activity, using an intervention of known efficacy (Infliximab) as external standard.

Methods Until now, 12 RA patients (ACR criteria) have been included (1 male), having high or moderate disease activity (DAS28 >3.2);³ 10 patients already had a 6-week follow-up. The intervention consisted of treatment with Infliximab and Methotrexate, which is likely to induce a relatively large improvement after 6 weeks. The RADAI was self-administered 1 week before the first infusion with Infliximab (T0). At the first infusion (T1), the patient filled in the RADAI again and the physician assessed the DAS28.

After 6 weeks (T2), the RADAI and the DAS28 were again assessed. For analysis of reliability (T0 and T1) the ICC3,1 and the Limits-of Agreement [4] were used. Responsiveness was studied by judging the change in RADAI at T2 in relation to the Limits-of-Agreement and the DAS28 response criteria.³

Results The RADAI scores at T0 and T1 were mean (sd) 5.0 (1.7) and 4.8 (1.9). The mean (sd) difference was -0.2 (0.8), (paired t-test, $p = 0.41$). The ICC3,1 was 0.89 ($p < 0.05$). The Upper Limit-of-Agreement was at 1.6 and the Lower at -2.0. According to the DAS28 response criteria, 3 patients were classified as having no response at T2, 3 had a moderate and 4 a good response. The change in RADAI did not exceed the Lower Limit-of-Agreement for 4 of the 7 responders. The responders had a median (range) change in RADAI of -2.1 (-0.9 to -8.0), signed rank test, $p = 0.02$.

Conclusion The data collection is ongoing till N = 20. The first results on reliability and responsiveness are promising. However, if the Limits-of-Agreement turn out to be much wider than -1 and +1, the reliability of the RADAI should be improved.

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AB0233 PRODUCTIVITY COSTS IN AS. COMPARISON AMONG 3 EUROPEAN COUNTRIES

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Background

Objectives To compare productivity costs due to inability to perform paid work for ankylosing spondylitis (AS) in three European countries: the Netherlands (NL), France (F) and Belgium (B).

Methods 216 consecutive prevalent out-patients with AS started a 2 year cost-of-illness cohort study. Questionnaires assessed AS-related health resource utilisation every 2 months. Productivity costs were calculated from societal perspective by friction costs (FC) method (costs of first 3 months of sick-leave) and human capital (HC) approach (costs of sick-leave and work-disability). In addition, loss of income for the patients was assessed. Differences in social security systems among countries were taken into account. Means and 95% CI after bootstrapping are presented. T-tests were performed on the results of the bootstraps to compare countries.

Results 209 patients completed follow-up. In NL, F and B respectively, 70, 69 and 74% were male, mean age 46 (SD:12), 38 (SD:12) and 42 (SD:14) yr, mean disease duration 24 (SD:12), 14 (SD:9) and 13 (SD:10) yr and 24, 13 and 24% had a manual profession.

Abstract AB0233 Table 1

	NL (n = 131)	F (n = 53)	B (n = 26)
Days sick-leave/yr: mean [95% CI]	8.2 [4.4–12.6]	4.5 [1.5–8.5]	5.3 [2.6–11.2]
FC (Euro/pt/yr): mean [95% CI]	556 [316–827]	324 [112–614]	274 [70–534]
HC costs (Euro/pt/yr): mean [95% CI]	8862 [7100–10630]	3188 [1190–5729]	3609 [859–7169]
Patient income loss (Euro/pt/yr): mean [95% CI]	3301 [2578–4027]	2069 [896–3477]	1189 [300–2269]

*NL-F $p < 0.001$; **NL-B $p < 0.001$.

Conclusion Productivity costs due to AS are substantial for society and patients and differ among countries. FC underestimate the economic impact of disease. These findings have implications for generalizability of economic studies.

AB0234 OBJEKTIV FUNCTIONAL PERFORMANCE TESTS IN PATIENTS WITH LOW BACK PAIN. REVIEW

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Background In the past few decades, a large number of physical performance (PP) tests for clinical assessment of patients with low back pain (LBP) have been introduced. Knowledge is limited, however, on the their appropriateness for treatment outcome, clinical and epidemiological studies, which require a high level of reliability and validity of measurements.

Objectives Our review focus on the psychometric properties and clinical usefulness of physical performance measurements in patients with LBP.

Methods In order to comprehensively identify instruments of physical performance measurement in LBP patients and studies on their reliability, validity and clinical usefulness, MEDLINE searches were performed for the time interval from 1998 to 2000 using the following controlled vocabulary: low back pain, measurement (s), outcome, tests, function, physical performance, muscle strength, range of motion, reliability, sensitivity, validity. In the second step reference lists of the retrieved papers were used for identification further studies, which were not included in MEDLINE database. The literature about sophisticated, special equipment requiring functional measurements, which application due to cost and time demand in daily clinical practise is restricted, was excluded from analysis.

Results 162 papers reporting on physical performance tests in patients with low back pain were analysed. Validity and reliability has been more comprehensively studied for ?Timed-up-and-go?, ?Loaded reach? and ?Sit-to-stand? tests. The high level of reliability of these test were reported (correlation coefficients ranged from $r = 0,89$ to $r = 0,99$). No one prospective follow-up study on responsiveness of PP tests was found.

