Improved and standardized method for assessing years lived with disability after injury

JA Haagsma, S Polinder, RA Lyons, J Lund, V Ditsuwan, M Prinsloo, JL Veerman & EF van Beeck

Objective To develop a standardized method for calculating years lived with disability (YLD) after injury.

Methods The method developed consists of obtaining data on injury cases seen in emergency departments as well as injury-related hospital admissions, using the EUROCOST system to link the injury cases to disability information and employing empirical data to describe functional outcomes in injured patients.

Findings Overall, 87 weights and proportions for 27 injury diagnoses involving lifelong consequences were included in the method. Almost all of the injuries investigated (96–100%) could be assigned to EUROCOST categories. The mean number of YLD per case of injury varied with the country studied. Use of the novel method resulted in estimated burdens of injury that were 3 to 8 times higher, in terms of YLD, than the corresponding estimates produced using the conventional methods employed in global burden of disease studies, which employ disability-adjusted life years.

Conclusion The novel method for calculating YLD after injury can be applied in different settings, overcomes some limitations of the method used to calculate the global burden of disease, and allows more accurate estimates of the population burden of injury.

Abstract in Arabic, Chinese, French, Russian and Spanish at the end of each article.

Introduction

The setting of priority in health care, surveillance and interventions is based increasingly on the results of studies on the burdens of disease and injury. The burden of a disease is now generally expressed in disability-adjusted life years (DALYs) – a summary measure of population health that integrates mortality and disability. Valid and representative data on the incidence of the disease or injury of interest, and the corresponding mortality rates, are essential in the calculation of DALYs. Disease-specific disability weights and information on the duration of the disability are equally important.

In many areas of medicine, disability weights are not tailored to the incidence or prevalence of the cause of the disability. In addition, disability weights for certain health outcomes may not be available or appropriate. If, for example, the general health status of the population of interest is markedly better or worse than that represented by the “disability weights” used, data on the incidence of a disease cannot be accurately linked to the functional outcomes of that disease. This problem is magnified in the field of injury, since a single type of injury may lead to several forms of disability and those disabilities may vary from being mild and short-term to being severe and lifelong. To assess the burden of injury, the global burden of disease (GBD) study group developed a set of 33 disability weights for injuries. Data on the incidence of injuries, which are typically classified into hundreds of different codes from the International Classification of Diseases (ICD), have to be collapsed before they can be linked to these 33 weights. Information about the duration of injury-related disability is needed to calculate years lived with disability (YLD). The proportion of injuries that result in lifelong consequences is important, since it makes such a large contribution to the non-fatal burden of injury. Although the GBD studies defined a proportion of cases with lifelong disability for each category of injury, the empirical foundation of these proportions is questionable and use of these proportions may lead to inaccurate estimates of the burden of injury.

This study aimed to refine the methods used to link data on injury incidence to empirically-derived disability information (i.e. disability weights and durations). Estimates of the burden of injury produced using the methods employed in GBD studies were then compared with the estimates produced, from similar incidence data, with the new methods. The data included in the study came from three countries on different continents and in different stages of economic development.

Methods

The calculation of injury-related YLD consists of three steps: (i) gathering data on the incidence and age distribution of the cases, (ii) breaking down the incidence data into injury categories that are each homogeneous at a functional level, and (iii) combining the grouped incidence data with the relevant disability weights and durations (Fig. 1). The challenge is to find the appropriate link between the epidemiological data and the disability weights and durations. In this process, the available epidemiological data should be leading.

