The SF-36 was converted into a utility using the preference-based SF-6D. Clinical outcomes such as the European League Against Arthritis (EULAR) Disease Activity Score (DAS), joint counts and laboratory measures were also recorded. We calculated single index utility scores from the preference-based instruments using UK population norms. We used regression analysis and correlation coefficients to compare relationships between the Quality of Life (Qol) outcomes and also the clinical outcomes and between observed and mapped utility scores. RESULTS: There was a significant difference between the mapped and observed EQ-5D and SF-6D. Overall the mapped utilities produced higher values than the actual observed scores. The mean change in utility due to treatment is greater with the EQ-5D for both mapped and observed utilities. A greater change was seen in the PA group. CONCLUSIONS: We present the different results produced when using mapped utility scores and directly obtained scores. We have highlighted the problems associated with deriving utilities from non-preference-based instruments and the differences in utilities when calculated using different methods. While these methods do offer alternatives for researchers when performing cost utility analysis they remain suboptimal to the direct method.

**PM574 DEVELOPMENT OF A TOOL TO HELP IN THE EARLY DETECTION OF FIBROMYALGIA (FM) IN GENERAL PRACTICE IN EUROPE**


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OBJECTIVES: To develop a European screening tool to help primary care physicians (PCPs) identify fibromyalgia (FM) patients in general practice. METHODS: A European multidisciplinary expert group was set up to provide clinical expertise and identify key issues around FM detection. A literature review and focus groups conducted with French (FR), German (DE) and English (UK) clinicians provided an overview of the knowledge on FM and of clinicians’ awareness and experience. Psychologists then performed face-to-face exploratory interviews with FM patients (FR, DE and UK, n = 29) to understand their attitudes and perceptions of the disease. Based on the findings, items were simultaneously generated in FR, UK and DE. The resulting tool was comprehensive tested with FM diagnosed or suspected patients (n = 3 and n = 2 in each country, respectively), and modified based on results. Its acceptability and applicability was then assessed in real-life conditions in general practice. RESULTS: The tool content defined using literature review, health professional and patient input had high consistency regardless of the source from which it was extracted. Factors found that may contribute to the early detection of FM included elements of FM definition; patient characteristics; personal and medical history; quality of life, attitude and personality, associated symptoms and influencing factors. The resulting pilot version of the FM screening tool included 14 questions assessing patients’ pain, fatigue, associated symptoms, impact on patients’ everyday life, personal history, and attitudes towards their symptoms. Face validity and feasibility have been confirmed by PCPs and patients when administered in general practice. CONCLUSIONS: In addition to the symptomatic picture, FM detection requires the assessment of multiple factors including patient past history and characteristics, impact of FM on patients’ daily life, and situations/factors affecting patients’ condition. By capturing each of these factors, the European FM screening tool will help PCPs identify potential FM patients. Quantitative validation of the tool is underway.

**PM573 CONTENT VALIDITY OF THE FIBROMYALGIA SYNDROME BURDEN ASSESSMENT (FMBA©)**


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METHODS: The FMBA© was tested to assess ease of comprehension, cultural equivalence, clarity, wording and acceptability of the structure and content to patients. The final tool contained 79 items grouped into 7 sections measuring aspects of fibromyalgia on patients’ daily lives, developed simultaneously in French, German, Spanish and UK English. These sections evaluate Pain, Physical Impact, Impact on daily activities, Social Impact, Work Impact, Psychological Impact, Relationship to doctor and hospital visits, and One general item. In total, 29 patients were interviewed in French, Germany, and Spain. UK comprehension tests are currently under way. Based on test results and deliberation with fibromyalgia experts, changes were made to the French, German, Spanish and UK English versions of the questionnaire using an international harmonisation meeting. RESULTS: Patients’ overall comprehension of the questionnaire was good. The comprehension tests identified problematic items, and suggestions for deletions or rewording. Seventeen items were deleted for reasons such as: lack of conceptual clarity e.g. “I have pain that changes from one moment to the next” not clear between location and intensity; items considered conceptually too close e.g. “I get tired for no reason” deleted because too close to “I lack energy” and “I get tired easily”; and wording too strong e.g. “I feel fatigued”. The answer choices were also modified to ensure cultural acceptance. The pilot version of the FMBA© contains 62 items divided into 7 sections. CONCLUSIONS: The FMBA© is a questionnaire that assesses the functional impact and burden of fibromyalgia on patients’ daily lives. The FMBA© will allow the consequences of FM on patients to be more widely recognised. A validation study is to be undertaken to validate psychometric properties and scoring of the questionnaire.

