PostScript

MATTERS ARISING

Guidelines for the treatment of osteoarthritis

Guidelines for the treatment of osteoarthritis (OA) have several purposes, but a major one relates to its use by regulatory or medical insurance agencies that use it to help guide their response to requests for drugs to treat patients. Data have been recently published which record the efficacy of non-steroidal anti-inflammatory drugs (NSAIDs) over paracetamol (acetaminophen) and report patients’ preferences for NSAIDs rather than paracetamol in the treatment of OA. Furthermore, inflammation is a common accompaniment of moderate to severe OA. Therefore it would seem appropriate to consider the use of NSAIDs as the primary treatment in the group of patients with OA with moderate to severe pain or inflammation as part of their disease. The EULAR Guidelines state that paracetamol is the first line of treatment for all patients with OA, despite the recent evidence that NSAIDs are more efficacious than paracetamol and that paracetamol is associated with more gastrointestinal toxicity than was previously thought. Would it not be more appropriate to suggest that patients who have moderate to severe pain and/or OA with inflammatory components be given NSAIDs as the first line of treatment, leaving paracetamol for symptomatic use in those patients with lesser degrees of pain or lack of overt inflammation?

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References

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Authors’ response

The pro’s and con’s of oral non-steroidal anti-inflammatory drugs (NSAIDs) and paracetamol are certainly of interest and relevance to the management of osteoarthritis (OA). However, the following points are relevant to the suggestions contained in Dr Furst’s letter:

1. The EULAR recommendations reflect an evidence based approach to key clinical questions. They clearly specify the end of 1998 as the time up until which published evidence was included for review. The recommendations will be revised in the light of more recent publications in the future and will then include the studies referenced by Dr Furst. It is clearly impractical regularly to change individual recommendations in response to every new publication—certain time points need to be taken to “close the door” on data while the formal review process takes place.
2. Again it is clearly stated in the EULAR document that the packaging of care offered to a patient with knee OA must take into account not only efficacy and side effects of individual interventions but also patient attitudes and preferences, comorbidity, concurrent drug treatment, costs, and availability. It will indeed be interesting to see if the EULAR Task Force do change their recommendations in the light of these recent data in the way suggested by Dr Furst. For example:
   - In the recent study by Pincus it is noteworthy that although 57% of patients thought that Arthrotec was better than paracetamol, 20% thought that paracetamol was better and 22% reported no difference. In other words almost half the patients found no perceived benefit from Arthrotec. Side effects were significantly more common with Arthrotec. Furthermore, this was a short term study of six weeks. The few long term studies show that many patients stop taking NSAID—in one study only 15–20% of patients with OA continued their NSAID for one year.
   - Traditional oral NSAIDs indeed kill a significant number of patients each year from gastrointestinal bleeding/perforation. Over half of the patients with symptomatic OA are in the high risk category for NSAID associated mortality (elderly, with comorbidity). Although there are now data that paracetamol may have a gastrointestinal risk, it is less than that caused by traditional NSAIDs. There are no renal or cardiovascular side effects from paracetamol, but there are from NSAIDs.
   - NSAIDs remain expensive compared with paracetamol.
   - Data show that NSAIDs (at least indometacin) may hasten cartilage and bone attrition—there are no data that paracetamol is such a negator of DMOAD.
   - It is for reasons such as this that most doctors keep oral NSAIDs in reserve for patients in whom the safer and cheaper drug, paracetamol, has failed.
3. It is perhaps unfortunate that many of us get hung up on the order of drug selection. In practice, of course, most patients receive a package of care, not a single treatment. Many patients take both NSAIDs and paracetamol (often as self medication of the over the counter drugs)—hopefully in addition to exercise, weight reduction, pacing of activities, etc etc. The argument about “first use” is therefore irrelevant to most patients. Furthermore, few studies use a factorial design to better inform us of effect sizes of combined treatments. Few also examine predictors of response. These points are again made in the EULAR document.
4. We would take issue with the suggestion that the major purpose of “eLetters” is that they be used by regulatory or insurance agencies. This may be true in America but is not a rationale for producing recommendations in Europe. The objectives of the EULAR recommendations are clearly listed. They summarise evidence to help directly (not indirectly through agencies) guide decision making by...
practitioners and patients. They also highlight gaps in our knowledge and inform the future research agenda.

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Reference


4 Brandt KD, Bradley JD. Should the initial drug used to treat osteoarthritis pain be a nonsteroidal antiinflammatory drug? J Rheumatol 2001;28:467–73.

