itself (participation in communication, communication themes and communication modes), and (3) strategies used for improving communication. It should be simple and easy to use. A questionnaire was created, the central part of which (2) comprised 15 questions to be presented to the patient’s carers or relatives. Quality criteria were analyzed in the environment of 40 in-patients admitted to an awaking unit.

Results.– The questionnaire was presented to caregivers. The intra- and interrater reliability was good, with intra-class correlation coefficients for the main parts of the test and the total score ≥ 0.90 and Cohen Kappa coefficients for each item ≥ 0.50. The reproducibility of questions about communication strategies was good. Internal consistency was excellent (Cronbach α-coefficient = 0.89) for the 15 questions. Convergent validity was good with the WHIM and the modified Rankin scale. There was no relationship of the scale with the age, gender and education level. On two assessments performed with a mean time interval of 37 days, the scale showed sensitivity to change (effect size = 0.82). The time required for presenting the 2nd part of the test ranged from 5 to 8 minutes.

Discussion.– This scale measures three key domains, participation, themes and modes of communication and participates in the implementation of facilitating means of this communication. She has fair metrological properties and is a practical tool for everyday practice.

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Reintegration to Normal Living Index in a population of community-dwelling people with slowly muscular diseases
F.-C. Boyer a,⁎, A. Rapin b, L. Percebois-Macadré b, J.-M. Coulon c, G. Bellassian d, E. Reignin e, V. Bombart f, M. Toussaint-Thoron g, F. Carré-Pigeon h, J.-C. Merot h, P. Nazezyrollas h, D. Perdu i, M.-P. Chunau j, R. Taïar k, D. Gaillard l
a Centre de référence des maladies neuromusculaires, CERNEST, hôpital Sébastopol, CHU de Reims, EA 3797, université Reims Champagne Ardenne, 48, rue de Sébastopol, 51092 Reims, France
b Service de neurologie, CHU de Reims, Reims, France
c Unités de médecine physique et de réadaptation, hôpital Hôtel-Dieu, AP–HP, 48, rue de Sébastopol, 51092 Reims, France
d Service de pneumologie, CHU de Reims, Reims, France
e Service de neurologie, CHU de Reims, Reims, France
f Service d’ORL, CHU de Reims, Reims, France
g EA 3797, université Reims Champagne Ardenne, Reims, France
h Service de pathologie, CHU de Reims, Reims, France
i Groupe de recherche en science pour l’ingénieur (GRESPI), université de Reims Champagne Ardenne, Reims, France
j Corresponding author.
E-mail address: fboyer@chu-reims.fr

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Introduction.– Reintegration to normal life index (RNLI) is a generic scale and assesses the degree to which the patient has been able to return to a normal life. This questionnaire has not been used, validated and interpreted for a sample of people with slowly genetic muscular diseases.

Patients and methods.– Prospective study with consecutive inclusions of patients with neuromuscular diseases in referral centers of Reims, Dijon and Besançon between April 2004 and June 2011. Patients included were age 18 years or more. Administration of five times RNLI D0, D15 for 2/3 of them, one year, three years and five years. The analysis of socio-demographic data, scores of scales and statistical tests are calculated by SPSS 21 software.

Results.– Hundred and twenty-four patients were included, 75 men (60.5%). The average age was 36.3 ± 11.2 (minimum 18, maximum 60). The Barthel Index is an average of 77 ± 28 (min 10, max 100). It is counted myotonic patients (n = 50), dystrophinopathies (n = 32 including 8 Duchenne), FSHD (n = 18), ASI (n = 8), LGMD (n = 12), congenital muscular dystrophies (n = 3), oculopharyngeal dystrophy (n = 1). Hundred and two patients have no missing data RNLI at the initial time with an average score of 70 ± 20 (min 7 and max
100), two thirds of the patients were asked to test retest D15: average of 74 ± 18 (29–100). The Cronbach’s alpha \( (n = 102) \) and test-retest ICC \( (n = 65) \) are each estimated to 0.86.

Discussion.– RNLI has satisfactory psychometric properties: no effect floor or ceiling effects, internal consistency and ICC are very satisfying. However, 22 scores are not calculated by missing some items. It will be interesting to study the distribution of missing items according to clinical subjects to identify the reasons for non-response. The RNLI score to measure integration in life and thus to identify modifiable factors that can improve the situation of people with neuromuscular disorders.

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