# Arthritis Deemed the Iceberg of U.S. Disability

BY MICHELE G. SULLIVAN

A recent government report finding that arthritis and rheumatism account for much of the disability in Americans may be an underestimate.

The estimated percentage of Americans reporting a disability increased by 7.7% from 1999 to 2005, from 44.1 million to 47.5 million, with arthritis and rheumatism the most common causes of physical problems that interfere with daily life, according to a report issued by the Centers for Disease Control and Prevention.

Almost 22% of the adult population reported a physical disability in 2005, Dr. Chad Helmick and his coauthors wrote. Although the percentage hasn't changed since the last disability survey in 1999, the number represents an absolute increase of 7.7%—probably because of an increase in the number of older people as Baby Boomers age, wrote Dr. Helmick, an epidemiologist for the Centers for Disease Control and Prevention, and a coauthor of the study.

The most commonly reported causes of disability were arthritis and rheumatism (8.6 million people), followed by back or spine problems (7.6 million) and cardiac problems (3 million), the report said.

Dr. John Klippel, president and chief executive officer of the Arthritis Foundation, said the survey might underestimate the true impact of arthritis and rheumatic disease.

"I believe that many people who report disability due to back pain have arthritis as the underlying cause of that pain," Dr. Klippel said in an interview. "If you add those two together, then the overwhelming reason for disability in American would be arthritis and musculoskeletal diseases."

The data were extracted from the 2005 Survey of Income and Program Participation, conducted by the U.S. Census Bureau. The survey included interviews with 70,300 noninstitutionalized people aged 18 years or older from 37,400 households (representing 83% of eligible households).

Disability was defined as a "yes" answer to one of three categories: required use of an assistive device (cane, crutches, walker, or wheelchair); difficulty performing activities of daily living or specified functional activities; and a limitation in the ability to work around the house or at a job or business. Respondents then chose the cause of their disability from a list of 30 disorders. National estimates were extrapolated from the completed survey.

The survey concluded that most of those reporting a disability were 65 years or older (52%) and that disability was significantly higher in women than in men (24% vs. 19%, respectively). The most commonly reported functional disabilities were difficulty walking three or more blocks (10%; 22 million people) and climbing a flight of stairs (10%).

Of those with a disability, 19%—an estimated 9 million people—identified arthritis or a rheumatic disease as the cause. These disorders were also the most common cause of disability for women, affecting 24%.

Back and spine problems affected 17% of the population, and were the leading cause of disability for men (17%). Cardiac disorders affected 7% overall (8% of men and 5% of women).

The report suggests that disability numbers will continue to rise as the American population ages.

"To accommodate the expected increase in demand for disability-related medical and public health services, expanding the reach of effective strategies and interventions aimed at preventing progression to disability and improving disability management in the population is necessary," according to the report (MMWR 2009;58:421-6).

Over the next 20 years as they age, the number of people reporting arthritis-related disability and the economic costs associated with it will skyrocket." Arthritis and other rheumatic disease cost the U.S. $128 billion annually. "These will go up logarithmically," Dr. Klippel said. "Given all the concerns for our economy, we have even more reasons to start focusing on health care reform, and arthritis and musculoskeletal diseases need to be at the top of the list."

Only 12 states have CDC-funded arthritis health programs, Dr. Klippel said. "We at the Arthritis Foundation would like to see the CDC invest more in chronic disease prevention programs, including those for osteoarthritis. Without a greater investment in research, we will not have more effective therapies." ■

# New Pain Management Guidelines Take Aim at NSAIDs

BY PATRICE WENDLING

CHICAGO — An updated guideline addressing persistent pain in older people takes a tough stance on the use of nonsteroidal anti-inflammatory drugs.

The American Geriatrics Society (AGS) guideline recommends that acetaminophen be considered for initial and ongoing treatment of persistent pain, particularly musculoskeletal pain. But in a significant departure from its 2002 guideline, the AGS recommends that nonselective NSAIDs and cyclooxygenase-2 (COX-2) selective inhibitors "be considered rarely, and with extreme caution, in highly selected individuals."

The AGS had recommended that seniors use over-the-counter or prescription NSAIDs, such as aspirin or ibuprofen, or COX-2 inhibitors before being prescribed an opioid. The current recommendation reflects recent good evidence that this is a risky strategy in older people, panel member Dr. James Katz said at the society's annual meeting, where the guidelines ("Pharmacological Management of Persistent Pain in Older Persons") were released.

