EULAR recommendations for the non-pharmacological core management of hip and knee osteoarthritis

Linda Fernandes,1 Kåre B Hagen,1 Johannes W J Bijlsma,2 Oyvov Andressen,3 Pia Christensen,4,5 Philip G Conaghan,6 Michael Doherty,7 Rinie Geenen,8 Alison Hammond,9 Ingvild Kjeken,1 L Stefan Lohmander,10,11,12 Hans Lund,11 Christian D Mallen,13 Tiziana Nava,14 Susan Oliver,15 Karel Pavelka,16 Irene Pitsillidou,17 José Antonio da Silva,18 Jenny de la Torre,19 Gustavo Zanoli,20 Theodora P M Vliet Vlieland21

ABSTRACT

The objective was to develop evidence-based recommendations and a research and educational agenda for the non-pharmacological management of hip and knee osteoarthritis (OA). The multidisciplinary task force comprised 21 experts: nurses, occupational therapists, physiotherapists, rheumatologists, orthopaedic surgeons, general practitioner, psychologist, dietician, clinical epidemiologist and patient representatives. After a preliminary literature review, a first task force meeting and five Delphi rounds, provisional recommendations were formulated in order to perform a systematic review. A literature search of Medline and eight other databases was performed up to February 2012. Evidence was graded in categories I–IV and agreement with the recommendations was determined through scores from 0 (total disagreement) to 10 (total agreement). Eleven evidence-based recommendations for the non-pharmacological core management of hip and knee OA were developed, concerning the following nine topics: assessment, general approach, patient information and education, lifestyle changes, exercise, weight loss, assistive technology and adaptations, footwear and work. The average level of agreement ranged between 8.0 and 9.1. The proposed research agenda included an overall need for more research into non-pharmacological interventions for hip OA, moderators to optimise individualised treatment, healthy lifestyle with economic evaluation and long-term follow-up, and the prevention and reduction of work disability. Proposed educational activities included the required skills to teach, initiate and establish lifestyle changes. The 11 recommendations provide guidance on the delivery of non-pharmacological interventions to people with hip or knee OA. More research and educational activities are needed, particularly in the area of lifestyle changes.

INTRODUCTION

Osteoarthritis (OA) is one of the most common chronic diseases, with an estimated overall prevalence in the general adult population of 11% and 24% for hip and knee OA, respectively.1 OA is age related, with manifestations often not occurring until middle age. In elderly people, OA is the most common cause of disability, including pain and limitations of activities and participation.2–4 As life expectancy is increasing the number of people living for prolonged periods with severe OA is expected to grow.

The need for high-quality care for a condition with major personal and societal impact is generally recognised and several guidelines for such care are available.5–9 International recommendations for management of OA are often divided into three main categories: non-pharmacological, pharmacological and surgical.5 During the past decade, much emphasis has been put on non-pharmacological management. However, recommendations are not sufficiently specific about the content, timing, intensity, frequency, duration and mode of delivery of each non-pharmacological option. This lack of detailed guidance may be one of the reasons why the quality of care for people with hip or knee OA is found to be suboptimal in several studies.10,11

In order to deal with this problem, the European League Against Rheumatism (EULAR) convened a group of experts to produce evidence-based recommendations for the non-pharmacological management of people with hip or knee OA, in accordance with the EULAR standard operating procedures,12 and to develop a research and educational agenda for future activities. These recommendations would provide more detail and would therefore be an addition to existing management guidelines and would be easier to implement. The target groups for these recommendations are all healthcare providers involved in the delivery of non-pharmacological interventions, researchers in the field of OA, officials in healthcare governance, reimbursement agencies and policy makers. In addition, people with hip or knee OA can use the recommendations for information on non-pharmacological management strategies.

METHODS

The task force aimed to aggregate available information on non-pharmacological management of hip and knee OA into practical recommendations, using EULAR standardised operational procedures.13 These involved the assembly of an expert committee to develop consensus, based both on research evidence provided by a systematic literature review and expert opinion.

The task force comprised 21 people with particular knowledge of OA from 10 European...
countries, specifically: two nurses (SO, JdlT); one psychologist (RG); one dietician (PC); two occupational therapists (AH, IK); three physiotherapists (KBH, HL, TN); five rheumatologists ([WJR, FGC, MD, KP, JAdS]); two orthopaedic surgeons (LSL, GZ); one general practitioner (CDM); two persons representing people with hip and/or knee OA (OA, IP); a clinical epidemiologist (TPMVV); and a research fellow (LF).

