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

learned helplessness, self-efficacy beliefs, cognitive distortions and coping. The introduction of these constructs have also advanced the understanding of psychological distress among RA patients, although they tend to explain only a smaller part of the variance in distress.⁷ As an alternative, other research has shown that more stable personality styles, particularly what has been labelled neuroticism, are relatively strongly associated with a broad range of subjective experiences and may act as a common factor behind several types of negative experiences, also among patients with rheumatic diseases. Thus, individuals high in negative affectivity seem to be more perceptive of physical sensations, to interpret physical symptoms as more threatening, to experience more of emotional distress regardless of the objective situation, to react more strongly to negative events and to choose and utilise less effective coping strategies.⁸ The suggestions that a stable temperamental trait seem to influence most types of self-reported data have important implications for the clinical practice, since illness status is now commonly assessed by standardised self-rating questionnaires. The extent that stable psychological traits confound such measures is an important issue to resolve. Furthermore, if patient differences in subjective wellbeing largely depend on temperamental dispositions then the efforts to change patients' coping style, or illness would be expected to have less impact in the long run. Thus, a further important research issue to perform more persistent followup studies of psychological. It may also be crucial to identify in what respects the interventions improve psychological wellbeing.

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SP0137 PSYCHOLOGICAL NEEDS OF PEOPLE WITH RARE RHEUMATIC DISEASES

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Objective To review the literature on the psychological needs of people with rare rheumatic diseases.

There is an extensive research literature on the psychological impact of rheumatic disease, the role of psychological factors in aetiology and outcome and psychological intervention. However the majority of psychological research on specific rheumatic diseases has focused on common conditions such as RA, OA, and AS.

Review of the literature on the psychological needs of adults with rare rheumatic diseases reveals few high quality studies.

Experiencing a “rare” rheumatic disease may present the person with particular psychological challenges e.g. diagnostic uncertainty, treatment side-effects and lack of peer support. There is evidence that many rare rheumatic diseases can have specific psychological consequences including Neuropsychological, emotional, body image and psychosexual difficulties. There is some evidence that psychological factors may be related to outcome in some rare rheumatic diseases. These issues will be illustrated with examples of studies with vasculitis, scleroderma, Sjorgren syndrome, Lyme's disease and Behcet's disease.

In conclusion many people with rare rheumatic diseases have specific and significant psychological needs. Research is needed to enhance our understanding of the contribution of psychological factors to the development and course of rare rheumatic diseases and on psychological interventions to address these issues.

SP0138 DEALING WITH PAIN

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A multi-modular approach to treating back pain and fibromyalgia, taking into consideration psycho-social factors.

“Chronic pain is not usual pain that simply has a greater duration; it has another quality to it. With chronic pain one has gone beyond the kind of pain that can be forgotten and it becomes one with which one lives constantly...”¹

With these words of Hans Saner, a Swiss philosopher, I wish to present various thoughts on the theme of “Dealing with Pain”. Chronic pain is not only a medical problem. At its core is suffering and the patient's individual experience of the illness. To gain some influence over this pain it is both necessary and helpful to elicit interdisciplinary cooperation in many areas, such as medicine, psychology, physiotherapy and ergo-therapy, as well as politics, sociology, anthropology and philosophy.

In medicine, as well as in rheumatology, we find ourselves in a phase of paradigmatic change. We are moving from a mono-causal, linear, dualistic and pathology-centred concept of illness and treatment (the thesis), to a multi-faceted, holistic and salutogenetic approach (the anti-thesis). Only in the future will we know what the synthesis of this dialectical process will be.

In contrast to the old biochemical model, the “new” bio-psycho-social system that had its inception in “gate control theory” of R. Melzack and P. Wall² is based upon an interrelatedness of somatic, psychic, social and cultural factors. Influences from both the inner and outer realities of patients have an impact upon the strength of pain, the quality of pain and the worsening of chronic pain.

While continuing to respect the dignity of their patients, research and treatment specialists are beginning to interest themselves in the patient's behaviour as well as in their emotional and cognitive reactions to their pain. Research has shown that the following areas are meaningful for a successful rehabilitation: characteristics of the origin and the controlling of pain (cause attribution, locus of control), individual experiences of the illness, cognitive and emotional reactions, coping strategies and influences of variables in the surrounding environment (interactive and structural). Under no circumstance should these observations allow one to ignore other areas under consideration. Specifically, these areas include somatic manifestations, daily stress and work stress. Positive and negative coping strategies