In this paper we provide a refined standardized method based on the three steps needed to calculate YLD due to injury. Once developed, this method was applied to assess the burdens of injury in the Netherlands, a South African town (Ceres) and Thailand. The results were then compared with the burdens...
assessed, from similar incidence data, using the conventional GBD methods.7

The development of the new method to assess injury-related YLD was

carried out within the framework of a European study called INTEGRIS (In-

tegrating European Injury Statistics), which aimed to improve the measure-

ment of the incidence and burden of injury.10

Calculating years lived with
disability

Step 1. Choosing cases to include

At the start of any attempt to quantify

the burden of disability at the popula-

tion level, one must begin by choosing

the source or sources of incidence data
to be used. Data on the rate of hospital

admissions have proved very useful in

quantifying the economic or health

burdens of a disease or injury at the

population level.11–13 If, however, only

hospitalized cases are considered, many
cases of injury, including some that lead to
substantial disability, are likely to be
missed, including those cases only seen
as outpatients at hospital emergency
departments.

In the method proposed in this

paper, cases of injury recorded by

emergency-department-based systems
for injury surveillance as well as those
in hospital discharge registries and traumacentre/trauma-network registries
were included. Since they are routinely
collected, such incidence data should
generally be available at the national,
regional and local levels.14 Furthermore,
the patient and injury characteristics
that are needed to assess the disability
component of the injuries are usually
well documented in these data systems,
generally in a way that makes linkage to
disability weights possible.14

Step 2. Grouping cases into injury categories

The breaking down of the data on injury incidence into injury categories that are
each homogeneous at a functional level is key to attempts to link incidence and
disability information. The func-
tional consequences of an injury vary widely according to the location, type
and severity of the injury. In general, injuries to the head, spine and lower
extremities have the largest impact on health-related quality of life,13,15–19 and
patients with fractures of the lower extremities (particularly hip fractures)
suffer from more severe consequences than patients with other lower-extremity
injuries.13,15,19 Compared with the injury severity scores – such as the Abbreviated
Injury Scale (AIS) and Injury Severity Score (ISS) – that were developed to
predict short-term death risks, injury location and type are better predic-
tors of the functional consequences of an injury. Many studies have revealed
only a weak association, if any, between severity scores and functional conse-
quences,15,17,20 indicating that the risk of death from any type of injury cannot be
used to predict accurately the subsequent disability in the survivors of such
an injury.

In an effective classification system
for linking data on the incidence of an
injury to information on that injury’s
functional consequences, both the type
and anatomical location of the injury
need to be considered. Injury type and
location are combined within the codes
of the International Classification of
Diseases, the Barell Injury Diagnosis
Matrix, the Classification by Body
Region and Nature of the Injury Matrix,
and the EUROCOST system for the
classification of injury diagnoses.22 The
International Classification of Diseases,
tenth revision (ICD-10), consists of 22
chapters that allow a detailed description of injury location and type, albeit
with the use of hundreds of different codes. The Barell Injury Diagnosis
Matrix uses three levels of anatomical location (each representing five, nine
or 36 separate locations) and 12 classes of injury type.22 The EUROCOST clas-
sification scheme identifies 39 injury groups.18

The detailed information needed to fit data on injury incidence to the
60 or more categories used in some of these systems of injury classification is
often unavailable. For the purpose of calculating YLD, the EUROCOST clas-
sification is recommended because it can usually be fitted to the routine informa-
tion that is generally available on injury incidence and it facilitates the linkage
diagnosis of such data to post-injury disability. The EUROCOST system has already
been used in the follow-up of patients with injuries to assess the functional outcome
of injury, and the feasibility of applying the EUROCOST classification to the
information held in injury databases has been proven.13 Appendix A (avail-
able at: http://www.rp7integris.eu/en/
pages/downloads.aspx?pg=1&kat=15/
Haagsma-BullWorldHealthOrgan-
2012-AppendixA.pdf) shows the EU-
ROCOST classifications corresponding to
the ICD-10 (S and T) codes for the
nature of the injury.

