# Evidence-Based Hand Arthritis Guidelines Issued

BY NANCY WALSH
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The first evidence-based recommendations on the management of hand osteoarthritis have been developed by a multidisciplinary group commissioned by the European League Against Rheumatism.

Previous European League Against Rheumatism (EULAR) task forces have issued guidelines on the management of knee and hip osteoarthritis (OA), but many of the clinical consequences of small-joint OA, such as interference with grip and fine precision pinch, differ from those associated with large-joint OA, making distinct recommendations necessary.

Interventions therefore have been developed in a site-specific fashion, with 11 key recommendations regarding various types of treatments having emerged from an examination of research-based evidence and expert consensus. (See box.)

Among general considerations addressed are the principle that treatment must be individualized according to the patient's symptoms, severity of disease, and expectations. The patient also should be educated regarding joint protection and exercise.

Nonpharmacologic measures that can be useful include splints and topical analgesics. Such local treatments are preferred over systemic treatments, particularly in limited, mild disease.

First-line pharmacologic therapy is oral paracetamol (acetaminophen), which can be given in doses up to 4 g/day. Other options include nonsteroidal anti-inflammatory drugs and slow-acting agents such as glucosamine and chondroitin sulfate.

Intra-articular injections of corticosteroids also can be beneficial for painful flares, and surgical procedures such as interposition arthroplasty are recommended for patients who do not respond to more conservative measures (Ann. Rheum. Dis. 2006 Oct. 17 [Epub doi:10.1136/ard.2006.062091]).

The EULAR task force noted that there is "a real paucity of clinical trials to guide recommendations for hand OA," and that many of their recommendations are based on expert committee reports and/or clinical experience, rather than randomized trials. Aside from their clinical recommendations, therefore, the task force also highlighted the need for well-conducted clinical trials that would provide a more definitive evidence base. ■

## The EULAR Recommendations

The guidelines for the management of hand OA are as follows:

1. Optimal management of hand OA requires a combination of nonpharmacologic and pharmacologic treatment, individualized to the patient's needs.
2. Individualize therapy according to site, risk factors, type of OA, presence of inflammation, severity of structural change, and level of pain and disability.
3. Educate patients on how to protect their joints and give them an exercise regimen involving both range of motion and strengthening exercises.
4. Application of heat, especially before exercise, and ultrasound are helpful.
5. Splints for thumb base OA and orthoses to correct lateral angulation and flexion deformity are recommended.
6. Topical nonsteroidal anti-inflammatory drugs (NSAIDs) and capsaicin are useful, especially for mild to moderate pain involving only a few joints.
7. Acetaminophen is the oral analgesic of choice in dosages of up to 4 g/day.
8. For patients who respond inadequately to acetaminophen, oral NSAIDs can be used in the lowest effective dose and for the shortest duration needed. Patients at risk for GI adverse effects should receive a gastroprotective agent or a selective COX-2 inhibitor, but for those at cardiovascular risk, coxibs are contraindicated and nonselective NSAIDs should be used with caution.
9. Symptomatic slow-acting drugs for osteoarthritis—including glucosamine, chondroitin sulfate, avocado soybean unsaponifiables, diacerhein, and intra-articular hyaluronan—may provide some benefit with low toxicity, but suitable patients have not been defined.
10. Intra-articular injections of long-acting corticosteroids are effective for symptomatic flares of OA, particularly at the trapeziometacarpal joint.
11. Surgical procedures such as interposition arthroplasty can be beneficial for severe thumb base OA and may be considered when conservative measures have failed.

# Gabapentin Prodrug May Ease Restless Legs Syndrome

BY JEFF EVANS
*Senior Writer*

CHICAGO — An investigational gabapentin prodrug may be an effective therapy for symptoms and sleep problems associated with restless legs syndrome, Dr. Arthur S. Walters reported at the annual meeting of the American Neurological Association.

The active compound gabapentin has already been shown to improve the sensory and motor symptoms of restless legs syndrome (RLS) and decrease periodic leg movements during sleep, but the drug is approved only for treating epilepsy and postherpetic neuralgia, according to Dr. Walters of the Seton Hall University School of Graduate Medical Education, Edison, N.J.

