EFFECTS OF DISEASE ACTIVITY, ILLNESS PERCEPTION, SOCIAL SUPPORT AND COPING METHODS ON QUALITY OF LIFE IN THE PATIENTS WITH RHEUMATOID ARTHRITIS AND FIBROMYALGIA SYNDROME

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Background: In chronic diseases, social support, illness perception and coping methods have important effect on quality of life.

Objectives: In the present study, we aimed to compare the quality of life (QOL) of the patients with rheumatoid arthritis (RA) with fibromyalgia (FMS) patients and healthy controls and to assess the relationship between QOL and illness perception, social support, disease coping methods in the patients with RA and FMS.

Methods: Fifty-eight patients with RA, 50 patients with FMS and 50 healthy controls were enrolled in the study. Pain (Visual Analogue Scale, VAS), QOL (Short Form SF-36), illness perception (Revised Illness Perception Scale, IPQ-R), social support (Multidimensional Perceived Social Support Scale, MSPSS) were assessed in the patients. In RA patients, disease activity was evaluated with DAS 28 and Clinical Disease Activity (CDAI), and functional status was evaluated with Health Assessment Questionnaire (HAQ). Fibromyalgia Impact Questionnaire (FIQ) scale was used in the clinical assessment of FMS patients.

Results: While RA and FMS patients had higher COPE-emotional and COPE-problem scores than the healthy controls (p<0.05), there was no significant difference between the patients with RA and FMS (p>0.05).

Regarding the all MSPSS scores, there was no significant difference between the three groups (p>0.05). FMS patients had lower scores than the RA patients and healthy controls regarding the physical function, pain, social functioning and mental health subscales of SF-36 (p<0.05).

In RA patients, MSPSS-friend and MSPSS-special one scores were positively correlated with all subscales of SF-36. IPQ-R timeline cyclical was negatively correlated with SF-36 mental health subscale (p<0.05). There was no significant difference between both groups regarding the physical function, pain, social functioning and mental health subscales of SF-36.

Conclusion: Increased COPE or CP might be unidentified if the risk is exclusively determined by CVR calculators. Patients with a CIMT >0.9 mm had an average score that placed them in the low risk strata, leading to an underestimation of their real CVR. Calculators can be helpful to estimate the CVR, however, they don’t seem to be an adequate screening tool for an increased CIMT or CP. Meanwhile, to assess CVR precisely, a carotid US should be performed in all RA patients.

References: