**Commentary on “Functional Ankle Instability and Health-Related Quality of Life”**

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In the November–December issue of the *Journal of Athletic Training,* Dr. Brent Arnold and his colleagues from Virginia Commonwealth University authored a study entitled “Functional Ankle Instability and Health-Related Quality of Life.” Their primary finding is that a group of physically active young adults with prolonged functional ankle instability (FAI) after ankle sprain reported diminished quality of life in comparison with a group of age- and activity-matched individuals who had no history of ankle sprain. Specifically, the FAI group scored significantly lower than the uninjured group on the SF-36 Physical Component and its Physical Function and Bodily Pain domains. The FAI group reported greater difficulty with the following activities: climbing stairs, squatting/bending/kneeling, and walking more than 1 mile. The FAI group also reported greater pain magnitude and pain interference than did healthy controls. Interestingly, no significant differences were seen in the SF-36 Mental Component scores between groups. The FAI group did, however, report significantly lower scores than the control group on the Foot and Ankle Ability Measure (FAAM) activity of daily living and sport subscales. Lastly, the authors found moderate correlations between FAAM scores and SF-36 Physical Component scores but no significant correlations between FAAM scores and the SF-36 Mental Component. The correlation results indicate that the FAAM and SF-36 are not capturing identical aspects of a patient’s self-reported function.

The FAAM is a region-specific, self-report outcomes instrument, whereas the SF-36 is a widely used measure of global health-related quality of life (HR-QOL). Although it is not surprising that the FAI group scored lower on the FAAM scores (similar findings have been reported previously), this is the first study to demonstrate deficits on the SF-36 among physically active young adults with FAI. The SF-36 is arguably the most widely used measure of global HR-QOL in all aspects of health care outcomes research. Arnold et al’s findings demonstrate that prolonged symptoms stemming from an ankle sprain adversely affect these patients’ HR-QOL. As our profession continues to place a greater emphasis on demonstrating the clinical outcomes of patients treated by athletic trainers, athletic trainers need to make assessments of HR-QOL a routine part of their initial and follow-up evaluations of their patients. The obvious next step to Arnold et al’s study is to assess whether these HR-QOL measures can be positively altered with a rehabilitation program administered by athletic trainers. If the athletic training profession plans to achieve its goal of making third-party reimbursement routine for athletic training services, such clinical practice habits and outcome studies need to become commonplace.

In closing, the results of Arnold et al’s study should also be applied to the education of patients incurring acute ankle sprains. There is a common perception that “it’s just an ankle sprain” and individuals can “just walk it off”; however, these results add to the body of evidence that a substantial percentage of individuals who suffer first- time ankle sprains will go on to develop longstanding instability and symptoms. These results clearly demonstrate that quality of life can be adversely affected as the result of “just an ankle sprain.” As athletic trainers, we need to educate our patients and the public that long-term and nontrivial consequences are frequent occurrences after ankle sprain and that proper care and rehabilitation of acute ankle sprains are required to diminish chronic symptoms associated with the injury.