The benefit of using assistive devices has been described as decreased pain and increased ability in performing daily activities. Research has shown that costs of these interventions related to their effectiveness have been considered rather low. Pain and reduced strength in the wrist and fingers, has a strong impact on the person's daily activity. It has been shown that hand exercise reduce pain and have a positive effect on the finger joints. Research has also shown that an elastic wrist orthosis used in ADL situations decrease pain and stabilise the inflamed joints.

ADL assessments are used by the occupational therapist to describe patients' problems, identify suitable intervention measures, establish goals, follow changes in ADL and evaluate treatment. The ADL instruments can also be used to measure whether the individual can perform the activity in a way that is satisfactory to the individual with assistance, or after special interventions. Research has revealed a significant reduction of patients' difficulties when they use assistive devices and altered working methods. The policy regarding assistive technology is based on two concepts: integration and normalisation. In recent years, the development of devices with good function and aesthetic design has become an area of increasing interest.

Patient education such as the Joint Protection Programme have been developed to influence the patient's knowledge, emotion and behaviour and the patient's own activity is in focus. In occupational therapy for individuals with arthritis a combination of assessments and treatments of grip force, pain, hand function and the subjects' perceived ability/difficulty and needs in performing daily activities is to be recommended.

The use of adaptive occupation, introducing alternative strategies, or modifying social environments are other aspects of the occupational therapists intervention process. Both the benefit of assistive technology in relation to the individual's goals and their own solutions should be identified and described. In order to understand why a person is more, or less, able to do the activities, it is important to consider both the person's physical capacity and the person's mental ability to perform in relevant situations.

The role of an occupational therapist entails the ability to switch between the role of "efficient professional" and that of a caring fellow human being and have the ability to see the person/patient with arthritis as both healthy and sick. The most important goal is to build a basis for the individual's creative thinking that will enable them to find their own solutions to their problems.

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SP0122 PLANNING SURGERY FOR PATIENTS WITH RHEUMATIC DISEASES

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Patients with rheumatic diseases often present with several problems amenable to orthopaedic surgical treatment. These problems are usually progressing at different rates, and the best surgical treatment for one may conflict with the treatment of the

others. Each patient presents with a unique set of problems, but some patterns tend to emerge. The crucial question is; what to do and when? I will be discussing how to make this decision logically in patients in whom several orthopaedic problems co-exist.

SP0123 PRE/POST SURGICAL INTERVENTIONS, POST-OPERATIVE CARE

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Aim of the study Strategies for rehabilitation following arthroplasty have been well described. However, these methods are not fully suitable for patients with rheumatologic diseases. We at the Institute of Rheumatology have worked out and practice principles of rehabilitation tailored to the special needs of these patients.

Subject and methods An optimal rehabilitation plan includes pre-operative and post-operative care. We recommend that rehabilitation treatment be commenced early in post-operative care. Care should be taken to accommodate differences typical of these patients: e.g., anatomical changes in joint systems, neurophysiological changes in muscles, deformities, changes in psychological area, general weakness, less tolerance for loading, changed pain threshold, and long-term pharmacotherapy.

Patients in the study ranged in age from 21 to 70 years old. Their average time of hospitalisation was 17 days. Rehabilitation therapy was administered two times per day.

Patient evaluations were performed at the beginning and end of the therapy regime. The pre-therapy evaluation was essential to prescribing an effective a comprehensive rehabilitation program. The physiatrist obtained functional and vocational information (including activities typical of the patient's daily life) and evaluated the patient's range of motion, muscle strength, short muscles, weak muscles, and basic movement stereotypes.

Results The knowledge of these differences leads as to specification rehabilitation technique. We changed conditions: length exercises, loading intensity, and daily time. The rehabilitation treatment in principle reduces insufficiency causes of arthroplasties.

Conclusions A comparison of the pre- versus post-therapy evaluations indicates that our modified technique can be successfully employed with rheumatology patients following arthroplasty of load bearing joints. Objective confirmation of this thesis is found in two different venues: the length of acute hospital stay is materially shorter and the occurrence of admissions for re-treatment after surgery is materially less frequent.

