- 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.

REFERENCES

- 1 Emery P. The Roche Rheumatology Prize Lecture. The optimal management of early rheumatoid disease: the key to preventing disability. *Br J Rheumatol.* 1994;**33**:765–8
- 2 Emery P. Therapeutic approaches for early rheumatoid arthritis. *How early? How aggressive? Br J Rheumatol.* 1995;**34**(Suppl 2):87–90
- 3 Hochberg MC. Early aggressive DMARD therapy. The key to slowing disease progression in rheumatoid arthritis. *Scand J Rheumatol Suppl.* 1999;**112**:3–7
- 4 Irvine S, Munro R, Potter D. Early referral, diagnosis and treatment of rheumatoid arthritis: evidence for changing medical practice. *Ann Rheum Dis.* 1999;**58**(8):510–13
- 5 Symmon DP, Jones MA, Scott DL, Prior P. Long term mortality outcome in patients with rheumatoid arthritis: early presenters tend to do well. *J Rheumatol.* 1998;**25**:1072–7
- 6 Scottish Intercollegiate Guidelines network. *Management of early rheumatoid arthritis.* Edinburgh: Royal College of Physicians, 2000
- 7 The Scope of Professional Practice. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London, 1992
- 8 Code of Professional Conduct. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London, 1992

Pain – Thursday, 14 June, 16.00-17.30/Club A-B

SP0128 PAIN – GENERAL ASPECTS, REVIEW ON PAIN CONTROL METHODS

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Pain is pervasive complaint of patients with musculoskeletal disease. There is a tremendous variability in the perception of pain that is modulated by cognitive, emotional and environmental factors. This symptom may result from both and peripheral factors and, in the individual patient, may have individual causes. Because of the interplay of this factors, treatment can entail a variety of pharmacological agents, with drugs modulating central pain as a common component even in patients with structural and inflammatory disease. In older patients and in patients with chronic inflammatory disease, frequent reevaluation may be needed to stage disease and detect intercurrent problems leading to pain. Psychosocial Assessment of Pain in Patients Having Rheumatic Diseases as well as the Role of Physical Therapy and Physical Modalities In Pain Management is discussed.

SP0129 PHARMACEUTICAL PAIN CONTROL IN RHEUMATOID ARTHRITIS

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Relief of pain is a problem which is difficult to handle in rheumatic diseases and multidisciplinary approach is necessary. Drugs play an important role in the control of pain. There are different groups of drugs which are relevant:

- Analgesics. In general – work fast, short duration of relief. However long-lasting formulations are available. 1.1. Non-opioid analgesics – Weak to medium effect. Often as a supplement to stronger analgesics. Give no addiction. 1.2. Opioid analgesics – Strong effect. May give addiction, important to have in mind when treating pain in chronic diseases.
- Non steroidal antiinflammatory drugs/coxibs. Reduce both pain and stiffness, tenderness and swollen joints. However, interaction problems with other drugs, may affect renal function, platelet function and give gastrointestinal (GI) problems. The new class coxibs have however reduced the GI and the platelet-problems.
- Psychotropic drugs – e.g. antidepressants, antipsychotics, antiepileptics, anxiolytics. Useful among others in neurogenic pain.

Strategies of pharmacological treatment of pain: Acute (e.g. postoperative pain) and chronic pain need different strategies.

SP0130 NON-PHARMACEUTICAL PAIN CONTROL

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The lecture will focus on non-pharmaceutical pain control methods in arthritis. In clinics, several pain control methods are available, although there is lack of good randomised controlled trials on different pain control methods. The results of the most interesting studies are summarised.

Acute pain is treated partly with different methods than chronic pain. Pain is always subjective. Thus, subjective report about pain is important when evaluating the effectiveness of a pain control method.

Important pain control methods are those, which patients can use themselves. These are local cold and heat, relaxation, exercise therapy, collars and splints, and some psychological methods (e.g. autohypnosis). The benefit of these methods is that they are easy available. However, they are dependent on patient's motivation.

Health professionals are needed for other pain control methods. Such methods are psychological methods (e.g. cognitive behavioural therapy and hypnosis), education, several physical therapy modalities, exercise therapies and manual physiotherapy, and acupuncture.

Pain is often a complex symptom. Usually, several treatment methods, including both pharmaceutical and non-pharmaceutical methods, are needed for achieving a good result.

Psychological aspects of patients with arthritis – Saturday 16 June, 10.00-11.45/Club A-B

SP0136 SUBJECTIVE WELL-BEING IN RHEUMATIC DISEASES – COPING OR PERSONALITY?

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Early studies dealing with the relations between psychological factors and rheumatic diseases, particularly rheumatoid arthritis, focused on whether there were some maladaptive psychological factors that could influence the onset of the disease. Personality styles like hostility¹ or neurotic behavior² were suggested. However, this line of research was soon abandoned, simply because no consistent conclusions could be made. Instead, questions were raised about the psychological and social consequences of rheumatic diseases. It was also proposed that treatment and rehabilitation should be evaluated from the patients' point of view, thus according to the effects it had on perceived symptoms, everyday functioning, well-being and social integration. Several instruments were also developed to catch various aspects of the subjective impact of the disease, for example the well-known HAQ.³ Since then the subjective burden of having rheumatic diseases have been extensively studied. Although some studies have found that the patients as a group show small tendencies toward increased emotional distress, it is apparent that the majority of patients do not seem to differ from that of a normal population.⁴ In that respect rheumatic patients also resemble several other patient groups with chronic diseases.⁵ One major finding was also that indicators of severity of disease had surprisingly small relations with psychological health.⁶ Such findings led in turn to an interest for the presence of psychological factors that could "buffer" the emotional impact of the disease among the patients. Constructs that were in special focus were