Step 3. Choosing disability weights and proportions

For the original GBD study, 33 disability
weights were derived for the conse-
quences of injury (both short-term and
lifelong).21 The usefulness of the 33 dis-
ability weights has been much debated,
mainly because each weight often has
to be assigned to a fairly heterogeneous
group of injuries. For instance, there is
only one disability weight for “intracra-
nial injury,” a category that includes a
spectrum of injuries varying from mild
concussion to severe brain trauma. Al-
though new disability weights are being
derived for an update of the GBD study,
they are not yet available.21

Increasingly, researchers believe that the best disability weights to use for
estimating the burdens of injury are those derived from empirical follow-up
data on the health-related quality of life of individual trauma patients.24–26 In
at least two studies, disability weights have been generated in this manner, with the
patients grouped by nature of injury to avoid heterogeneity within groups.11,27

For the present study, we used data from a study of functional outcomes in injury patients in the Netherlands13 to generate a disability weight for each of the 39 injury-diagnosis groupings of the EUROCAST classification system. In this Dutch study, data on functional outcome and health-related quality of life were collected, using a generic health-status classification (EQ-5D) and a sample of over 8500 injury patients aged 15 years or older who had minor or severe injury, 2.5, 5 and 9 and 24 months after the patients had attended the emergency department of a hospital in the Netherlands.13 These data have restrictions with regards to the short-lived consequences of minor injuries (i.e. injuries of low severity) that the patients may have experienced.28 In the present study, therefore, the empirically-derived disability weights for 15 injury groups (e.g. concussion, eye injury, and fracture of facial bones) were supplemented with disability weights, from a different study, that were derived in such a way that the restrictions to measure the effects of any short-lived consequences of injury (i.e. temporary health states) should have been alleviated.28 Appendix A includes the methodological details of the generation of the disability weights used in the new method.

Disability weights were determined separately for cases seen in emergency departments and those recorded in hospital discharge registers because these two groups of patients tend to differ in injury severity and associated disability.15 Injury cases admitted to hospital tend to have more severe injuries than non-admitted cases with the same type of injury. The absence of routine measures of injury severity (such as the Abbreviated Injury Scale) in the data collected in emergency departments and hospital discharge registers made it impossible to use other discriminators of severity. The recommended set of 87 disability weights (68 and 19 for the temporary and lifelong consequences of injury, respectively) is presented in Table 1.

Although the proportions of injuries with lifelong consequences were estimated in the GBD, the estimates were based on expert opinion rather than empirical data. In the present study such proportions were re-estimated using data collected – in the same study on which disability weights were largely based – two years after injury cases had attended the emergency department of a Dutch hospital. A patient was assumed to have long-term disability if, at the two-year follow-up, he or she still claimed to be experiencing injury-related health problems and also reported symptoms compatible with the injury suffered (e.g. reduced mobility after a fracture of a lower extremity).29,30

The proportions of patients with lifelong consequences were determined for each of the EUROCAST injury categories, separately for emergency department cases and inpatients recorded in hospital discharge registers. The proportions of patients with lifelong disability and the corresponding disability weights are presented in Table 1. Appendix A presents in detail how the proportions of patients with lifelong consequences were assessed.

Applying the new calculation method

Fig. 2 shows the conceptual approach of the new standardized method. For comparison, the burden of injury in each of three areas – the Netherlands, the South African town of Ceres, and Thailand – was estimated twice using similar incidence data: once using the commonly used GBD method and once using the newly developed standardized method. The West Level 26 life-table was used for all the calculations.

Incidence data and EUROCAST injury categories

National data on the incidence of unintentional injury in the Netherlands were provided by the Dutch Injury Surveillance System – a registry of injured patients who have been treated in a hospital’s emergency department and/or required admission to hospital.11 Each year, according to this registry, about 830,000 people attend the emergency departments of Dutch hospitals for unintentional injury and about 11% of these are admitted. In the present study, each of the recorded injuries could be assigned to a EUROCAST injury category.

Incidence data on patients hospitalized because of unintentional or intentional injury were obtained from government hospitals in Thailand, which together registered approximately 380,000 hospitalized injury cases in 2004. Incidence data on patients who were only treated in emergency departments because of unintentional or intentional injury were obtained from three tertiary hospitals (one each in the south, north and north-east of Thailand) that formed part of a national injury surveillance system. In 2004, approximately 43,000 people were treated for injuries in the emergency department of one of these three hospitals. Almost all (98%) of the cases included in the analysed data could be assigned to an injury category using the EUROCAST classification scheme.

