taux moyens d’ACTH, de cortisol, de cholestérol et de triglycérides. À la sortie, la diminution des taux d’ACTH était corrélée à la diminution des taux de cortisol ($r=0.25$ ; $p<0.008$) de même, les taux d’ACTH et de cortisol étaient corrélés de façon statistiquement significative ($r=0.41$ ; $p<0.0001$). La réduction du taux d’ACTH était corrélée significativement à l’importance du déconditionnement évaluée par la présence d’une intolérance musculaire à l’effort.

**Discussion–Conclusions.**—Les résultats de notre étude montrent qu’au cours d’un processus douloureux chronique, il existe des anomalies de l’axe corticotrope hypothalamo-hypophysaire. La prise de poids semble être liée non seulement à l’inactivité mais aussi à des anomalies centrales neuro-endocriniennes. La correction de ces anomalies semble être obtenue par le rééquilibrage progressif à l’effort. L’action centrale neuro-endocrinienne est à prendre en compte dans les indications des programmes de restauration fonctionnelle.


**Version anglaise**

**CO09-002–EN**

**Mechanical pain management after orthopaedic surgery**

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**Keywords:** Mechanical pain; Orthopaedics surgery

**Aim.**—To assess efficiency of pain management in a rehabilitation unit, to correlate pain and anxiety status.

**Patients and methods.**—Pain was evaluated by Visual Analogic Scale (VAS) by all patients hospitalised in our rehabilitation unit after orthopaedic surgery: VAS was assessed on night, morning, evening, before and after physiotherapy. Patients assessed their psychological status answering the HAD scale. VAS were compared with subgroups: scales A (anxiety)> 7, D (depression)> 7.

**Results.**—Mean VAS was 1,86 (sd 1,62). Mean VAS was higher after physiotherapy (2.29), before physiotherapy (1.93) and at evening (1.5). VAS was higher than 4 at least one time in a day in 1/3 of patients. There was no correlation between psychological status and pain.

**Discussion.**—Mean VAS was acceptable. Drugs management was changed to improve pain after physiotherapy. Management of neuropathic pain was created. Lack of correlation between psychological status and pain may be explained by better individual management in anxious patients and side effects of antidepressants drugs on pain.


**CO09-003–EN**

**Neuropathic pain management after orthopaedic surgery**

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**Aim.**—To assess efficiency of neuropathic pain management in a rehabilitation unit.

**Patients and methods.**—Neuropathic pain (NP) was assessed by all patients consecutively hospitalised in our rehabilitation unit after orthopaedic surgery during 1 month with the DN4 scale [1]. Were also evaluated pain intensity with Visual Analogic scale (VAS) and triggering condition.

**Results.**—Thirty-one patients were hospitalised after orthopaedic surgery between 10/01 and 10/02/2011. Nine had a neuropathic pain. Mean VAS at admission was 5.62 (sd 3.06). Triggering condition was spontaneous in 4 patients, light touch in 5 patients. Seven days after admission, mean VAS was 3.14 (sd 1.86). Triggering condition was unchanged, one patient had no more NP. Fourteen days after admission, mean VAS was 1.5 (sd 1.09). Triggering condition was unchanged.

**Discussion.**—Neuropathic pain management is efficient on pain intensity and pain area, but not on triggering condition.

**Reference**


**CO09-004–EN**

**Pain and beliefs after musculoskeletal trauma: Complex relationships during the first year of rehabilitation**

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**Keywords:** Pain; Beliefs; Rehabilitation
Introduction.—Pain and beliefs have an influence on the patient’s course in rehabilitation and their relationships are complex. The aim of this study was to understand the relationships between pain at admission and the evolution of beliefs during rehabilitation as well as the relationships between pain and beliefs one year after rehabilitation.

Patients and methods.—Six hundred and thirty-one consecutive patients admitted in rehabilitation after musculoskeletal trauma, were included and assessed at admission, at discharge and one year after discharge. Pain was measured byVAS (Visual Analogical Scale) and beliefs by judgement on Likert scales. Four kinds of beliefs were evaluated: fear of a severe origin of pain, fear of movement, fear of pain and feeling of distress (loss of control). The association between pain and beliefs was assessed by logistic regressions, adjusted for gender, age, native language, education and bio-psycho-social complexity.

Results.—At discharge, 44% of patients felt less distressed by pain, 34% are reinsured with regard to their fear of a severe origin of pain, 38% have less fear of pain and 33% have less fear of movement. The higher the pain at admission, the higher the probability that the distress diminished, this being true up to a threshold (70 mm/100) beyond which there was a plateau. At one year, the higher the pain, the more dysfunctional the fears.

Discussion.—The relationships between pain and beliefs are complex and may change all along rehabilitation. During hospitalization, one could hope that the patient would be reinsured and would gain self-control again, if pain does not exceed a certain threshold. After one year, high pain increases the risk of dysfunctional beliefs. For clinical practice, these data suggest to think in terms of the more accessible “entrance door”, act against pain and/or against beliefs, adapted to each patient.

Keywords: Physical modalities; Steroids; Neuropathic pain; Analgesia

CO09-005–EN
What kind of relationships between the evolution of pain, beliefs and bio-psycho-social complexity after musculoskeletal trauma?

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Keywords: Pain; Beliefs; Rehabilitation; Bio-psycho-social complexity

CO09-006–EN
Paravertebral and radicular pain: Drug and/or physical analgesia

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Keywords: Physical modalities; Steroids; Neuropathic pain; Analgesia

CO09-007–EN
Short-time and long-time effects of rehabilitation exercise training on functional balance tests and gait markers in patients with fibromyalgia

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Keywords: Fibromyalgia; Gait; Posture; Rehabilitation

Purpose.—The purpose of this study was to assess the short-term and long-term impact of a rehabilitation exercise training (RET) program on functional capacities and gait markers. Exercise, mainly aerobic training, is a common recommendation in the management of fibromyalgia (FM) with evidence of efficacy. Functional locomotion tests and gait analysis are considered as a new