Osteoarthritis Guidelines Aim for Clinical Utility

BY DENISE NAPOLI
Assistant Editor

European guidelines on diagnosing hand osteoarthritis aim to be more clinically useful in the practice setting than the 1990 classification criteria from the American College of Rheumatology, according to their authors.

"Until now, the main reference cited for the diagnosis [of hand osteoarthritis] has been the [American College of Rheumatology] criteria," noted the authors of the guidelines issued by the European League Against Rheumatism (EULAR). The ACR criteria focus more on classifying disease rather than diagnosing it, they stated, adding that the updated guidelines provide evidence-based guidance from a multidisciplinary team of physicians representing 15 countries.

The strength of EULAR's recommendations is ranked 1-100 based on the quality of the supportive evidence. A strength of 100 is fully recommended and 0 is not at all recommended.

The first recommendation (strength: 69) spells out risk factors for hand OA, which include female sex, age over 40 years, family history of the disease, obesity, joint injury, and certain occupations. Although a reduction in estrogen at menopause may also be a risk factor for hand OA, this evidence is not supported by findings from hormone therapy (HT) studies. However, "as these studies were observational studies, they may be confounded by the increased bone density [a potential risk factor for hand OA] due to HT," which would necessitate further studies on the link between estrogen and hand OA (Ann. Rheum. Dis. 2008 Feb. 4 [doi 10.1136/ard.2007.084772]).

"Pain on usage has limited value for the diagnosis of hand OA," due to its extremely low sensitivity (strength: 85), wrote the investigators. "Limited duration of localized morning or inactivity stiffness is more specific to hand OA than inflammatory arthritis (stiffness persists 22 minutes on average for hand OA versus 58 minutes for rheumatoid arthritis affecting the hand)." Pain that is specific to the distal interphalangeal, proximal interphalangeal, and thumb base joints is also a hallmark of the disease.

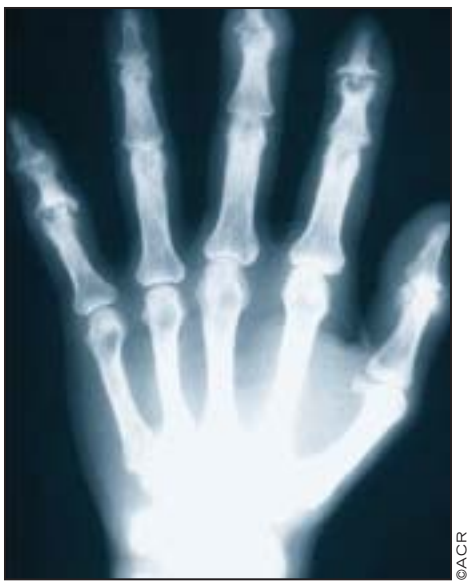
Heberden's and Bouchard's nodes, which "have limited value as a single diagnostic marker" are nevertheless important, "especially when used in combination with other features of hand OA" (strength: 80).

The investigators also state that functional impairment resulting from hand OA may be as severe as is seen with rheumatoid arthritis (strength: 57).

As to associations between hand OA and other diseases, the authors wrote that "patients with hand OA have increased risk of both knee OA ([odds ratio] = 3.0, 95% [confidence interval] 1.2, 7.5) and hip OA (OR = 3.25, 95% CI 2.19, 4.84)" (strength: 77). However, "there is no clear justification to include assessment of other target joints for OA for the purpose of diagnosis and treatment planning of hand OA."

The recommendations acknowledge that there may be specific subsets of hand OA, including interphalangeal joint (IPJ) OA (which can occur with or without nodes), thumb-base OA, and erosive OA, all of which carry unique risk factors, associations, and outcomes. "For example, hypermobility has been reported as a risk factor for thumb-base OA but a negative risk ('protective') factor for IPJ OA," the researchers wrote (strength: 68). Furthermore, "erosive hand OA targets IPJs and shows radiographic subchondreal erosion, which may progress to marked bone and cartilage attrition." In general, this type of OA has worse outcomes than nonerosive IPJ OA, they point out (strength: 87).

However, Dr. Altman expressed skepticism of this conclusion. "The question as to whether the erosive form of hand OA is indeed a separate subset or whether it is part of the spectrum of disease has been addressed but may not have been answered in this report," said Dr. Altman, who is also professor of medicine of the University of California, Los Angeles.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An x-ray shows erosive disease that may progress to bone and cartilage attrition.

