processes in order to create awareness about the importance and value of each medical specialty, mainly in patients with moderate or severe disease activity.

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SAT0722-HPR THE VALIDITY AND TEST-RETEST RELIABILITY OF THE TURKISH PATIENT SPECIFIC FUNCTIONAL SCALEIN CHRONIC NECK PAIN PATIENTS

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Background: Current clinical guidelines recommend to use both clinical and self-reported measurements for evaluation of chronic neck pain. Among the self-reported outcomes, Neck Disability Index (NDI) and Patient Specific Functional Scale (PSFS) are the most widely used and recommended instruments.[1] Although, NDI was validated in Turkish language before, but no validation study related to the PSFS was detected in the literature.
Objectives: The purpose of our study was to determine the validity and reliability of PSFS which was not validated in Turkish language previously.
Methods: The PSFS has been translated into Turkish (PSFS-T) according to "translation-backward translation" method as recommended in the guidelines. Demographic data, PSFS-T, and NDI were recorded at the initial assessment. For the test-retest reliability analysis, the first 30 patients were called by phone. Intra-class correlation coefficient (ICC) was established for reliability analyses. The correlations between PSFS-T and NDI was examined for the validity analysis.
Results: The final form was completed by 110 chronic neck pain patients (F:77, M:33). The mean age of patients was 44±14 and the average duration of pain was 43±49 months. Test retest reliability of PSFS-T was found good level (ICC: 0.85). The relationship between PSFS-T and NDI was found moderate level ($p<0.05$, rho:−0.578). Furthermore, reading books/newspapers, cleaning and carrying heavy things were reported by Turkish neck patients as the first three activities which are the most problematic for their daily activities of life.
Conclusions: PSFS-T is a valid and reliable method of measuring outcome in patients with neck pain. Future studies should focus on the validity and reliability of PSFS-T in different populations.

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SAT0723-HPR COMPARISON OF PHYSICAL ACTIVITY, FATIGUE, HEALTH-RELATED QUALITY OF LIFE, ANXIETY AND DEPRESSION BETWEEN ANKYLOSING SPONDYLITIS AND RHEUMATOID ARTHRITIS PATIENTS

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Background: Rheumatoid arthritis (RA) and ankylosing spondylitis (AS) are chronic progressive inflammatory diseases, leading to joint damage and reducing the physical fitness of patients. They are among the most common rheumatic diseases. Physical inactivity, fatigue, low health-related quality of life (HRQoL), higher anxiety and depression levels are common problems reported in patients both ankylosing spondylitis (AS) and rheumatoid arthritis (RA) although the clinical manifestations differ in many ways. These low outcomes have been found to be associated with functional limitations in both AS and RA serves as mediators in the link between disease activity and functional limitations in spite of NSAIDs and DMARDs therapies. Although many studies have assessed the outcomes of a single disease state, either RA or AS, few studies have focused on a direct comparison between those both diagnostic groups.
Objectives: The aim of this study to assess and compare physical activity, fatigue, HRQoL, anxiety and depression levels between AS and RA patients.
Methods: Twenty-six RA patients and 18 patients with AS were recruited from the outpatient clinic. Physical activity was assessed using the International Physical Activity Questionnaire-Short Form (IPAQ-SF), a validated instrument comprising of four items that estimates the levels of vigorous activity, moderate activity, walking and time spent sitting during the previous 7 days. The Fatigue Severity Scale (FSS) was used to measure the severity of fatigue. Disease-specific instruments to measure (HRQoL) in patients with RA and AS (RAQoL and ASQoL) were used. The Hospital Anxiety and Depression Scale (HADS) were used to assess anxiety and depression. The patient groups were compared using the Kruskal-Wallis test and the Chi-square test.
Results: Disease durations were similar between RA (mean age=48.92±12.50 years, disease duration=10.81±7.68 years) and AS (mean age=43.44±12.36 years, disease duration=11.39±8.87 years) patients (p=0.867). There was no statistically difference between FSS (RA=45.27±16.95; AS=41.00±12.95; p=0.173), IPAQ-SF (RA=1289.65±839.75; AS=2110.06±1210.86; p=0.062) and HADS scores (RA=18.31±2.93; AS=17.00±2.87; p=0.123) in both patient groups.
Conclusions: Our results support that physical inactivity due to impaired mobility as well as fatigue, anxiety/depression and low (HRQoL) are common and similar features of both RA and AS. In conclusion, management of disease activity with drug therapies should be targeted not only to improve physical function for RA and AS but also to improve physical activity levels, restore fatigue, anxiety and depression levels and preserve HRQoL.

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SAT0724-HPR TECHNOLOGICAL ASSISTED REHABILITATION FOLLOWING TOTAL KNEE JOINT REPLACEMENT. A RANDOMISED CONTROLLED NON-INFERIORITY TRIAL

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Background: Supervised rehabilitation after total knee arthroplasty (TKA) has been suggested effective for quicker recovery. The effect of Technological Assisted Rehabilitation (TAR) in the participant´s home compared to supervised rehabilitation has been investigated in trials and results suggest it being equal to supervised rehabilitation on short time follow-up (6 weeks to 4 months). No studies have been found that evaluate the effect of TAR on follow-ups longer than 4 months.
Objectives: The aim of this study was to evaluate the effect of TAR compared to supervised rehabilitation (usual care) on participants with TKA after 6 and 12 months.
Methods: This was a single-blinded, randomised controlled, non-inferiority study. 155 participants were randomised to either TAR (ICURA) or usual care. Intervention time was 6 weeks, follow-ups were after intervention, at 6 and 12 months. This study only concluded on 6 and 12 months. Primary outcome was 10 m walk test. Secondary outcomes were 2.45 m up and go, 30 s. Sit to Stand, active knee flexion and extension and the KOOS questionnaire. All outcomes were measured at all time points by a blinded assessor. Non-inferiority margin was no statistical significant- and less than 10% between group difference at 6 and 12 months, estimated by a repeated measurement analysis, adjusted for relevant baseline variables.
Results: Overall, the groups did not differ at baseline. No statistical between group difference was detected after 6 and 12 months for primary and secondary outcomes. A power analysis suggested severe lack of power to detect a statistical between group difference, due to high numbers of participants lost to follow-up after 6 and 12 months. The between group difference at 6 and 12 months was less than 10% for all outcomes except KOOS Quality of Life at 6 months, were a difference of 12.2% was detected, in favour of ICURA
Conclusions: The results show that the effect of ICURA is equal to usual care after 6 and 12 months. Because lack of power after 6 and 12 months, the statistical significance should be interpreted with caution, but overall between group difference after 6 and 12 months was less than 10% for primary and secondary outcomes.

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