29.6% of GPs, insoles by 8.4%, and a knee brace by 3.7%. At least one non-pharmacological treatment was recommended by 88.1% of GPs.

**Conclusions:** Although most GPs in France used non-pharmacological treatment in combination with drugs to treat patients with persistent pain from knee osteoarthritis, the choice of non-pharmacological measures was not always appropriate to the clinical profile. Efforts are needed to improve the use by GPs of non-pharmacological treatments in patients with knee osteoarthritis.

**508 MULTIDISCIPLINARY REHABILITATION AFTER PRIMARY TOTAL KNEE ARTHROPLASTY**

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**Purpose:** To investigate the effectiveness of multidisciplinary outpatient rehabilitation program (MRP), implemented 2–4 months after primary total knee arthroplasty (TKA), on functional recovery, health related quality of life (HRQoL), and rehabilitation service utilization.

**Methods:** In the prospective, randomized, controlled trial a total of 88 participants were scheduled for TKA due to osteoarthritis (OA) of the knee. Participants (n = 86) were randomized on the day of their discharge after surgery to a control group (usual orthopedic care) or an active group (additional 10-day MRP). Each MRP course consisted of up to 8 participants. The aim of the MRP was to improve participants’ coping with the activities of daily living, including improvement of lower-limb strength, increase of lower-limb joint mobility, improvement of endurance and cardiovascular fitness, and reinforcement of coping strategies. Further objectives were motivating the participants to carry out a regular exercise program, and weight control or weight reduction. The final aim of the MRP was psychosocial recreation, especially through peer support.

Assessments of both groups, performed preoperatively, and at the 2, 6, and 12-month follow-ups, included questionnaires [the Western Ontario and McMaster Universities OA Index (WOMAC), the 15D and the RAND36-ItemHealthSurvey1.0 (RAND-36)] and physical performance tests [15-meter (m) walk test, stair test, and isometric strength measurement of the knee]. The use of rehabilitation services was asked by means of a self-administered questionnaire. Response to the treatment was analyzed at the 12 month-follow-up according to the guidelines of the Outcome Measures in Rheumatology-Osteoarthritis Research Society International (OMERACT-OARSI). The mixed model approach was used to analyze repeated measurements. \( P_{\text{RR}} \) indicates time-group interaction.

**Results:** Self-reported disability and pain declined, objectively measured physical performance, and HRQoL improved significantly in both groups. No difference was found between groups in any outcome measure during the study period. The results of the WOMAC scores are presented in Figure 1. In the 15D score participants in both groups reached the level of the general public of the same age at the 12-month follow-up. The absolute change in 3 physical domain scales of the RAND-36 (PF, BP, and RP) during the study period was \( \geq 20 \) in both groups, indicating significant clinical improvement. Remarkable improvement, which plateaued at 6 months, was found in the results of all physical performance tests. No difference was found between groups in the use of additional postoperative rehabilitation services (\( p = 0.77 \)). According to the OMERACT-OARSI criteria high improvement was detected in 26 (72.2%) participants of the AG, and in 27 (69.2%) participants of the CG at the 12-month-follow-up.

**Conclusions:** The MRP 2–4 months after TKA did not yield faster attainment of functional recovery than did standard orthopedic care alone. Dramatic improvement in functional ability, pain, HRQoL, and physical performance was gained in both groups within the first 6 months after surgery.