Incidence data on injured patients in the South African town of Ceres were obtained from the unpublished results of the Ceres Injury Burden Study. Ceres is largely a farming community, with a population of about 40,000, in a rural area of the Western Cape. Data on all 1300 cases of unintentional injury that presented to government or private hospitals in the area of Ceres in 2008 were analysed. Again, almost all (96%) of the patients investigated could be assigned to a EUROCAST injury category.

The percentage of injury cases that could be successfully assigned to an injury category was higher with the EUROCAST classification system than with the GBD system. Only 54% of the injury cases investigated in Thailand, for example, could be assigned to a GBD category.

Years lived with disability

Table 2 shows the YLD values resulting from the application of the new method to the incidence data from the Netherlands, the South African town of Ceres, and Thailand.

In the Netherlands, 98% of the injury patients treated in emergency departments sustained short-term injuries and had a mean burden of just 0.03 YLD per case, whereas the remaining 2% suffered lifelong impairments and had a mean burden of 4.6 YLD per case. In both Thailand and Ceres, 99% of the injury patients seen in emergency departments had short-term injuries (with mean burdens of 0.02 and 0.05 YLD per case, respectively) and 1% had lifelong impairments (with mean burdens of 6.6 and 10.4 YLD per case, respectively). The mean burdens for all injury cases seen in emergency departments in the Netherlands, Ceres (South Africa) and
Thailand were 0.10, 0.07 and 0.13 YLD per case, respectively. The mean burdens for all patients hospitalized because of injury in the Netherlands, Ceres (South Africa) and Thailand were 0.9, 1.2 and 1.1 YLD per case, respectively.

Compared with the GBD method, the new method resulted in estimates of YLD that were between 2.7 and 8.2 times higher (Table 2).

Appendix A presents more detailed results of applying the newly developed standardized method to the assessment of injury-related YLD in the three study areas.