Salmonella arthritis
I was interested to read the “Lesson of the month” on salmonella arthritis in a 70 year old Afro-Caribbean man.1 The discussion mentioned that male sex and pre-existing atherosclerosis are risk factors for salmonella arthritis and that the condition is extremely uncommon below the age of 50.

No mention was made of the possibility of sickle cell disease in this man. Sickle cell disease may be complicated by salmonella infection, rarely producing an osteomyelitis, and I should be interested to know if haemoglobin electrophoresis was carried out, and whether the sharp drop in haemoglobin might be accounted for by a sickle cell crisis.

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Reference

Author’s response
It is a valid point that sickle cell disease can be complicated by salmonella infection and as a sequel salmonella osteomyelitis. This usually follows a painful crisis, which is more common in male than female patients and has an increased incidence between the ages of 15 and 25. An episode of painful crisis lasting for more than two weeks and associated with a temperature of 38°C or more should raise the suspicion of osteomyelitis, and the patient with a temperature of 38°C or more should be interested to know if haemoglobin electrophoresis was carried out, and whether the sharp drop in haemoglobin might be accounted for by a sickle cell crisis.

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Reference

Rheumatic pneumonia
I read recently in the Annals a letter by Fuente et al on rheumatic pneumonia.3 Despite the authors stating that they had completely reviewed Spanish and English publications, an article by us published in 1995 was not included.

Our article would have added to the information contained in the letter by Fuente et al because it described the case of a 3 year old girl (an uncommon age for the onset of rheumatic disease), in whom arthritis and carditis occurred together, with valvular sequelae (mitral insufficiency) that required surgical intervention a year later.

In Pernambuco, in the northeast of Brazil, which has serious socioeconomic problems, rheumatic fever is endemic among the poor, particularly in children and adolescents, causing early damage to mitral and aortic valves. Rheumatic pneumonia, though uncommon, can be seen in about 2% of our acute cases, mostly recurrent, with severe concomitant valvulitis.

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References

Authors’ response
We thank Dr Saraiva for his letter and think that the case reported is very interesting as they describe rheumatic pneumonia associated with mitral insufficiency at an unusually early age of onset in a region where rheumatic fever continues to be prevalent. This emphasises even more the rarity of this complication.

Unfortunately, we were unable to include the article in our review because it was not indexed in the bibliographic sources we used (Medline, Medline plus, and PubMed of the United States National Library of Medicine databases) and it was not referred to in the bibliography of papers reviewed in our article.

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Reference
FORTHCOMING EVENTS

**International Congress: New Trends in Osteoarthritis**
9–11 May 2002; Milan, Italy
Contact: Organising Secretariat, O.I.C. S.r.l., Via Fatebenefratelli 19, 20121 Milan, Italy
Tel: +39 02 65 71 200
Fax: +39 02 65 71 270
Email: osteoarthritis@ioc.it

**IOF World Congress on Osteoporosis**
10–14 May 2002; Lisbon, Portugal
Contact: IOF Secretariat, 71 Albert Thomas, F-69003 Lyon, France
Tel: +33 472 91 41 77
Fax: +33 472 36 90 52
Email: info@ioflyon.org
Website: www.osteoporosis.org

**6th International Symposium on the Immunotherapy of the Rheumatic Diseases**
15–19 May 2002; Limassol, Cyprus
Contact: Tammi Wenham, Department of Rheumatology, 5th Floor, Thomas Guy House, Guy’s Hospital, London SE1 9RT, UK
Tel: +44 (0)207 955 4394
Fax: +44 (0)207 955 2472
Email: tammi.wenham@kcl.ac.uk
Website: www.e20pr.com

**5th European Conference on Systemic Lupus Erythematosus**
26–30 May 2002; Athens, Greece
Chairman Professor IM Moutsopoulos
Contact: AmphiHitron Congress Organising Bureau
Email: hmoutsop@med.uoa.gr
Website: www.eular.org

**Annual European Congress of Rheumatology**
12–15 June 2002; Stockholm, Sweden
Contact: Fred Wyss, Executive Secretary EULAR, Witikonerstrasse 15, CH-8032, Zurich, Switzerland
Tel: +41 1 383 9125
Fax: +41 1 383 9125
Email: eular@bluewin.ch
Website: www.eular.org

**10th International Congress on Behçet’s Disease**
27–29 June 2002; Berlin, Germany
Contact: Professor Ch C Zouboulis, Department of Dermatology, University Medical Centre Benjamin Franklin, The Free University of Berlin, Fabriekstrasse 62–66, 14195 Berlin, Germany
Fax: 49 30 4445908
Email: zoubbere@zedat.fu-berlin.de
Website: www.10bc.com