SP0124 PRE-POST OPERATIVE CARE/JOINT REPLACEMENT

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The aim of surgical treatment of patients with rheumatic diseases is to provide pain relief and to improve the ability to function.

The surgical offers of today are replacement of the joints, stiffening of the joints, synovectomy and various joint and tendon – correctioning operations.

According to the shared care model the professional, contribution can be described as follows:

- Before the operation
- During the operation
- After the operation

Ad. 1. Before the operation

- Information about the operation (the operation and the weeks after the operation due to training, medicine, helping-aids and rehabilitation resuming work)
- Physical training (specific and general training)
- Regulation of medicine in collaboration with the rheumatologist
- Occupational therapy (aids/splints)
- Talking over the work situation of the patient before and after the operation
- Diet and other lifestyle-habits (f.x. loss of weight, stop smoking)
- Good advice while the patient is waiting for the operation

Ad. 2. The operation

Mentioning of the most frequent types of operations on people with rheumatic diseases. New types of operations to come.

Ad. 3. After the operation

- Painrelief
- Rehabilitation
- Temporary aids/splints
- Resuming work, driving, leisure-time activities

Development of advanced practice in rheumatology – Thursday 14 June, 14.00-15.30/Club A-B

SP0126 MULTIDISCIPLINARY CARE IN THE LOCAL COMMUNITIES, AT HOME AND IN SELF-HELP GROUPS

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The authors discuss existing models of care for rheumatic patients and the concept of “good practices”. The strategy of “good practices” is based on the assumption, that realisation of any design or project, also those concerning health care, depends not only on economic conditions and shortages, but also on what people think about it, on their aspirations, knowledge and imagination. The authors come to the conclusion that the strategy of “good practices” would be important particularly for multidisciplinary care provided in the local communities, for rehabilitation at home and in self-help groups. Many countries, especially those in central and Eastern Europe, are facing the problems with health care reforms. They are trying to learn from others and look for recommendations, in the hope, that this will help them to avoid some mistakes and overcome barriers of development. The authors examine the question of recommendations concerning “good practice” in multidisciplinary community care and the involvement of self-help groups in rehabilitation of rheumatic patients. It is suggested that in this area only some general guidelines can be stated. The models of good

practice can be conditional, not universal. So, the reasonable way of learning from others is to discuss the problems and not simply to imitate the existing patterns.

SP0127 PRIORITISATION OF PATIENTS WITH INFLAMMATORY ARTHRITIS – A NURSE LED PRE-ASSESSMENT CLINIC

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It is now widely accepted that Rheumatoid Arthritis should be treated with disease modifying anti-rheumatic drugs (DMARDs) early in the disease process,¹⁻⁴ in order to reduce the incidence of erosive change, and improve long term outcome.⁵

A national Clinical Guideline for Scotland⁶ has recently been published, which advocates that all patients with disease duration greater than 6–8 weeks “should be considered for referral for Specialist rheumatology opinion and DMARD therapy, preferably within 12 weeks”.

This course of action should, if followed, lead to the early diagnosis and treatment of patients with inflammatory arthritis. There are, however, two inherent difficulties for hospital rheumatology services. Firstly, even if the referral is made promptly, many referral letters contain insufficient clinical information for the Consultant Rheumatologist to determine from the letter whether or not the patient has inflammatory arthritis. Secondly, in many services the waiting time for a first appointment with a consultant is several months long, thus negating the benefit of an early referral.

In an initiative to identify those patients who would benefit from early diagnosis and treatment, a nurse-led rheumatology Pre-assessment clinic was developed in Wolverhampton.

This was run by an experienced Rheumatology Specialist Nurse, supported and supervised by a Consultant Rheumatologist, and complied with professional^{7,8} and legal guidelines for nursing practice within the UK.

It has been found that the clinic has been effective in identifying patients with inflammatory arthritis and expediting the commencement of DMARD treatment.

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