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

will be briefly illustrated in the lecture. The following concepts will be clarified as well: characteristics of the origin of pain (cause attribution), characteristic of the controlling of pain (locus of control), individual illness experiences and the cognitive and emotional reactions to pain.

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Awareness of people with rheumatism/ arthritis – Friday 15 June, 14.00-15.30/Club A-B-C-D

SP0159 PERSONAL IMPORTANCE OF A GOOD RELATIONSHIP TO A THERAPIST FROM A PATIENT'S POINT OF VIEW

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For a patient, it is very important, how the relationship to a therapist looks and feels like. First of all, patient and professional have a business-relationship: the professional offers a kind of 'service' and gets money for it, and they have an agreement what is included and so on. So the customer (patient) is the one who can 'buy or refuse'; the professional has to respect the wishes. They have to work out conditions, that are ok for all parties. They have to define expectations and roles; possibilities and limits of it.

Of course the relationship also has more components:

Arthritis makes you feel small, dependent and insecure. So one effect of the relationship should be, that the patient feels more self-confident, to get supported in its own personality.

Therapists aren't really experts for the illness; for the 'technical part', yes; but not for the other components. Every patient is the expert of his own illness; nobody can feel, how it feels like, and whether it feels better or worse; nobody else can finally say, which therapy, remedy or diet really helps you the best. Therapists can help us to have an overview of the possibilities we have and they can tell us what experience (positive and negative-ones) have been made with them; but proof and decide we have ourselves. The most important thing is, that a therapist should show me a way to an easier way of life, that is realistic and not too complicated.

That also means, that therapists should inform us in an objective way, to really help us decide, which way we choose.

And: if we decide in another way, the professional suggested: he should accept it fully and not judge or treat the patient worse than before.

The example of my personal relationship to 'my' therapists will be given at the meeting.

Communication and partnership – Friday 15 June, 16.00-17.30/Club A-B-C-D

SP0178 SURGERY IN THE PATIENT WITH RHEUMATOID ARTHRITIS

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The person with Rheumatoid Arthritis has a higher than average chance of undergoing surgery at some stage in the disease process. Surgery is not without risks and a benefit/risk assessment is essential in all patients for selection.

This presentation will address care of the patient with RA before and after surgery from a multi-disciplinary view point. General considerations prior to surgery will be mentioned. Potential problems specific to the person with RA include care of the cervical spine during intubation, infection both due to low haemoglobin and drug therapy, care of the skin and other joints whilst recumbent and management of drug therapy. These will be analysed along with possible management protocols and strategies.

Pre and post surgical intervention physiotherapy is a luxury for some patients, for those with RA it is an essential component of the continued care of this group.

Intl. scientific forum for young rheumatologists – Thursday 14 June, 10.30-12.30/Meeting Hall V

OP0139 REGULATION OF CD154 IN SYSTEMIC LUPUS ERYTHEMATOSUS

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CD40-ligand (CD154) is expressed on the surface of activated CD4 T cells and as a soluble cytokine. CD154 is a critical regulator of the immune response via its interaction with CD40 on various cell types, and, therefore, it is not surprising that its expression is tightly controlled. Current reports have described abnormal expression (increased and prolonged levels) of CD154 in adult patients with systemic lupus erythematosus (SLE), similar to observations in lupus-prone mice. We have recently confirmed these findings in paediatric SLE patients. Normally, like several tumour necrosis factor cytokine family members, CD154 expression is primarily controlled at the level of gene transcription and mRNA stability. Moreover, regulatory defects in intracellular signalling pathways that may effect cytokine mRNA levels have recently been described in CD4 T cells from patients with SLE. Using real-time quantitative PCR we have found that CD154 mRNA levels are increased in SLE patients versus matched controls. Preliminary results from nuclear run-on assays also suggest that increased CD154 transcription plays a role in CD154 hyper-expression in SLE. The CD154 *cis*-element (s) responsible for this increase in transcription is unknown. Although we had previously identified a relatively weak proximal 5' flank transcriptional promoter, very little is known about