The process was based on both research evidence and consensus (see online supplementary appendix tables S1–S2 and figures S1–S12), and included, between June 2011 and May 2012, two task force meetings, systematic literature reviews (SLR) and extensive discussions. If a recommendation was shown to be inaccurate, based on data from the SLR, it could be rejected. Research evidence was graded in categories I–IV (table 1).12 During the second task force meeting, votes for level of agreement (LOA) were cast anonymously, by giving a score on a numeric rating scale from 0 (total disagreement) to 10 (total agreement) for each recommendation; mean and 95% CI of scores were calculated. Topics for the research and educational agenda were formulated based on discussions of the lack of evidence to substantiate the recommendations and weaknesses in current healthcare delivery.

RESULTS
Development of the recommendations
After the first meeting, a total of 168 propositions were suggested by the experts. Propositions that were identical were merged and propositions containing one word only were excluded. The second Delphi round comprised 140 propositions, with topics being very broad and including far more non-pharmacological interventions than currently included in these recommendations. After five Delphi rounds, consensus on 11 recommendations was achieved, which are presented with complete formulation in table 2 with the accompanying level of evidence (LOE) and LOA. The 11 recommendations are ordered in a logical sequence or procedural and chronological hierarchy rather than by any considered importance.

The terms ‘non-pharmacological’ and ‘non-surgical’ management were discussed by the expert group. The terms were considered to be negative owing to their prefix ‘non’ and were therefore not considered optimal; finding a new terminology was included in the research agenda (table 3). In addition, research evidence specifically for hip OA was sparse and, in general, recommendations for the management of people with hip OA were derived largely from trials including people with both hip and knee OA or with knee OA only.

Initial assessment
Research data on how a comprehensive assessment of people with hip or knee OA should best be carried out are scarce. Since initial assessment will always be a part of the management in any person with hip or knee OA, controlled trials evaluating assessment will have difficulties in selecting the most appropriate comparator. One randomised, controlled trial (RCT) comparing a comprehensive assessment and management approach with usual care showed no difference in pain or physical function.13 However, in that study, both approaches included initial assessments, but with different content and were executed by different professionals.13

The group considered a comprehensive initial assessment to be a prerequisite for the individualised management strategy described in recommendation 2. The recommendation on the initial assessment included the following elements: the person’s physical status, activities of daily living, participation, mood and health education needs, health beliefs and motivation to self-manage. In the absence of evidence from studies on the effectiveness of various forms of assessment, the group based the recommended content of the initial assessment on the main areas of disease consequences, including potentially interacting personal and environmental factors described in the literature.14–22 Evaluation of cardiovascular disease, people’s expectations and self-efficacy were also discussed as important aspects in a biopsychosocial approach.14 17 Moreover, the group found that a comprehensive assessment, which is applicable to the initial consultation, should also be repeated during regular follow-up of the person.

Individualised treatment
The task force agreed unanimously that the overarching principle for treatment of a person with hip or knee OA should be individualised, which is in line with previous guidelines.7–9 23 Individualised treatment does not imply that every treatment should be individually provided, it means rather that treatment is personalised, or tailored. RCTs on individualised non-pharmacological management are scant. The available studies showed reduced pain (mean difference, 95% CI (0–20 point scale): −1.19, −2.1 to −0.3 and −1.10, −1.84 to −0.19; and (0–100 scale): −17.0, −23.6 to −10.4) and improved physical function (mean difference, 95% CI (0–68 point scale): 3.65, 1.0 to 6.3 and 3.35, 0.78 to 5.88) compared with usual care,24 26 but not compared with group-based rehabilitation25 27 28 or information on healthy lifestyle.29 30 Follow-ups at 9, 18 or 30 months showed no effect on pain.31 32

As the data underpinning this recommendation are limited, it was considered that the factors affecting the tailoring of management were mainly based on prognostic factors shown in the literature. An important and modifiable risk factor for knee OA is weight,20 33 34 implying individualised targeting at weight reduction in people who are overweight or obese.

Moreover, individualised treatment being the standard of care in OA and chronic disease in general7 35 36 was considered to imbibe informed, shared decision-making, taking into account the person’s wishes and preferences. The group noted that with the conduct of an RCT to study the impact of individualisation, the patient’s view cannot be wholly taken into account and that some element of individualisation will always be incorporated in any treatment. To better understand individualised treatment, the group found that future research should focus on factors that affect outcome—that is, moderators, not individualisation as such.

