Osteoarthritis (OA) is the most common joint disorder in the world; it occurs in the majority of people over the age of 65 and is an important cause of (work) disability. The public health impact of OA is immense and will further increase with the growing elderly population. Therefore, the search for, and evaluation of, treatments for OA are relevant research topics, not only for the medical community, including individual patients and doctors, but also for pharmaceutical companies and health economists. Assessment of present and future treatment modalities in OA is important and requires a balanced approach.1

OUTCOME ASSESSMENT
Outcome assessment is the measurement process whereby the consequences of disease and health management interventions are evaluated.2 Outcome measures may be divided into two broad categories: observer dependent (or assessor rated) and observer independent (or self rated). In general, observer independent clinical measures are based on self administered questionnaires, whereas observer dependent clinical measures include questionnaires scored by the interviewer, physical findings, and tests of performance rated on technical instruments, such as walking time.

Many physicians tend to value assessor rated outcome measures higher than self rated outcome measures. However, this interpretation is obsolete and does not allow consideration of the patients’ perspectives. In line with the OMERACT recommendations,3 most studies in OA use clinical outcome measures of pain, function, and patient global assessment (all self rated) and, only for studies over 1 year, imaging (assessor rated). Clinical trials in OA assess short term changes in symptoms and long term changes in structural improvement. As yet, no definite proof of structural improvement has been documented in OA research.

PATIENTS’ PERSPECTIVES
The sequential OMERACT conferences have boosted the science of clinical measurement to generate new knowledge and to develop consensus on the use of methodology in rheumatology. The first focusing on rheumatoid arthritis (RA), but more recently also, on other rheumatic diseases, including OA. As a new development at the 6th conference, in Australia in 2002, the incorporation of patient perspectives in arthritis measurement research was introduced.4 This major step was based on the recognition that outcome assessment, and in turn, treatment decisions, vary greatly among healthcare providers.5

“Outcome assessment and treatment decisions vary greatly among healthcare providers”

Given the lack of treatment standardisation, it is therefore thought essential to involve patients in better defining outcomes, that are comprehensive and that meaningfully influence clinical decision making. This conclusion is now widely accepted and patients are now more than before involved in outcome research in rheumatic diseases. One of the consequences is that present studies not only deal with the magnitude of improvement of individual variables in the whole group of patients, but also with the number of patients who really feel improved.

PATIENT REPORTED OUTCOME
In this issue of the Annals two important studies are published on patient reported outcomes in OA of the knee and hip that are indeed meaningful for the individual patient. Both use a prospective multicentre cohort study of 4 weeks’ duration involving 1362 French outpatients with OA of the knee or hip.

The first study deals with clinically relevant changes in patient reported outcomes, discussing the minimal clinically important improvement.6 The second deals with clinically relevant states in patients reported outcomes, discussing the patient acceptable symptom state.7 These two interesting outcomes warrant some further thoughts.

Minimal clinically important improvement
The concept of minimal clinically important improvement (MCII) is defined as the smallest change in measurement that signifies an important improvement in a patient’s symptom. The MCII can be considered as a treatment target from the patient’s perspective. The MCII interprets changes in scores at the individual level, by expressing the results as a proportion of improved patients, making the results more meaningful.

To calculate this score patients own assessment of their response on a five point Likert scale at the final visit as “good” was the “gold standard”. For instance, patients with knee OA consider themselves clinically improved if the decrease in pain exceeds 19.9 mm on the 0–100 mm visual analogue scale (VAS). It is based on the patient’s opinion as an external anchor and contrasts changes within patients at the individual level (proportion of improved patients) instead of at the group level (mean change in a variable).

Let us look at this finding a bit further: is it broadly applicable, or only in the context of this French population, evaluating the use of a non-steroidal anti-inflammatory drug during 4 weeks? The timeframe has been arbitrarily set at 4 weeks; the MCII probably will be different at 2 or 6 weeks and the timeframe will have implications for the use of the MCII. In the French study 399 rheumatologists included 1362 patients, fewer than four patients for each doctor, probably biasing the sample towards a population with more severe OA. This is mirrored in the high scores on the VAS for pain, patient global assessment, and WOMAC function score. Therefore, we cannot from this particular study conclude that 20 mm improvement in VAS pain in a patient with knee OA is always clinically relevant; we need to validate these results in other patient populations.

In addition, probably not only the described actual decrease but also the decrease below a certain level will be relevant. Improvement of pain of 20 mm on a 0–100 mm VAS, will be differently experienced by a patient who started with a pain score of 60 mm at baseline in comparison with a patient
with a baseline VAS score of 30 mm. Therefore, a combination of change in disease activity (pain, function) as well as the level of current disease activity is useful, as rheumatologists now are using in RA. To be classified as a responder, patients with RA should have a significant change in Disease Activity Score as well as low current disease activity.\textsuperscript{5,6} When we try to target our treatment aims in OA: improvement of 20 mm on a 0–100 mm VAS as well as the level of current disease activity.\textsuperscript{7,8} The knowledge thus obtained in OA will certainly help us to better understand and appreciate findings from OA research, but in the end, for the patient it all comes down to the most relevant questions: Do you feel good? Do you feel improved? Is this treatment worthwhile?

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**REFERENCES**