The gabapentin prodrug XP13512 has several potential advantages over standard gabapentin for treating RLS: The agent has linear pharmacokinetics, doesn't reach a saturation point, and is formulated for sustained release. The capacity for once-daily dosing differentiates gabapentin prodrug XP13512 from the active compound gabapentin (Neurontin), which cannot be manufactured in a sustained-release delivery and must be taken three to four times per day, Dr. Walters discussed on his poster at the meeting.

XenoPort Inc., the drug's manufacturer, has sponsored two phase II, randomized, double-blind trials. One of these trials was a crossover study with 38 patients testing 1,800 mg XP13512 against placebo. The other trial compared XP13512 at 600 mg and 1,200 mg and placebo in 95 patients without any crossover. In both studies, patients had RLS symptoms on at least 4 nights during a 7-day baseline period and had a score of at least 15 (out of a possible 40) on the International RLS Study Group rating scale (IRLS). Most patients were white and had a mean age of about 50 years.

Compared with patients given placebo, patients who were treated with the gabapentin prodrug had significantly greater improvement (decreases) in IRLS scores at doses of 1,800 mg (20.4 to 8.4 vs. 20.4 to 18.5) and 1,200 mg (22.4 to 6.3 vs. 22.4 to 13.5) at the end of the 2-week trial. The patients who received XP13512 at 1,200 mg also had significantly greater improvement than those who received 600 mg. Clinical global impressions of change from both patients and investigators followed the same trend and were significantly in favor of patients who received XP13512, reported Dr. Walters, who received compensation for consulting with XenoPort.

Polysomnographic assessments in the crossover study found that patients had significantly more total sleep time (25 minutes) while receiving the gabapentin prodrug than when they received placebo. In both studies, patients who received XP13512 had significantly fewer awakenings during the night and spent less time awake per night because of RLS symptoms. ■

# *Fibromyalgia Diagnosis Does Not Lead to Uptick in Office Visits*

BY BRUCE JANCIN
*Denver Bureau*

AMSTERDAM — The diagnosis of fibromyalgia is not followed by a surge in physician office visits, according to Dr. Ernest H.S. Choy, speaking at the annual European Congress of Rheumatology.

A recent study using data from the U.K. General Practice Research Database, led by Dr. Simon Wessely, a King's College psychiatrist, compared health care utilization from 10 years before through 4 years after diagnosis of fibromyalgia in 2,260 patients and a group of age- and gender-matched controls, said Dr. Choy, of King's College London.

**'Patients demand less tests and have less consultations after the diagnosis is made.'**

**DR. CHOY**

The investigators found that the rates of office visits, prescriptions, and medical tests were markedly higher and rising in the years prior to diagnosis in fibromyalgia patients, compared with control patients.

In the year prior to diagnosis, patients averaged 25 office visits and received 11 prescriptions, compared with 12 office visits and 4.5 prescriptions during the same year for controls. The most common reason for prediagnosis office visits by fibromyalgia patients was depression, followed by fatigue, chest pain, headache, and disrupted sleep.

Diagnosis of fibromyalgia was not followed by a surge in illness behavior and health care utilization. In fact, health care utilization declined for 2-3 years following the diagnosis before climbing back up, probably because the patients were not getting effective treatment, according to the investigators (Arthritis Rheum. 2006;54:177-83).

"Patients demand less tests and have less consultations after the diagnosis is made," Dr. Choy commented.

Fibromyalgia is a high-cost medical condition, he noted. A classic University of Kansas 7-year prospective study determined that the mean annual per-patient cost was $2,274 in 1996 dollars. "These patients are consuming a vast amount of health care resources," he said at the congress sponsored by the European League Against Rheumatism (EULAR).

Another recent large observational study undercuts claims that fibromyalgia is simply part of a single larger, ill-defined somatization disorder that also includes conditions like chronic fatigue syndrome, irritable bowel syndrome, and regional pain disorders. This study involved 18,122 U.K. patients diagnosed by their primary care physician as having a fatigue syndrome during 1988-2001.

The key finding was that outcomes differed significantly for patients with various diagnostic labels, being best for those with postviral fatigue syndrome, worst for myalgic encephalomyelitis and chronic fatigue syndrome, and intermediate for those with fibromyalgia (Fam. Pract. 2005;22:383-8). ■