Comprehensive package of care
This recommendation deals with the provision of an integrated package of care rather than single treatments alone or in succession. The group recommended five core interventions to be
**Table 2** EULAR recommendations for the non-pharmacological core management of hip and knee OA, with levels of evidence (LOE) and level of agreement (LOA). The propositions are ordered by topic

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>LOE I-IV</th>
<th>LOA (95% CI)</th>
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<tbody>
<tr>
<td>1</td>
<td>In people with hip or knee OA, initial assessments should use a biopsychosocial approach including:</td>
<td>Ib, mixed</td>
<td>8.6 (7.9 to 9.2)</td>
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<td></td>
<td>a. physical status (including pain; fatigue; sleep quality; lower limb joint status (foot, knee, hip); mobility; strength; joint alignment; proprioception and posture; comorbidities; weight)</td>
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<td></td>
<td>b. activities of daily living</td>
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<td></td>
<td>c. participation (work/education, leisure, social roles)</td>
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<td></td>
<td>d. mood</td>
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<td></td>
<td>e. health education needs, health beliefs and motivation to self-manage</td>
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<td>2</td>
<td>Treatment of hip and/or knee OA should be individualised according to the wishes and expectations of the individual, localisation of OA, risk factors (such as age, sex, comorbidity, obesity and adverse mechanical factors), presence of inflammation, severity of structural change, level of pain and restriction of daily activities, societal participation and quality of life</td>
<td>Ib, mixed</td>
<td>8.7 (8.2 to 9.2)</td>
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<td>3</td>
<td>All people with knee/hip OA should receive an individualised management plan (a package of care) that includes the core non-pharmacological approaches, specifically:</td>
<td>lb, hip</td>
<td>8.7 (8.2 to 9.3)</td>
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<tr>
<td></td>
<td>a. information and education regarding OA</td>
<td>lb, knee</td>
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<td></td>
<td>b. addressing maintenance and pacing of activity</td>
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<td></td>
<td>c. addressing a regular individualised exercise regimen</td>
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<td></td>
<td>d. addressing weight loss if overweight or obese</td>
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<td></td>
<td>e. reduction of adverse mechanical factors (eg, appropriate footwear)</td>
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<td></td>
<td>f. consideration of walking aids and assistive technology</td>
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<td>4</td>
<td>When lifestyle changes are recommended, people with hip or knee OA should receive an individually tailored programme, including long-term and short-term goals, intervention or action plans, and regular evaluation and follow-up with possibilities for adjustment of the programme</td>
<td>Ib, mixed</td>
<td>8.0 (7.1 to 9.0)</td>
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<td>5</td>
<td>To be effective, information and education for the person with hip or knee OA should:</td>
<td>la, mixed</td>
<td>8.4 (7.7 to 9.1)</td>
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<td></td>
<td>a. be individualised according to the person’s illness perceptions and educational capability</td>
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<td>b. be included in every aspect of management</td>
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<td></td>
<td>c. specifically address the nature of OA (a repair process triggered by a range of insults), its causes (especially those pertaining to the individual), its consequences and prognosis</td>
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<td></td>
<td>d. be reinforced and developed at subsequent clinical encounters;</td>
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<td>e. be supported by written and/or other types of information (eg, DVD, website, group meeting) selected by the individual</td>
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<td></td>
<td>f. include partners or carers of the individual, if appropriate</td>
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<td>6</td>
<td>The mode of delivery of exercise education (eg, individual 1:1 sessions, group classes, etc) and use of pools or other facilities should be selected according both to the preference of the person with hip or knee OA and local availability. Important principles of all exercise include:</td>
