associations within the SRA and continues co-operation in seminars, conferences and medical projects.

Conclusions At the moment the only possible conclusions to be drawn are about the preparation process and we can identify a great interest from our members and Apoteket AB to carry out a successful thematic year together.

Arthritis/rheumatism as a public health issue

SP0152 WHY CAMPAIGNING IS GOOD FOR ARTHRITIS!

N Betteridge. *Head of Public Policy and Campaigning Arthritis Care, UK*

10.1136/annrheumdis-2001.1281

The paper will explain why people with arthritis are beginning to campaign in new ways and how this can benefit themselves as individuals, the community of people with arthritis and society as a whole.

It will explore the sometimes fractious, and still evolving, history of how people with arthritis have gradually moved away from seeing themselves in an entirely medical context; but also how the social model of disability has been both a liberation and a limitation. The energies of people with arthritis have been released by developing a vision where we are more than just patients or passive recipients of care. We now know that we can be actively involved in managing our condition and have a right to be actively involved in society. But where is that release of energy taking us?

Citing anti-discrimination legislation in both the UK and the USA, the paper will seek to summarise the public policy position for people with arthritis in 2001 but will also be forward looking. Does the advent of new technologies mean that science once more becomes the focus for people with arthritis? Or will the links with the civil rights movement of disabled people strengthen and grow so that medicine will be overshadowed by a political drive based entirely on social issues?

The speaker, Neil Betteridge, has personal experience of arthritis and is Head of Public Policy and Campaigning at Arthritis Care in the UK. Whilst working for the Royal Association for Disability and Rehabilitation (RADAR) he was involved in campaigning for, and helping to influence, the Disability Discrimination Act 1995. He is currently actively involved in the European Manifesto for People with Arthritis and Rheumatism in Europe.

SP0161 WHY RHEUMATIC DISEASES ARE UNDERESTIMATED IN POLAND?

B Moskalewicz. *Institute of Rheumatology, Warsaw, Poland*

10.1136/annrheumdis-2001.1282

Poland has a population of 38 millions people, what means an eighth rank among 43 European countries. When 5 million (13% of total population) suffer from chronic rheumatic problems and rheumatic diseases constitute the first cause of disability, arthritis should be defined as public health problem at the national and perhaps European level too. Unfortunately, public opinion is under the pressure of clinical, individual approach to health care.

Individualisation of health issues produces invisible social dramas, id est: social isolation of disabled, enormous bureaucratic disfunctions of care system and also shifting out cost of treatment to patients' family. Rheumatic patients have serious troubles to maintain satisfying personal relations and to participate in religious or social/political life. Those results of chronic rheumatic diseases are usually neglected in public dispute on health priorities.

Three "curtains" exist in public health theatre making difficult to perceive rheumatic problems:

- social attitudes towards disability
- self marginalisation of arthritis patients
- family support instead of systemic resolutions.

Governmental agencies, using a traditional model of public activity are highly bureaucratic: centralised, impersonal, hierarchical and specialised. Self-help groups are quite opposite: locally centred, personal, non-hierarchical and non-specialised. The two actors of public health performance act in different ways and their political influence changes. As governmental agencies failed so far to remove all three curtains, it is time for NGOs to play a crucial role.

Other inflammatory arthritides

HP0009 AUDIT OF A RHEUMATOLOGY NURSE SPECIALIST (RNS) SHOULDER INJECTION CLINIC

WD Pointer, PL Williams. *Rheumatology, Medway Maritime Hospital, Kent, UK*

10.1136/annrheumdis-2001.1283

In order to shorten waiting times for referrals for shoulder pain, we have set up a dedicated clinic, run by a RNS trained in assessment and management of shoulder problems, including injection of corticosteroid, to which all consecutive new patients, who were thought likely from the letter of referral to benefit from an injection were allocated. Diagnosis was discussed and confirmed with the Rheumatologist.

The results of the first 56 patients (23 male) to attend have been audited.

Diagnosis was as follows:

Adhesive Capsulitis 21, Supraspinatus Tendonitis 11, Rotator Cuff Lesion 7, Non-specific shoulder pain 5, Occupation related shoulder pain 3, Bicipital Tendonitis 3, Thoracic outlet compression 1, Acromioclavicular joint pain 1, Posture related shoulder pain 1, Fibromyalgia 1, Referred pain from hepatic secondaries 1, Secondary deposit 1.

In 18 patients (32%) the clinic and GP diagnoses were the same. In 16 (28.6%) they differed and in 22 (37.5%) the GP letter indicated painful shoulder but no specific diagnosis.

Of these patients 36 (64%) were treated with injection. The remaining 20 (36%) were not injected for the following reasons: Symptoms resolved 12, Patient declined 3, Inappropriate 4, Reason not recorded 1.

Of the 56 patients audited, 49 were available for review by telephone at a minimum of 3 months after initial visit. The results of this interview showed that 17 had complete resolution of symptoms, 21 had more than 50% improvement, 1 less than 50% improvement, 5 said their symptoms were unchanged and 5 stated their symptoms were worse.

Conclusion A RNS shoulder injection clinic works well but the range of possible diagnoses requires close collaboration with the Rheumatologist.

