Target Area: Fatigue & Low Work Tolerance/ Anxiety, Depression, Stress & Adjustment / Quality of Life

<table>
<tr><td>Egner, Phillips, Vora & Wiggers (2003).
Depression, Fatigue, and Health-Related Quality of Life Among People with Advanced Multiple Sclerosis: Results from an Exploratory Telerehabilitation Study.
NeuroRehabilitation 18(2): 125-133</td><td>PEDro score - 5/10</td></tr>
<tr><td>Method/Results</td><td>Rehabilitation Program</td></tr>
<tr><td>Design:
Y Study type: RCT.
Y Population: n=27 patients with advanced Multiple Sclerosis and an Expanded Disability Status Scale score of ≥ 7, M=46 9.0±years, 37% male.
Y Groups:
1. Video (n=9).
2. Telephone group (n=11).
3. Standard care (n=7).
Y Setting: In-home sessions delivered via telephone or video.

Primary outcome measure/s:
Y Fatigue Severity Scale (FSS).
Y Quality of Well-Being Scale.
Y Center for Epidemiologic Studies Depression Scale (CES-D).

Secondary outcome measure/s:
Y None.

Result: No significant differences were observed between the groups immediately post intervention, however some improvements were noted for the video group compared with other groups at 6 months and beyond. Significantly lower fatigue scores emerged for the video group compared with the other groups at 6 months and 18 months. Improvements in quality of life measures were observed in the video group at 12 months, but with no other significant differences. Overall depression scores were generally lower for the video group than for other groups but this was not significant.</td><td>Aim: Primarily to prevent pressure sores in people with severe mobility impairments, by providing education, however secondary aims regarding impact upon levels of depression and fatigue.

Materials: Telephone, video equipment run over the Plain Old Telephone System.

Treatment plan:
Y Duration: 9 weeks (approx 4hrs direct contact).
Y Procedure: 5 weekly sessions then 2 fortnightly sessions, of around 30-40 mins each.
Y Content:
1. For groups 1 and 2, in-home, individual education and counseling sessions were delivered via telephone or video by a rehabilitation nurse. The same protocol was followed for video and phone groups. Education sessions included review of skin care, nutrition, bowel and bladder routines, psychosocial issues and equipment needs.
2. For group 3 (standard care) the regular follow-up offered by the rehabilitation facility was received.</td></tr>
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