<td>la, knee, delivery mode</td>
<td>8.9 (8.5 to 9.3)</td>
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<td></td>
<td>a. ‘small amounts often’ (pacing, as with other activities)</td>
<td>la, mixed, water-based exercise</td>
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<td></td>
<td>b. linking exercise regimens to other daily activities (eg, just before morning shower or meals) so they become part of lifestyle rather than additional events</td>
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<td></td>
<td>c. starting with levels of exercise that are within the individual’s capability, but building up the ‘dose’ sensibly over several months</td>
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<td>7</td>
<td>People with hip and/or knee OA should be taught a regular individualised (daily) exercise regimen that includes:</td>
<td>la, hip, overall exercise</td>
<td>8.5 (7.7 to 9.3)</td>
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<td></td>
<td>a. strengthening (sustained isometric) exercise for both legs, including the quadriceps and proximal hip girdle muscles (irrespective of site or number of large joints affected)</td>
<td>la, knee, overall exercise</td>
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<td></td>
<td>b. aerobic activity and exercise</td>
<td>la, knee, strength</td>
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<td></td>
<td>c. adjunctive range of movement/stretching exercises</td>
<td>la, knee, aerobic</td>
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<td>* Although initial instruction is required, the aim is for people with hip or knee OA to learn to undertake these regularly on their own in their own environment programmes</td>
<td>la, mixed, mixed programmes</td>
<td></td>
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<td>8</td>
<td>Education on weight loss should incorporate individualised strategies that are recognised to effect successful weight loss and maintenance* for example:</td>
<td>III, hip</td>
<td>9.1 (8.6 to 9.5)</td>
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<tr>
<td></td>
<td>a. regular self-monitoring, recording monthly weight</td>
<td>la, knee</td>
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<td></td>
<td>b. regular support meetings to review/discuss progress</td>
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<td></td>
<td>c. increase physical activity</td>
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<td></td>
<td>d. follow a structured meal plan that starts with breakfast</td>
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<td></td>
<td>e. reduce fat (especially saturated) intake; reduce sugar; limit salt; increase intake of fruit and vegetables (at least ‘5 portions’ a day)</td>
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<td></td>
<td>f. limit portion size</td>
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<td></td>
<td>g. addressing eating behaviours and triggers to eating (eg, stress)</td>
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<td></td>
<td>h. nutrition education</td>
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<td></td>
<td>i. relapse prediction and management (eg, with alternative coping strategies)</td>
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<td>9</td>
<td>a. The use of appropriate and comfortable shoes is recommended.</td>
<td>Ib, knee</td>
<td>8.7 (8.2 to 9.2)</td>
</tr>
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<td></td>
<td>b. Recommendation rejected: a lateral-wedged insole could reduce symptoms in medial knee pain.</td>
<td>Ib, knee</td>
<td>8.0 (7.0 to 9.1)</td>
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<td>10</td>
<td>Walking aids, assistive technology and adaptations at home and/or at work should be considered, to reduce pain and increase participation—for example:</td>
<td>III, hip</td>
<td>8.9 (8.5 to 9.3)</td>
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<td></td>
<td>a. a walking stick used on the contralateral side, walking frames and wheeled ‘walkers’</td>
<td>III, knee</td>
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<td>b. increasing the height of chairs, beds and toilet seats</td>
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<td>c. hand-rails for stairs</td>
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<td></td>
<td>d. replacement of a bath with a walk-in shower</td>
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<td></td>
<td>e. change to car with high seat level, easy access and automatic gear change</td>
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considered comprehensively in every patient with hip or knee OA. The recommendation specifically implies that a person with hip or knee OA should receive education about her/his condition (5a), and be managed accordingly (3b–e).

