scale. These problems need to be addressed before
the QLDS can be considered a valid and useful outcome measure.

DEVELOPMENT AND ACCEPTABILITY OF A NEW INTERNATIONAL
QUALITY OF LIFE INSTRUMENT SPECIFIC TO PHYSICAL APPEARANCE: BEAUTYQOL

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1Whips Cross University Hospital, Leytonstone, London, UK, 2Royal London Hospital, Whitechapel, London, UK, 3Oripington Hospital, Oripington, London, UK, 4Royal Cornwall Hospital, Truro, Cornwall, UK, 5Amersham Hospital, Amersham, Buckinghamshire, UK, 6The Princes Royal Hospital, Hun, Kingston-Upon-Hu, UK, 7NH Associates, Marlow, Buckinghamshire, UK

OBJECTIVES: To check clinical compliance with guidance specified by NICE Tech-
ology Appraisals 103 (etanercept & efalizumab2), 134 (infliximab3) and 146 (adal-
mumab1). METHODOLOGY: A retrospective audit of medical records of patients treated
with biologics for psoriasis, since issue of relevant NICE guidance in 6 UK Dermatol-
ogy centres. The audit was conducted between December 2008 and February 2009 in accordance with a standardised protocol and data collection form, with local manage-
dement approval to release anonymised data for pooled analysis. RESULTS: A total of
173 courses of biologic treatment (in 149 patients) were included in the audit. PASI
and DLQI were recorded at initiation of 96% (n = 166) of treatments. Biologics were
initiated for appropriately severe disease in 92% of cases (n = 159) and only after failure
of conventional or contra-indication to standard systemic therapies in 98% (n = 170) of cases. In 69% (n = 120) of cases, PASI and DLQI were recorded at the appropriate review dates (10, 12 or 16 weeks, depending on biologic). Eta
ercept was prescribed at the licensed dose of 50 mg weekly in 92% of cases (n = 120) but was
discontinued appropriately in responders before week 24 in only 6.5% (n = 3 of 45). Only
37% of cases with an inadequate response to biologics at the appropriate review
date (n = 50 of 135), had therapy withdrawn. CONCLUSIONS: In the 6 sites audited,
compliance with national guidance was entirely appropriate for the commencement
and dosing of biologic therapy. However, the requirement to discontinue etanercept
in responders was rarely followed. Similarly, discontinuation of biologics in non-
responders was not routine practice. These results indicate that despite guidance to
the contrary etanercept is used continuously in practice in these specialist centres. This
may indicate a reluctance of both patients and clinicians to withdraw an at least partly
effective therapy in these refractory patients. Review of this aspect of NICE guidance
may be warranted.