Traditional NSAIDs are associated with adverse gastrointestinal events in 20% of patients, with 107,000 hospitalizations and 16,500 deaths yearly attributed to NSAID-related GI complications.

COX-2 inhibitors seem to produce fewer upper GI events than do other NSAIDs, but "all nonsteroidals, whether they are [COX-2 inhibitors] or not, have a significant portfolio of adverse effects that is noteworthy for the elderly population," said Dr. Katz, director of rheumatology at George Washington University in Washington. "They can aggravate hypertension, they can cause renal impairment by a variety of mechanisms, [they can cause] edema [and] gastrointestinal problems, and now we know cardiovascular and cerebrovascular disease can be attributed to nonsteroidal interaction."

Last year's study of 336,906 community-dwelling Medicaid beneficiaries by the Veterans Affairs Tennessee Valley Healthcare System extended concerns about COX-2 selective inhibitors to cerebrovascular disease, said Dr. Katz. The study suggested an increased risk of stroke with rofecoxib (Vioxx) and valdecoxib (Bextra), compared with the effects of nonselective agents (Stroke 2008;39:2037-45). The finding was not statistically significant, he noted, but both drugs have been withdrawn from the market.

Recent evidence also showed that combining a traditional NSAID with low-dose aspirin therapy increases the risk of GI bleeding beyond that of the traditional NSAID alone (Curr. Opin. Rheumatol. 2008;20:239-45). In 2006, the Food and Drug Administration warned against taking aspirin and ibuprofen together because ibuprofen interferes with aspirin's acetylation effect.

More research is needed to determine whether other NSAIDs interfere with the cardioprotective benefits of low-dose aspirin, said Dr. Katz, who was part of a panel unveiling the guidelines at the meeting. Panel members also said that more data are needed on the safety of topical preparations of NSAIDs.

The revised guideline recommends the eradication of *Helicobacter pylori* prior to initiating NSAIDs for pain, and the use of a proton pump inhibitor or misoprostol for gastrointestinal protection in older persons taking nonselective NSAIDs or in patients taking a COX-2 selective inhibitor with aspirin.

The guideline recommends that physicians consider opioid therapy for patients with moderate to severe pain, pain-related functional impairment, or diminished quality of life because of pain. People with continual or frequent daily pain may be treated with around-the-clock, time-contingent dosing aimed at achieving steady-state opioid therapy, said Dr. Perry Fine of the pain management center at the University of Utah, Salt Lake City.

The recommendations are based on a systematic review of 2,400 abstracts and 240 data-based, full-text articles. The update is to be published in the Journal of the American Geriatrics Society.

Dr. Katz has served as a consultant for the American Academy of CME Inc. and for UCB Pharma Inc. Dr. Fine is as a consultant or speaker for numerous pharmaceutical companies and has interests in Johnson & Johnson and Cephalon Inc. ■

## NSAIDs Tied to Sudden Cardiac Arrest

ORLANDO — Diclofenac, celecoxib, and rofecoxib are associated with dose-dependent increased risks of sudden cardiac arrest, according to a large national Danish study.

No increased risk was noted in conjunction with the use of ibuprofen or naproxen, Dr. Frederik Folke reported at the annual meeting of the American College of Cardiology.

He presented a case-crossover study involving 12,288 Danes who experienced out-of-hospital sudden cardiac arrest in 2001-2004. They were included in the unique Danish Cardiac Arrest Registry, which incorporates all cases of out-of-hospital cardiac arrest occurring in the country. Their prior use of all NSAIDs was identified through linkage to nationwide pharmacy drug-dispensing records.

Forty percent of patients used an NSAID within 30 days prior to their cardiac arrest. The most widely used NSAIDs were ibuprofen (Advil, Motrin), used by 44.5%; diclofenac (Voltaren), used by 23%, the selective cyclooxygenase-2 inhibitors celecoxib (Celebrex) and rofecoxib (Vioxx), used by 13.9% each; and naproxen (Aleve), used by 4.7% of patients within 30 days of their cardiac arrest.

Under the study's case-crossover design, patients' use or nonuse of NSAIDs within 30 days prior to cardiac arrest was compared with their use or nonuse during two control periods: 60-90 and 90-120 days prior to their cardiac event, Dr. Folke, a cardiologist at Gentofte University Hospital, Hellerup, Denmark.

Use of diclofenac, celecoxib, or rofecoxib within 30 days was associated with increased risks of sudden cardiac arrest ranging in dose-dependent fashion from about 1.5-fold to 2.5-fold.

**—Bruce Jancin**