

Editorial

Cross cultural adaptation and validation of the Stanford health assessment questionnaire in patients with rheumatoid arthritis: Current scenario and future prospects

Patient reported outcomes (PROs) gives us information about patients' assessment of efficacy of treatment, which plays a role in physician-patient therapeutic decision making.^[1] PROs that evaluate symptoms or functional limitations address the problems that are of primary interest to the physician as these are most indicative of disease severity.^[2] They are crucial, consistent and complementary in physician-patient interaction. More recently, PROs have also been used in clinical trials to address issues of patient satisfaction, compliance with the therapy and therapeutic alternatives. They are designed to measure a specific concept in a standardized way.^[2] Pain visual analog scale (VAS) is considered as the gold standard to assess pain because it is simple and it is considered as a useful method of assessment for PROs.^[1] While, choosing a PRO, it is necessary that evidence is available to show that each of these key issues has been considered and addressed during instrument development and validation. A wide range of PRO instruments have been developed to assess the outcomes. Measures of symptoms, activity limitations, health status, health-related quality-of-life (HRQoL) and QoL filled by patients are all examples of PROs.^[2]

In the absence of a cure for rheumatoid arthritis (RA), improving patients' HRQoL is a primary objective of treatment and is one of the few ways to measure therapeutic outcomes in addition to clinical or biochemical data. Measures of pain severity are sensitive indicators of daily activity impairment and are also associated with physiologic, social and emotional disturbances. A recent study has proved that questionnaire results for physical function are more highly correlated to severe long-term

outcomes, such as disability and premature mortality, than biochemical and radiographic data. Thus, assessments of joint function and functional ability should be supplemented with PROs.^[3] They have good psychometric properties: Some PROs have been found to be as informative as joint counts, biochemical and radiographic data for the assessment of baseline status, changes in therapy and are predictive of long-term outcomes. This is especially true for the health assessment questionnaire (HAQ).^[1] It is one of the first instruments to measure PROs.

Patient's assessment of functional disability helps in the measurement of disease activity, mortality, work disability, joint replacement, therapeutic outcomes and cost-effectiveness of the treatment. HRQoL measures can help to identify problems that patient is facing and also help to form a broader insight on patient's progress.^[3] These outcomes can be measured by the Stanford improved HAQ containing a set of 20 questions which relates to the functional disability and scoring ranges from 0 (without any difficulty) to 4 (unable to do), assessment of pain by VAS and patient's global health assessment scale. Results of analyses showed that the addition of the fifth response option decreased the number of responses to "without any difficulty," thereby reducing ceiling effects. This process resulted in HAQ-disability index (HAQ-DI) items with better structure, clarity and reliability. In contrast to the HAQ-DI, items in the improved HAQ are not grouped by physical function category. Rather than listings of aids/devices or assistance as in the HAQ-DI, the improved HAQ uses four questions asking about the use of aids/devices or assistance. HAQ is self-administered and takes only 5-10 min to complete.^[4]

Cross cultural adaptation has two components: The translation of the HRQoL measure and its adaptation, i.e. a combination of the literal translation of individual words and sentences from one language to another and an adaptation with regard to idiom and to cultural context and life-style. The degree of adaptation required depends on the similarities in language and culture.

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Website: www.jrpp.net

DOI: 10.4103/2279-042X.122362

The HAQ has been translated into many languages in non-English-speaking countries, since cultural groups vary in disease expression and in their use of various health-care systems. These countries include Russia, Sweden, Scandinavia (multiple languages), Brazil, France, The Netherlands, Austria, Spain, Norway, Italy, Germany, Iran, India (Modified-HAQ), China, Korea, Thailand and Japan which indicates the usefulness and reliability of this instrument. However, there are no studies established for the improved HAQ translation and validation. The need to identify those patients who continue to have active disease despite therapy, results in the adaptation and validation of the improved HAQ.

In a majority of RA clinical trials, practice and observational studies, HAQ is the primary and often sole measure of QoL; hence it is essential to have an effective strategy for monitoring treatment response in order to achieve the long-term disease management goals of each patient. Assessment of a patient's response to treatment through patient-filled questionnaires can help to identify areas within the HRQoL dimensions for which patient is performing poorly and help the physicians to focus those areas during treatment.^[3]

The HAQ helps to categorize the patients with mild, moderate and severe disease and also on the basis of remission, early onset and progression. It also describes the effectiveness of disease modifying anti-rheumatic drugs (DMARDs) over expensive biologics in the treatment of RA. Thus, we believe that this instrument will be a valuable tool for the evaluation of functional disability in RA patients after

treatment with DMARDs or biologic agents or both in clinical trials and daily practice.

ACKNOWLEDGMENTS

The authors thank Kasturba Hospital, Department of Pharmacy Practice and Department of Statistics, Manipal University, for their support.

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How to cite this article: Doddapaneni S, Khara K, Prabhu V, Nagappa AN. Cross cultural adaptation and validation of the Stanford health assessment questionnaire in patients with rheumatoid arthritis: Current scenario and future prospects. *J Res Pharm Pract* 2013;2:97-8.