ACR to Review Proposed OA Guideline Revisions

BY SHARON WORCESTER

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

ATLANTA – The best available evidence suggests that exercise should be recommended as a nonpharmacologic treatment option for hip and knee osteoarthritis.

So says a technical panel of experts convened by the American College of Rheumatology to revise existing treatment recommendations on the nonpharmacologic treatment of hand, hip, and knee OA. The panel began work in 2008; the proposed consensus revisions are now under review by the ACR.

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Water aerobics can help reduce OA pain and improve physical function, and will be recommended by the panel.

The panel found "strong" evidence that aerobic land-based exercise, resistance land-based exercise, aquatic exercise, and weight loss for overweight patients can be helpful for reducing pain and improving physical function in hip and knee osteoarthritis, and the panel plans to recommend them, reported Carol Oatis, Ph.D., professor of physical therapy at Arcadia University in Glenside, Pa., and a panel member.

This was the only time the panel deemed supporting evidence to be "strong," based on the GRADE (grades of recommendations, assessment, development, and evaluation) methodology used in developing the revised recommendations. GRADE rates the available evidence as "strong," "weak," or "none."

Strong evidence is of high quality with a large gradient between benefits and risks, and little uncertainty or variability in values and preferences; weak evidence has moderate quality with a small gradient between benefits and risks, and moderate uncertainty or variability in values and preferences; and "none" means the evidence was of low or very low quality with no difference between benefits and risks.

Weak evidence of benefit in hip OA was found for manual therapy in combination with supervised exercise programs; the panel suggests – but does not recommend – that this modality be considered for patients with hip OA, Dr. Oatis said.

No evidence was found either in support of or against balance exercises or tai chi, so the panel provided no guidance for these approaches, Dr. Oatis said.

The panel also considered the evidence for hand OA, and for various specific nonpharmacologic approaches to treating OA.

For hand OA, weak evidence was found for the following:

- ► Evaluating patients regarding activities of daily living.
- ► Providing instruction on joint protection techniques.
- ► Providing assistive devices as needed.
- ► Instructing patients regarding the use of thermal modalities.
- ► Using splints for the trapeziometacarpal joint (carpal metacarpal joint at the base of the thumb).

Thus, the panel "suggests" use of these modalities, said Catherine Backman, Ph.D., an occupational therapist at the University of British Columbia, Vancouver, and a panel member.

When it comes to suggestions based on weak evidence, patient preference comes into play, because this generally means there is no evidence against – and there is some evidence in favor of – use of these modalities, Dr. Backman said.

"Clinicians may want to discuss [these modalities] with patients," she said.

No other recommendations or suggestions were made for hand OA.

As for specific treatment modalities, weak evidence was found for the following:

- ► Medial wedge shoe insoles for lateral compartment knee OA.
- ► Subtalar strapping and lateral wedge insoles for medial compartment knee OA.
- ► Medial patellar femoral taping.
- ► Transcutaneous electrical nerve stimulation (TENS) for knee OA with chronic moderate to severe pain.
- ► Traditional Chinese acupuncture for knee OA with moderate to severe pain.
- ► Thermal modalities.
- ► Walking aids.

No evidence was found for or against valgus bracing for knee OA, or for lateral patellar-femoral taping; therefore, the panel chose not to provide guidance on these, said G. Kelley Fitzgerald, Ph.D., a physical therapist at the University of Pittsburgh, and a panel member.

The panel, which reviewed existing English-language studies and existing guidelines from the ACR and other organizations, based its evidence-strength determinations on the quality of the evidence and the extent to which the evidence demonstrated pain relief and improved physical functionality.

The panel did not determine that any of the reviewed modalities should not be used.

"The lack of 'do not do' recommendations or suggestions means that there was no definitive evidence of harm or lack of efficacy for the interventions examined, Dr. Oatis explained.

These proposed revisions to the current ACR recommendations, which were last revised in 2000 with an update in 2005 following the withdrawal of rofecoxib from the market, are currently under review by the journal Arthritis Care and Research, and have been submitted to the ACR Committee on Quality of Care for review before they are sent the ACR board of directors for final approval, said Dr. Marc C. Hochberg, head of the division of rheumatology and clinical immunology at the University of Maryland, Baltimore.

The ACR awarded the contract for the project to the University of Maryland with Dr. Hochberg as the principal investigator. He is also a member of the project steering committee.

"Hopefully, these will come to the point where the ACR board of directors will be satisfied, and we'll have a publication in 2011," he said.

Dr. Hochberg disclosed that he has received research support from the National Institutes of Health, and has served as a consultant or on an advisory board or data safety monitoring board for numerous pharmaceutical companies. The other presenters had no disclosures. ■

Spondyloarthritis Seen in 20% With Chronic Back Pain

BY HEIDI SPLETE

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

ATLANTA – Approximately 20% of cases of chronic low back pain in younger adults seen in primary care settings might be caused by spondyloarthritis, based on data from 364 patients aged 19-45 years. The findings were presented at the annual meeting of the American College of Rheumatology.

In the cross-sectional study, 77 of 364 patients (22%) met the diagnosis of axial spondyloarthritis on examination by a rheumatologist. The average age of the patients was 36 years, 43% were male, and the average duration of chronic low back pain was 9 years.

The diagnostic techniques included a detailed patient questionnaire about inflammatory back pain; physical examination and patient history; blood tests to assess C-reactive protein levels and the presence of HLA-B27 (a gene that has been linked to spondyloarthritis); and conventional and MRI images of sacroiliac joints. Two radiologists reviewed the images for the signs of inflammation and bone lesions that might indicate axial spondyloarthritis.

In all, 52 patients were diagnosed according to MRI criteria plus one additional spondyloarthritis feature. The other 12 patients were diagnosed according to a positive HLA-B27 test plus two additional spondyloarthritis features, Dr. Angelique Weel of Maasstad Ziekenhuis in Rotterdam, the Netherlands, said at press conference.

In addition, 24 patients (6.6%) met the criteria for ankylosing spondylitis.

The results suggest that spondyloarthritis is underdiagnosed as a cause of chronic back pain in the general population. Dr. Weel recommended that primary care physicians suspect spondyloarthritis when they see younger adults with chronic back pain, and refer these patients to a rheumatologist if they suspect an inflammatory basis for the pain.

Heidi Splete/Elsevier Global Medical News

Dr. Angelique Weel suggested that spondyloarthritis might be underdiagnosed in younger adults who have chronic back pain.

"We also tried to make a simple questionnaire for general practitioners, so they can determine which patient with chronic low back pain should be sent to a rheumatologist to investigate possible spondyloarthritis," she noted. Possible red flags from the standardized questionnaire include the response to NSAIDs and a family history of spondyloarthritis, Dr. Weel said.

"Of course, we need to validate these data in another population, and we also have to validate our referral tool [for general physicians]," she noted.

Dr. Weel said that she had no financial conflicts to disclose. ■