**29th Scandinavian Congress of Rheumatology**
15–18 Aug 2002; Tromso, Norway
Contact: Hans Nossent, Department of Rheumatology, University Hospital Tromso, Norway
Tel: 47 776 27294
Fax: 47 776 27258
Email: 29sc2002@rit.no or revhan@rit.no

**24th Annual Meeting of the American Society for Bone and Mineral Research**
20–24 Sep 2002; San Antonio, TX, USA
Contact: ASBMR, 2025 M Street, NW, Suite 800, Washington DC 20036-3309, USA
Tel: +1 202 367 1161
Fax: +1 202 857 1880
Email: asbmr@dc.sba.com

**Translational Research in Autoimmunity**
21–22 Sep 2002; Pavia, Italy
Contact: Organising secretariat: eventi S.R.L., Corso Cavour, 18/20 - 27100 Pavia, Italy
Email: tra@e20pr.com
Website: www.oarsi.org

**OsteoArthritis Research Society International (OARSI) World Congress**
22–25 Sep 2002; Sydney, Australia
Contact: OsteoArthritis Research Society International (OARSI), 2025 M Street, NW, Suite 800, Washington DC 20036, USA
Tel: +1 202 367 1177
Fax: +1 202 367 2177
Email: oarsi@oarsi.org
Website: www.oarsi.org

**Third International Conference on Familial Mediterranean Fever and Hereditary Inflammatory Disorders**
23–27 September 2002; La Grande Motte, France
Contact: Dr Isabelle Touitou, Laboratoire de Généétique Moleculaire et Chromosomique, Hôpital A de Villeneuve, Montpellier, France
Tel: 33 6 67 33 58 59
Fax: 33 6 67 33 58 62
Email: isabelle.touitou@igh.cnrs.fr
Website: www.congres.igh.cnrs.fr/FMF/2002

**10th International Congress on Antiphospholipid Antibodies**
02–3 Sep 2002; Sicily, Italy
Contact: Secretariat, 10th International Congress on Antiphospholipid Antibodies, c/o Kences International, PO Box 50006, Tel Aviv 61500, Israel
Tel: 972 3 5140018/9
Fax: 972 3 5140077 or 972 3 5172484
Email: aps@kences.com
Website: www.kences.com/aps

**Third international Congress on Spondyloarthropathies**
2–5 Oct 2002; Gent, Belgium
Topics covered will be:
- Innate immunity
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- Animal models and pathogenesis
- Clinical research and therapy

**Organisers of the 26th Annual Meeting of the American Society for Bone and Mineral Research**
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Fax: +32 9 344 40 10
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Website: www.medici-congress.com

**7th International Conference on Eicosanoids and Other Bioactive Lipids in Cancer, Inflammation and Related Diseases**
14–17 Oct 2002; Nashville, Tennessee, USA
Contact: Lawrence J Garnett, Biochemistry Department, Vanderbilt University, School of Medicine, Nashville, TN 37232-0146, USA
Tel: (615) 343 7329
Fax: (615) 343 7534
Website: www.eicosanoids.science.eayne.edu

**3rd International Conference on Sex Hormones, Pregnancy, and the Rheumatic Diseases**
21–24 Oct 2002; New Orleans, LA, USA
Contact: Anne Parke
Tel: 860 679 8190
Fax: 860 679 1287
Email: parke@nso.uchc.edu

**66th American College of Rheumatology AGM**
25–29 Oct 2002; New Orleans, USA
Contact: ACR, Ronald F Olejko, Director of Conferences and Meetings, 1800 Century Place, Suite 250, Atlanta, Georgia 30045–4300, USA
Tel: +1 404 633 3777
Fax: +1 404 633 1870
Email: acr@rheumatology.org
Website: www.rheumatology.org

**Third International Meeting on Social and Economic Aspects of Osteoporosis and Osteoarthritis**
7–9 November, 2002; Barcelona, Spain
Contact: Yolande Piette Communication, Boul-levard Kleyer 108, 4000 Liège, Belgium
Tel: 32 4 254 12 25
Fax: 32 4 254 12 90
Email: ypc@compuserve.com

**Certifying Examination in Pediatric Rheumatology**
18 Nov 2002
Contact: American Board of Pediatrics, 111 Silver Cedar Court, Chapel Hill, NC 27514-1513, USA
Tel: 919 929 0461
Fax: 919 918 7114 or 919 929 9255
Website: www.abp.org

**Future EULAR congresses**
18–21 June 2003; EULAR 2003 Lisbon, Portugal
9–12 June 2004; EULAR 2004 Berlin, Germany
8–11 June 2005; EULAR 2005 Vienna, Austria
21–24 June 2006; EULAR 2006 Amsterdam, The Netherlands

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