<p>| Table 1. Mean disability weights(^a) (DW) and proportions of injuries with lifelong consequences |
|-----------------------------------------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Injury group</th>
<th>DW for acute phase</th>
<th>Proportion with lifelong consequences (%)</th>
<th>DW for lifelong consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ED</td>
<td>HDR</td>
<td>ED</td>
</tr>
<tr>
<td>Concussion</td>
<td>0.015</td>
<td>0.100</td>
<td>4</td>
</tr>
<tr>
<td>Other skull–brain injury</td>
<td>0.090</td>
<td>0.241</td>
<td>13</td>
</tr>
<tr>
<td>Open wound on head</td>
<td>0.013</td>
<td>0.209</td>
<td>0</td>
</tr>
<tr>
<td>Eye injury</td>
<td>0.002</td>
<td>0.256</td>
<td>0</td>
</tr>
<tr>
<td>Fracture of facial bone(s)</td>
<td>0.018</td>
<td>0.072</td>
<td>0</td>
</tr>
<tr>
<td>Open wound on face</td>
<td>0.013</td>
<td>0.210</td>
<td>0</td>
</tr>
<tr>
<td>Fracture/dischloication/sprain/strain of vertebrae/spine</td>
<td>0.133</td>
<td>0.258</td>
<td>0</td>
</tr>
<tr>
<td>Whiplash injury/spain of cervical spine</td>
<td>0.073</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Spinal-cord injury</td>
<td>ND</td>
<td>0.676</td>
<td>ND</td>
</tr>
<tr>
<td>Internal-organ injury</td>
<td>0.103</td>
<td>0.103</td>
<td>0</td>
</tr>
<tr>
<td>Fracture of rib/sternum</td>
<td>0.075</td>
<td>0.225</td>
<td>0</td>
</tr>
<tr>
<td>Fracture of clavicula/scapula</td>
<td>0.066</td>
<td>0.222</td>
<td>2</td>
</tr>
<tr>
<td>Fracture of upper arm</td>
<td>0.115</td>
<td>0.230</td>
<td>17</td>
</tr>
<tr>
<td>Fracture of elbow/forearm</td>
<td>0.031</td>
<td>0.145</td>
<td>0</td>
</tr>
<tr>
<td>Fracture of wrist</td>
<td>0.069</td>
<td>0.143</td>
<td>0</td>
</tr>
<tr>
<td>Fracture of hand/fingers</td>
<td>0.016</td>
<td>0.067</td>
<td>0</td>
</tr>
<tr>
<td>Dislocation/spain/strain of shoulder/elbow</td>
<td>0.084</td>
<td>0.169</td>
<td>0</td>
</tr>
<tr>
<td>Dislocation/spain/strain of wrist/hand/fingers</td>
<td>0.027</td>
<td>0.029</td>
<td>0</td>
</tr>
<tr>
<td>Injury to nerves of upper extremity</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Complex soft-tissue injury of upper extremity</td>
<td>0.081</td>
<td>0.190</td>
<td>3</td>
</tr>
<tr>
<td>Fracture of pelvis</td>
<td>0.168</td>
<td>0.247</td>
<td>30</td>
</tr>
<tr>
<td>Fracture of hip</td>
<td>0.136</td>
<td>0.423</td>
<td>14</td>
</tr>
<tr>
<td>Fracture of femur shaft</td>
<td>0.129</td>
<td>0.280</td>
<td>46(^b)</td>
</tr>
<tr>
<td>Fracture of knee/lower leg</td>
<td>0.049</td>
<td>0.289</td>
<td>23</td>
</tr>
<tr>
<td>Fracture of ankle</td>
<td>0.096</td>
<td>0.203</td>
<td>12</td>
</tr>
<tr>
<td>Fracture of foot/toes</td>
<td>0.014</td>
<td>0.174</td>
<td>8</td>
</tr>
<tr>
<td>Dislocation/spain/strain of knee</td>
<td>0.109</td>
<td>0.159</td>
<td>8</td>
</tr>
<tr>
<td>Dislocation/spain/strain of ankle/foot</td>
<td>0.026</td>
<td>0.151</td>
<td>4</td>
</tr>
<tr>
<td>Dislocation/spain/strain of hip</td>
<td>0.072</td>
<td>0.309</td>
<td>23</td>
</tr>
<tr>
<td>Injury to nerves of lower extremity</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Complex soft-tissue injury of lower extremity</td>
<td>0.093</td>
<td>0.150</td>
<td>10</td>
</tr>
<tr>
<td>Superficial injury (including contusions)</td>
<td>0.006</td>
<td>0.150</td>
<td>0</td>
</tr>
<tr>
<td>Open wound</td>
<td>0.013</td>
<td>0.093</td>
<td>0</td>
</tr>
<tr>
<td>Mild burn(s)(^c)</td>
<td>0.055</td>
<td>0.191</td>
<td>0</td>
</tr>
<tr>
<td>Poisoning</td>
<td>0.245</td>
<td>0.245</td>
<td>0</td>
</tr>
<tr>
<td>Multitrauma</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Foreign body</td>
<td>0.044</td>
<td>0.060</td>
<td>0</td>
</tr>
<tr>
<td>No injury after examination</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other and unspecified injury</td>
<td>0.111</td>
<td>0.212</td>
<td>0</td>
</tr>
</tbody>
</table>

ED, cases recorded attending emergency department; HDR, cases recorded in hospital discharge registers; ND, not determined (because the relevant data were missing or too scarce).

\(^a\) Varying from 0 for full health to 1 for worst possible health state.

\(^b\) Value based on fewer than 10 cases.