A final recommendation states that since inflammatory markers like erythrocyte sedimentation rate, rheumatoid factor, and C-reactive protein are not typically elevated in patients with hand OA, blood tests are not required for a diagnosis. However, blood tests "may be required to exclude coexistent disease" (strength: 78). ■

Straight Talk and Paraffin Baths Favored Over NSAIDs

BY BETSY BATES
Los Angeles Bureau

BEVERLY HILLS, CALIF. — A variety of practical and psychological approaches may be the best medicine for highly active seniors suffering from osteoarthritis and overuse syndromes, speakers said at a multidisciplinary forum at the annual meeting of the American Association for Hand Surgery.

An audience member asked the panel to recommend nonsteroidal anti-inflammatory drugs (NSAIDs) that would be safe for seniors aged 80 years and older who flock to sunny locales each winter to play golf and tennis four times a week, but then come in with aching joints.

"There are no safe nonsteroidals," replied panelist Steven R. Ytterberg, a rheumatologist at the Mayo Clinic, Rochester, Minn.

Dr. Ytterberg said physicians need to consider "hierarchies" of risk according to side-effect threats. For example, he would rate aspirin as riskiest to the gut, with cyclooxygenase-2 inhibitors "maybe a little safer for the gut, but not nearly as safe for the gut as they were promoted to be."

Cyclooxygenase-2 inhibitors have cardiac risks of their own, he noted, but may be safer than aspirin for heart-healthy patients with a history of peptic ulcer disease.

When patients absolutely require an NSAID, Dr. Ytterberg said he tends to favor "regular" nonsteroidals.

"For some reason a lot of rheumatologists like naproxen, twice a day," he said. At this dose, the drug has a "relatively good safety profile … but none are absolutely safe."

Attention then turned to several certified hand therapists (CHTs), who suggested that active elderly patients can benefit from education about ergonomics and joint protection principles.

They also may need to readjust their expectations and realize they might not be able to match the performance goals they had when they were 20, said Ann Lund, an occupational therapist and CHT at the Mayo Clinic in Rochester.

Paul Brach, a physical therapist, CHT, and director of The Hand Center of Pittsburgh, said referral for an analysis of a patient's grip and/or sporting equipment may be very useful in these patients.

Joint support devices and custom-designed grips can alleviate unnecessary aggravation of osteoarthritis, he said.

"How about paraffin baths? Do they do any good?" asked Dr. Robert Beckenbaugh, professor of orthopedics at the Mayo Clinic.

"They love the paraffin. Once they start the paraffin baths it's almost impossible to get them out of our offices," Mr. Brach said. Getting serious, he concluded, "Supportive modalities and heat modalities certainly play an important role."

None of the speakers disclosed ties to manufacturers of drugs or devices. ■

Forthcoming Advice Aims for Pragmatic Approach on NSAIDs

BY GREG MUIRHEAD
Contributing Writer

MAUI, HAWAII — An as-yet unpublished white paper on the appropriate use of nonsteroidal anti-inflammatory drugs by the American College of Rheumatology contains common sense advice such as using the lowest possible dose and the least costly agent when treating the pain of patients with osteoarthritis.

Controversy centers on whether to use naproxen in patients taking low-dose aspirin for cardioprotection.

The white paper sanctions the use of either acetaminophen or naproxen in such patients, Dr. John Cush, an author of the white paper as well as director of clinical rheumatology, Baylor Research Institute, and professor of medicine and rheumatology, Baylor University Medical Center, Dallas, reported at a symposium sponsored by Excellence in Rheumatology Education. However, Dr. Vibeke Strand of Stanford (Calif.) University, an audience member, criticized the ACR's support of the use of naproxen in patients with, or at risk of developing, cardiovascular disease. She argued that there is no statistically significant evidence to support its use.

When aspirin is required, Dr. Cush said that a gastroprotective drug or a proton pump inhibitor should be used. For patients who are at GI risk, a selective cyclooxygenase-2 inhibitor is recommended, he continued. "But if you're going to use a nonselective nonsteroidal, you should use a PPI or misoprostol with it."

'If you're going to use a nonselective nonsteroidal, you should use a PPI or misoprostol with it.'
DR. CUSH

ACR based its recommendations on evidence culled from existing ACR/osteoarthritis guidelines, osteoarthritis guidelines from the European League Against Rheumatism, and reviews by the Cochrane Collaboration, Dr. Cush said.

Nonsteroidal anti-inflammatory drugs (NSAIDs) are the preferable choice to acetaminophen for relieving pain. Patients on long-term NSAIDs require close monitoring of the complete blood count, liver function, and blood pressure. Physicians should avoid nonselective NSAIDs and cyclooxygenase-2 inhibitors in patients with renal or liver disease. Dr. Cush disclosed that he is a clinical investigator and/or consultant/adviser for Abbot, Biogen/Idec, Genentech, Pfizer, Targeted Genetics, UCB, Wyeth, Centocor, and Novartis. ■