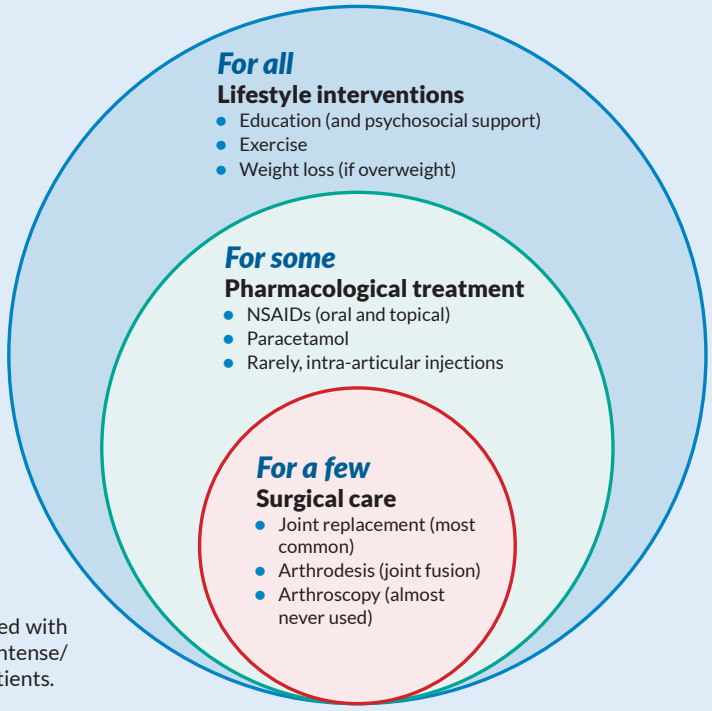
bpacnz PRIMARY CARE UPDATE SERIES

OSTEOARTHRITIS (OA)
– KEY PRACTICE POINTS

The risk of a patient developing OA increases significantly with age. Much like in other Western countries, the average life expectancy in New Zealand is rising, and therefore the burden of OA is anticipated to grow accordingly. Although OA management is often considered to be a "bread and butter" aspect of primary care, it is important to re-evaluate our understanding of what causes this condition and identify changes in the recommended approach to treatment.

Individualisation is key*
– it is a matter of finding which approach works best for the patient in front of you, and for the joint affected



* Ideally, the patient's clinical condition can be maintained or improved with less intense/invasive options, i.e. lifestyle changes; however, more intense/invasive options, i.e. surgery, may inevitably be required for some patients.

Key practice points:

- Contrary to popular opinion, OA is not caused solely by "degenerative wear and tear"; its pathogenesis involves a combination of biomechanical, inflammatory, enzymatic and metabolic factors
- A diagnosis of OA can be made clinically in people aged ≥45 years if they have activity-related joint pain with no other explanation, e.g. recent trauma, and morning stiffness lasting less than 30 minutes (or not at all)
  - Assess patients using the **four "P's"**: (1) the nature and occurrence of their **pain**, (2) how pain affects their **performance**/function, (3) how pain impacts them **psychologically**, and their **past** medical history
  - X-rays are rarely required in patients presenting with mild-to-moderate OA; instead, they should be requested if an alternative diagnosis is suspected, or if orthopaedic assessment is required, e.g. patients with severe pain or significant joint deformity
- The first-line treatments for patients with OA are exercise and weight loss (if relevant), accompanied by education regarding their condition
  - Reassure patients that they are unlikely to damage the joint further with exercise, and that it is okay to perform physical activity with some discomfort
  - Patients should clearly understand the causes of OA, how the body perceives pain, their prognosis, treatment options, and be directed to social support options if required

- If exercise and weight loss do not improve OA symptoms over time, or if a patient is experiencing severe pain as a result of OA, then pharmacological treatment is indicated
  - International guidelines now recommend oral non-steroidal anti-inflammatory drugs (NSAIDs) as the first line treatment for patients with OA, however, decisions should always be individualised, e.g. if the patient is elderly with a history of gastrointestinal issues, then paracetamol is still a reasonable first choice
  - Topical NSAIDs (and capsaicin cream) can be considered for patients with superficial joints affected by OA
  - Opioid medicines should be avoided whenever possible and used for the shortest possible duration if required
  - Adjuvant analgesics, e.g. pregabalin or gabapentin, should only ever be prescribed if there is a clear neuropathic component to the patient's pain (not for "classic" OA pathology)
- Corticosteroid injections should be only be used for patients ongoing symptoms despite NSAID treatment to help them manage non-operatively for as long as possible (or if surgery is contraindicated), or for flares; they are not a requirement to progress to surgery and should only be considered in a small number of patients
  - Hyaluronic acid injections should not be used as a routine treatment for patients with OA
- Surgery (most often joint replacement) may inevitably be required for some patients if analgesia, exercise and weight loss are unable to alleviate the pain and disability associated with progressive joint damage, or if the patient is severely limited in their range of motion and cannot engage in daily activities
  - Patients should be encouraged to lose weight (if relevant) prior to surgery to improve outcomes, however, this is generally not a contraindication
  - Pre-habilitation (engaging in tailored pre-surgical exercise) programmes can improve fitness post-operatively and reduce the length of hospital stays
- Currently, there is insufficient evidence to support the use of alternative "advanced" treatments, including stem cell transplants or platelet rich plasma (PRP) injections

NSAIDs, non-steroidal anti-inflammatory drugs; OA, osteoarthritis

1. Victorian Model of Care for Osteoarthritis of the Hip and Knee. Victorian musculoskeletal clinical leadership group. 2018. Available at: http://www.acsep.org.au/content/Document/MOVE_MoC_WebVersion_WithHyperlinks.pdf (Accessed Feb, 2021); 2. Kolasinski SL, Neogi T, Hochberg MC, *et al.* Arthritis Care Res. 2020;72:149–62.