\(^c\) Patients with severe burns would have been treated at specialized burn units, which were not included in the study.
Discussion

This study aimed to refine the methods used to calculate injury-related YLD by using the EUROcost classification to link incidence and disability information and developing a set of 87 injury-related disability weights and proportions of injuries with lifelong consequences for 27 categories of injury diagnoses tailored to the available incidence data. Unlike the older GBD method, which was largely based on expert opinion, the new method is based on a coherent set of empirical data. In all three study areas where the new method was applied to data on injury incidence, almost all cases of injury could be successfully assigned to one of the EUROcost injury categories, and in this respect the EUROcost system appeared far superior to the system of injury categorization employed in the GBD study.

Application of the new method resulted in estimates of the burden of injury in YLD which were 2.7 to 8.2 times higher than those produced using the older GBD method. There are several possible reasons for these differences. First, the GBD method uses just 33 disability weights for injuries, whereas the new method uses 87 such weights. Compared with the GBD weights, the disability weights used in the new method can be linked to the epidemiological data more precisely and are more sensitive to differences between injuries. As an example, there is no separate disability weight for concussion in the GBD method. As a result, the disability weight and proportion of cases with lifelong consequences for intracranial injury have to be applied to concussion when using the GBD method, which results in an apparently enormous burden due to concussion. However, if we had chosen to exclude cases of concussion from the present study (rather than applying an inappropriate disability weight when using the GBD method), the total estimate of the burden of injury among the injury cases investigated in the Netherlands, as derived using the new method, would have almost halved, falling to 25 000 YLD. According to the estimates made using the new method, concussion contributed about 10% of all the DALY lost as a result of injury to the cases investigated in the present study. This example indicates the importance of disability weights that are tailored to the epidemiological data.

The new method and the older GBD method also differed in the number of injury categories that could have lifelong consequences. In the GBD method, lifelong disability was assumed to occur in some of the cases, in each of 19 injury categories. As an example, there is no separate disability weight for concussion in the GBD method. As a result, the disability weight and proportion of cases with lifelong consequences for intracranial injury have to be applied to concussion when using the GBD method, which results in an apparently enormous burden due to concussion. However, if we had chosen to exclude cases of concussion from the present study (rather than applying an inappropriate disability weight when using the GBD method), the total estimate of the burden of injury among the injury cases investigated in the Netherlands, as derived using the new method, would have almost halved, falling to 25 000 YLD. According to the estimates made using the new method, concussion contributed about 10% of all the DALY lost as a result of injury to the cases investigated in the present study. This example indicates the importance of disability weights that are tailored to the epidemiological data.

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ability weight for the new state can be easily derived from the data on health-related quality of life. Estimation of the same disability weight using the panel approach would, however, require a new, costly and time-consuming panel study. It has been argued that the value of EQ-5D disability weights is limited by an assumption that underlies the calculation of such weights. This assumption, that health remains constant for relatively long periods of time, is untenable for injuries with very short duration and low severity. We therefore used panel-derived disability weights for some conditions in the development of the new method. This conservative approach may have resulted in underestimates of the burdens associated with these conditions (Appendix A).

Although the global use of the same set of disability weights has advantages in terms of comparability, diseases and injuries rated as less severe by experts in high-income settings may be considered much more burdensome by health-care workers in resource-poor settings. Two studies have shown that the ranking of health states is generally similar across countries but that there are clear intercultural differences in the ways people perceive health problems and how such problems affect their lives. Further research on the effects of cultural differences on disability weights is needed.

### Conclusion

The newly developed method for calculating YLD after injury overcomes some of the limitations of the older, GBD method. Our approach includes the analysis of emergency-department data (rather than only data on hospital admissions), a classification of injury that was specifically designed to assess functional outcome among homogeneous groups of injured patients, and the use of empirical data to describe functional outcomes for injured patients. Use of the GBD method to calculate YLD after injury apparently led to highly inaccurate estimates of the burden of injury. The use of such poor estimates could adversely affect resource allocation and the identification of important prevention priorities.

The new, improved and standardized method for calculating YLD after injury could be applied in future burden-of-injury studies in populations across the world.