Conclusion In our literature search we found that all validated PP tests were designed as a discriminative instruments, whose purpose was to measure differences between the people. In order to use them as a qualitative clinical outcome measurement instruments, their psychometric property such a responsiveness should be investigated.

Available in our review.

AB0235 RELATIONSHIP BETWEEN THE NOTTINGHAM HEALTH PROFILE AND THE HEALTH ASSESSMENT QUESTIONNAIRE: EVIDENCE OF VALIDITY IN RHEUMATOID ARTHRITIS

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Background

Objectives To assess the validity of the Nottingham Health Profile (NHP) health-related quality of life measure in subjects with rheumatoid arthritis. It was hypothesised that improvements in the Health Assessment Questionnaire (HAQ) would be significantly related to the NHP.

Methods Data on both the NHP and the HAQ were collected as part of a multicenter clinical trial conducted in Europe (n = 473). The NHP was administered at baseline and at weeks 12 and 24. The NHP consists of 38 items which assess physical mobility (MOB), pain (PAIN), energy (ENRG), sleep (SLP), emotional reactions (EMO), and social isolation (ISO). Both the NHP and the HAQ are scored so that lower scores indicate better HRQOL, and negative change scores indicate improvements. Validity was assessed by estimating the correlation between the scales of the NHP and the HAQ in cross-section and longitudinally (change score from baseline to week 24, Δ). It was hypothesised that both relationships would be positive, and that stronger relationships would be seen in the more physical HRQOL scales of the NHP (MOB and PAIN).

Results In cross-section (first row of the Table 1), all six of the NHP scales were positively and statistically significantly correlated with the HAQ. Additionally, as shown in the second row, the changes in all six of the NHP scales were positively and statistically significantly correlated with the change in the HAQ (Δ HAQ). As predicted, the highest correlations were seen in the more physical HRQOL scales, MOB and PAIN.

Abstract AB0235 Table 1 Correlation between NHP Scales and the HAQ (n = 473)

	MOB	PAIN	ENRG	SLP	EMO	ISO
HAQ	0.773***	0.537***	0.494***	0.270***	0.425***	0.325***
Δ MOB		Δ PAIN	Δ ENRG	Δ SLP	Δ EMO	Δ ISO
Δ HAQ	0.562***	0.521***	0.435***	0.268***	0.343***	0.220***

*p < 0.05, **p < 0.01, ***p < 0.001.

Conclusion These data support the validity of the Nottingham Health Profile as a measure of health-related quality of life in subjects with rheumatoid arthritis.

AB0236 PEOPLE WITH ARTHRITIS/RHEUMATISM IN EUROPE – MANIFESTO FOR THE THIRD MILLENNIUM: EMPOWERING SOCIAL LEAGUES SINCE LAUNCH IN JUNE 2000 IN NICE

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Background There are organisations of people with Arthritis/Rheumatism in many of the European countries. They are part of EULAR. Nevertheless their voice is hardly heard, neither on a national level, nor on the European level.

Therefore in March 2000 the EULAR Social League's Standing Committee, Arthritis and Rheumatism International (ARI) and the International Organisation of Youth with Rheumatism (IOYR) agreed on a Manifesto of People with Arthritis/Rheumatism. It's core is a catalogue of 10 Commandments, concerning Health care, Education and Awareness for rheumatic diseases.

This Manifesto has been launched at the EULAR congress in Nice, France, in June 2000.

Objectives The Manifesto is a platform for people with arthritis: People gather to discuss ways to translate the Manifesto into action. They feel strengthened knowing, that they are part of a European network that also allows them to exchange experiences. Projects are kicked off by one or another Commandment.

Methods A secretariat has been established in Bonn in the office of Deutsche Rheuma-Liga to support the Chair Michael Bernady and to endorse all activities on a national level and bring forwards European activities.

Results The Manifesto helps people with Arthritis/Rheumatism all over Europe to make understand what their disease means for them and what are their needs. It gets high approval from everybody who is concerned with health care and enables us to have rheumatic diseases on the agenda.

Conclusion

AB0237 NATIONAL REGISTRY FOR CHILDREN WITH JUVENILE IDIOPATHIC ARTHRITIS (JIA) AND SYSTEMIC CONNECTIVE TISSUE DISEASES

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Background Centre for Rheumatic Diseases is a National Centre for children with JIA and Connective Idiopathic Arthritis. In 1999 we established a registry to increase the knowledge about JIA and Connective Idiopathic Arthritis in addition to insure diagnosis and the treatment of the patients. The registry will also serve as a research database for the centre.

Objectives

Methods To get an impression of disease development one uses seven questionnaires covering different areas. The medical part consists of 5 elements; Disease debut and diagnosis, classifications, doctors evaluation of disease activity, use of medicine and eventual side effects, and laboratory results.

The parents and if the patients are 15 years or older the patients themselves will fill in questionnaires covering Child Health Assessment Questionnaire (CHAQ) and the family history.

The patients in the registry will be registered ones every year with a tolerance of ± 3 months.

The questionnaires have been prepared in the software program TELEFORM, and the data is read automatically with help