Bone and joint decade

SP0154 THE BJD: EXPERIENCES FROM SWEDEN AND (SOMEWHAT) FROM THE NORDIC COUNTRIES

LM Oehrsvik. Chair, The Swedish Rheumatism Association, Stockholm, Sweden

10.1136/annrheumdis-2001.1284

The work with the Bone and Joint Decade is well underway in many countries by now. In Sweden the practical work is led by a small 5 person steering group and as a complement to this there is a foundation used to gather funds for the project. There is also a larger reference group whose opinions and ideas are tapped every once in a while. In this group there are representatives from the rheumatologists as well as orthopaedics, other health professionals but also patients.

In this short summary the activities undertaken on part of the Bone and Joint Decade in Sweden will not be listed. Our intention is to cease every opportunity to spread the message, different conferences for doctors and health professionals, and in the patient societies but it also gives us a good opportunity to spread information through the media and directly to decision makers at different levels.

The main benefits of the work with the decade are the following: It increases co-operation between the patients and doctors and all the health professionals. The decade also puts focus on the need for more co-operation between the different disciplines within medicine, which is of great importance.

In order to lessen the suffering and bring down the costs for the individual as well as societies we must spread information and influence politicians.

In the other Nordic countries the work has been organised in a somewhat different manner and as the chair of the Nordic Rheuma Council (www.nrr.nu) I will take the liberty of giving some examples from the other Nordic countries in the cases where they are not speaking of this themselves.

At a purely Nordic level the Nordic Rheuma Council has been active and has managed to get the Committee for Nordic Affairs inside the Nordic Council, a body made up of Nordic parliamentarians, to urge the Nordic governments to all sign the declaration of the Bone and Joint Decade.

Osteo-arthritis

HP0010 LONG-TERM EFFECTS OF NONSTEROIDAL ANTINFLAMMATORY DRUGS ON HUMAN CHONDROCYTES IN ALGINATE BEADS

C Sanchez, M Deberg, J-Y Reginster, Y Henrotin. Bone and Cartilage Metabolism Research Unit, University Hospital, Sart-Tilman, 4000 Liège, Belgium

10.1136/annrheumdis-2001.1285

This study was designed to compare the long-term effects (12 days) of nonsteroidal anti-inflammatory drugs (NSAID) on the metabolism of human chondrocytes cultured in alginate beads.

Enzymatically isolated osteoarthritic (OA) chondrocytes were cultured in alginate beads in a well-defined culture medium (DMEM +ITS+) for 12 days. Interleukin-6 and -8 (IL-6, IL-8), stromelysin (MMP-3) and aggrecan (AGG) productions were assayed by specific enzyme amplified sensitivity immunoassays (EASIA), and prostaglandin E2 (PGE2) production by a specific radioimmunoassay. All NSAID were tested at the mean peak plasmatic concentration (Cmax) obtained after oral administration of a therapeutic dose. The Cmax used in this study were 7.5 mg/ml for aceclofenac (ACECLO), 1.4 mg/ml for diclofenac (DICLO), 2 mg/ml for indomethacin (INDO), 3 mg/ml for nimesulide (NIM), 1 mg/ml for rofecocib (ROFE), 0.7 mg/ml for celecoxib (CELE), 7 mg/ml for piroxicam (PIROX), and 25 mg/ml for ibuprofen (IBUP).

At the therapeutic concentration, all NSAID tested fully blocked PGE2 production. Interestingly, ACECLO, DICLO, INDO, NIM and IBUP significantly inhibited both basal and IL-1b-stimulated IL-6 production, whereas ROFE, CELE and PIROX had no significant effects. No NSAID showed significant effects on basal and IL-1b-stimulated IL-8 production, excepted CELE and IBUP which slightly increased basal IL-8 production. ACECLO and INDO increased by 25% AGG content in the alginate beads, while the other NSAID were without significant effect. Furthermore, none NSAID were able to modify the inhibitory effect of IL-1b on AGG production. Finally, NSAID did not modify MMP-3 production.

From this study, we can conclude that the mechanism of action of NSAID seems to be multifactorial and not limited to the inhibition of cyclooxygenases. Furthermore, in our culture conditions, at the Cmax and by comparison with other NSAID ACECLO and INDO show a advantageous profile of activity. They fully block PGE2 production, inhibit IL-6 synthesis and increase aggrecan synthesis. These effects would appear to be advantageous for the long-term treatment of chronic joint diseases such as osteoarthritis.

HP0011 WHAT IS THE DEMAND FOR OSTEOARTHRITIS SELF-MANAGEMENT EDUCATION?

MM Rooney, DV Doyle, C Tierney, M Greenwood. Rheumatology, Whipps Cross Hospital, London, UK

10.1136/annrheumdis-2001.1286

Background People with arthritis in the UK can obtain significant health benefits from attendance at a lay-led arthritis self management programme.¹ We have found significant improvements in knowledge relevant to self-management following attendance at a nurse-led community-based osteoarthritis (OA) education programme and an 82% reduction in OA-related visits to the GP in the 12 months following.² It was envisaged that there could be substantial benefits to quality of care and savings in terms of healthcare resources if in future GPs were to have the option of referring patients with OA-related problems to such a programme run regularly within their own surgery by their practice nurse. Potentially demand could be high. Over the period of one year, 25% of UK and Netherlands over 55 year olds are reported to have experienced persistent knee pain prompting one in six to have consulted their GP.³

Aim To evaluate the feasibility of implementing such a scheme in general practice and to assess the uptake of the course by both GPs and their patients.