### Competing interests

None declared.

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**Table 2.** Estimates of the years lived with disability (YLD) as the result of unintentional injury, in the Netherlands, South Africa (Ceres) and Thailand

<table>
<thead>
<tr>
<th>Country/Treatment</th>
<th>Disability estimated using:</th>
<th>New method</th>
<th>GBD method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Short-term</td>
<td>Lifelong</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Netherlands</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cases treated in ED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence</td>
<td>731,237</td>
<td>12,379</td>
<td>743,616</td>
</tr>
<tr>
<td>YLD</td>
<td>20,436</td>
<td>56,861</td>
<td>77,297</td>
</tr>
<tr>
<td>YLD per case</td>
<td>0.028</td>
<td>4.593</td>
<td>0.104</td>
</tr>
<tr>
<td>Hospitalized cases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence</td>
<td>66,703</td>
<td>17,523</td>
<td>84,226</td>
</tr>
<tr>
<td>YLD</td>
<td>19,181</td>
<td>60,312</td>
<td>79,493</td>
</tr>
<tr>
<td>YLD per case</td>
<td>0.288</td>
<td>3.442</td>
<td>0.943</td>
</tr>
<tr>
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<td>1908</td>
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<td>YLD per case</td>
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<td>344,180</td>
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<td>1.164</td>
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<td>YLD</td>
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<td>Hospitalized cases</td>
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<td>15</td>
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<td>184</td>
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<tr>
<td>YLD per case</td>
<td>0.194</td>
<td>10,344</td>
<td>1.105</td>
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ED, emergency departments; GBD, Global Burden of Disease.
Assessing years lived with disability after injury

JA Haagsma et al.

Assessing years lived with disability after injury

ملخص

шликов

أسلوب محسن وموحد لتقييم سنوات العمر المقضية مع العجز بعد الإصابة

غرض ووضع أسلوب موحد لقياس سنوات العمر المقضية مع العجز بعد الإصابة.

الطريقة يكون الأسلوب الذي تم وضعه من الحصول على البيانات المتعلقة بحالات الإصابة التي تم ملاحظتها في أقسام الطوارئ بالإضافة إلى حالات داخل المستشفيات المرتبطة بالصدمات، باستخدام نظامEUROCOST للربط بين الإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique 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للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique للإصابات، واستخدام البيانات القائمة بوصف clinique 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Método mejorado y estandarizado para evaluar los años vividos con una discapacidad después de un traumatismo

Objetivo
Desarrollar un método estandarizado para calcular los años vividos con una discapacidad (YLD) por sus siglas en inglés) después de un traumatismo.

Métodos
El método desarrollado consiste en la obtención de datos acerca de los casos de traumatismos vistos en los servicios de urgencias y en hospitalizaciones relacionadas con traumatismos por medio del sistema EUROCAST para relacionar los casos de traumatismos con la información sobre la discapacidad y utilizar los datos empíricos para describir los resultados funcionales en pacientes con traumatismos.

Resultados
En total, se incluyeron en el método 87 pesos y proporciones de 27 diagnósticos por traumatismo con consecuencias para toda la vida. La mayoría de los traumatismos investigados (96–100%) pudieron asignarse a una de las categorías de EUROCAST. El número medio de YLD por traumatismo varió en cada país estudiado. El uso del método novedoso dio como resultado cargas estimadas de traumatismo que fueron de 3 a 8 veces más altas, desde el punto de vista de los YLD, que los cálculos correspondientes obtenidos a través de los métodos convencionales empleados en los estudios mundiales sobre la carga de traumatismos, que utilizan los años de vida ajustados por discapacidad.

Conclusión
El método novedoso para calcular los YLD después de un traumatismo puede aplicarse en entornos distintos, aunque algunas de las limitaciones del método empleado para calcular la carga global de morbilidad y permite realizar estimaciones más exactas de la población con traumatismos.

References

Research
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