**PM576 OAKHQOL, A DISEASE-SPECIFIC HEALTH RELATED QUALITY OF LIFE QUESTIONNAIRE FOR OSTEARTHROSIS OF THE LOWER LIMB. VALIDITY AND RESPONSIVENESS**

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OBJECTIVES: Health related quality of life (HRQoL) is an important issue to evaluate outcomes after health interventions. The aim of this study was to study construct validity and responsiveness of the Osteoarthrips of Hip and Knee Quality of life questionnaire (OAKHQOL), a disease-specific HRQoL for osteoarthritis of the lower limb. METHODS: OAKHQOL is a self administered questionnaire and has 43 items and five dimensions: physical activities (16), pain (4), mental health (13), social support (4) and social functioning (3). There are 3 independent items about relationships, sexual activities and professional life. The score ranges from 0 (worst) to 100 (best health). Patients were recruited from the waiting list to undergo joint replacement. The internal consistency was measured by Cronbach’s alpha (771 patients). The test-rest reliability (413 stable patients who fulfilled the questionnaire two times) was measured by intraclass correlation coefficient (ICC), 95% confidence interval (CI), and test-retest reliability (0.75) was calculated using the mean of standard error of measurement (SEM) in 6 months post-surgical replacement. RESULTS: Cronbach’s alpha were all higher than 0.8 but in social activities dimension (0.64). Regarding test-retest reliability the ICCs were higher than 0.75 but in the social support (0.4) and social support (0.4) dimensions. Finally, responsiveness parameters were: physical dimension (S = 1.26; SRM = 0.89); pain (S = 1.37; SRM = 0.94); mental health (S = 0.65; SRM = 0.56). CONCLUSIONS: These results support the validity and responsiveness of the Spanish version of the OAKHQOL, a disease specific HRQoL questionnaire to be used in patients with osteoarthritis of the lower limb and surgical management.

**PM577 PATIENT REPORTED QUALITY-OF-LIFE ISSUES IN MYOTONIC DYSTROPHY TYPE-I (DM1): A FIRST STEP IN THE DEVELOPMENT OF A DISEASE-SPECIFIC INSTRUMENT**

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OBJECTIVES: Development of validated patient-reported outcome (PRO) measures has the potential to positively impact scientific research and patient management. To date, the specific issues and symptoms most relevant to DM1 patients’ health related quality-of-life (HRQoL) have not been systematically assessed. Our goal is to identify those aspects of HRQoL that are most important to patients with DM1, a neuromuscular condition with multisystemic organ dysfunction. METHODS: We conducted in-depth individual patient interviews with twenty genetically confirmed, adult, DM1 patients representing varied levels of disability. Each interview focused on identifying the DM1 issues that have the greatest impact on patient HRQOL. Interviews were recorded, transcribed, coded, and analyzed using a qualitative framework technique, triangulation, and three investigator consensus approach. RESULTS: A total of 1175 direct quotes were coded resulting in 223 like themes. These themes were subsequently categorized into 7 subdomains representing physical, mental, and social aspects of DM1 HRQOL. A disease-specific HRQoL conceptual model was created for DM1 representing the most relevant symptomatic and psychosocial issues in this population. Categories in this model included: 1) mobility and ambulation; 2) fatigue and upper extremity dysfunction; 2) emotional distress; 3) cognitive impairment; 4) social role limitations; 5) social role dissatisfaction; 6) activity impairment; and; 7) DM1-specific symptoms of: sleep disturbance, fatigue, pain/myotonia, gastrointestinal dysfunction, central sensory impairment, and communication difficulties. Difficulty with ambulation and fatigue issues were frequently mentioned as having the greatest impact on patient HRQOL. CONCLUSIONS: There are multiple themes and symptoms, some previously underrecognized, that play a key role in DM1 patient reported HRQOL. These issues must be carefully examined in order to develop a representative disease-specific conceptual model and PRO measure of HRQOL. The development of such an instrument has the potential to improve DM1 clinical care and maximize the impact and relevance of future DM1 clinical research.

**PM578 FURTHER DEVELOPMENTS OF THE RHEUMATOID ARTHRITIS QUALITY OF LIFE SCALE (RAQOL)**

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OBJECTIVES: The Rheumatoid Arthritis Quality of Life scale (RAQOL) is the first true Qol measure for RA and is widely used in clinical practice and trials. The scale has good psychometric properties and has been shown to be responsive to changes in disease severity. The objective of the study was to adapt the RAQOL for USA, Mexico,