With the exception of walking aids and assistive technology and dealing with adverse mechanical factors, the literature supports the delivery of combined interventions including information and education, exercise and/or weight reduction.

In people with hip and/or knee OA the combination of patient education or self-management intervention plus exercise was found to have a significant effect on pain, but a less marked effect on function. In people with hip OA the effect of such combinations was mainly seen on function (0–100 point scale) at 3 and 6 months after intervention (mean difference, 95% CI −7.5, −13.9 to −1.0; and −8.4, −15.1 to −1.7). In people with knee OA effects on pain and/or function were seen in eight studies, whereas no effect was seen in four studies. The addition of advice from a dietician for overweight or obese patients to the combination of patient education or self-management intervention plus exercise was found to improve both pain and function in patients with hip or knee OA.

**Principles of lifestyle changes**
Recommendation 4 deals with key elements of the delivery of interventions aimed to initiate and maintain lifestyle changes. It is known that behavioural changes are difficult to achieve and maintain, and the effect of advice and counselling by healthcare providers is disappointing. The literature search for this recommendation was limited to lifestyle changes considered most relevant for hip and knee OA—that is, exercise and weight loss.

The common feature in the trials supporting this recommendation was to teach and encourage behaviour change strategies through goal setting of physical activity and weight changes, action plans to maintain changes and regular follow-up over at least 1 year to re-evaluate and discuss goals and action plans.

Reports examining the effectiveness of specific elements to be included in interventions aiming to change behaviour are scarce. The literature suggests that the following factors improve adherence to exercise or physical activity: individual exercise, graded activity, individualisation according to the person’s exercise goals, feedback on progress made towards the goals, iterative problem solving with emphasis on skills that will improve adherence, reinforcements of maintaining exercise such as additional motivational programmes, exercise plans and log books, written information and audiotape or videotape, and booster sessions. In addition, some studies found an effect on pain or function from lifestyle interventions that integrate such elements. A systematic review including a mixed population of people with OA and/or rheumatoid arthritis and the public.

### Table 2 Continued

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>LOE I–IV</th>
<th>LOA (95% CI)</th>
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<tbody>
<tr>
<td>11</td>
<td>People with hip or knee OA at risk of work disability or who want to start/return to work should have rapid access to vocational rehabilitation, including counselling about modifiable work-related factors such as altering work behaviour, changing work tasks or altering work hours, use of assistive technology, workplace modification, commuting to/from work and support from management, colleagues and family towards employment</td>
<td>III, hip</td>
<td>8.9 (8.3 to 9.5)</td>
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Recommendations with different LOE within the recommendation are listed below. In the absence of grading of evidence for hip OA populations, the LOE equals IV. LOA was computed as a 0–10 scale, based on 17 votes of agreement with the recommendation.

<table>
<thead>
<tr>
<th>No.</th>
<th>Research theme</th>
<th>Research questions</th>
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<tbody>
<tr>
<td>1</td>
<td>Terminology</td>
<td>Defining non-pharmacological management</td>
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<tr>
<td>2</td>
<td>General</td>
<td>Finding an appropriate terminology for non-pharmacological management</td>
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<tr>
<td>3</td>
<td>Individualised treatment</td>
<td>Evaluating effectiveness and safety of non-pharmacological management strategies, specifically in hip OA</td>
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<tr>
<td>4</td>
<td>Delivery of care</td>
<td>Assessing moderators of the outcome of hip and knee OA to optimise individualised treatment</td>
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<td>5</td>
<td>Lifestyle changes</td>
<td>Defining to whom, and at what stage, the package of care needs to be delivered</td>
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<td>6</td>
<td>Footwear</td>
<td>Assessing the long-term outcomes (≥ 2 years) of exercise, physical activity and weight reduction with outcomes including adherence and cardiovascular morbidity</td>
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<tr>
<td>7</td>
<td>Assistive technology</td>
<td>Assessing the use of, and satisfaction with, assistive technology</td>
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<tr>
<td>8</td>
<td>Work ability</td>
<td>Assessing the effectiveness and costs of interventions aiming to prevent or reduce work disability and/or increase return, or entering, the workforce</td>
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<td>9</td>
<td>Research method</td>
<td>Developing and including measures of societal participation</td>
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<tr>
<td>10</td>
<td>Education</td>
<td>Need for training courses on the required skills to initiate and establish lifestyle changes; this education should be aimed at professionals, people with arthritis and the public</td>
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</table>
Principles of exercise education
Recommendation 6 deals with the principles of the delivery of education about exercise and physical activity. There is convincing evidence for the overall effectiveness of exercise on pain (ES, 95% CI: 0.40, 0.50 to 0.58) and function (ES, 95% CI: 0.37, 0.25 to 0.49) in people with knee OA, and to a lesser extent in people with hip OA (ES, 95% CI, pain 0.38, 0.08 to 0.68). Few studies have directly compared different exercise ‘dosage’ (frequency, intensity and duration) and progression approaches in people with OA. One RCT reported reduced pain from attending a progressive functional strengthening programme compared with a non-progressive programme in people with knee OA, but two trials could not show any differences from attending various intensity levels of aerobic or resistance-exercise programmes. Hence, the optimal exercise ‘dosage’ and rate of progression remain uncertain.

In patients with knee OA different delivery modes (individual, group-based or home programmes) have all been shown to effectively reduce pain (individual, ES, 95% CI 0.55, 0.29 to 0.81; group-based, ES, 95% CI 0.57, 0.24 to 0.51; and, home, ES, 95% CI 0.28, 0.16 to 0.39) and improve function (individual, ES, 95% CI 0.52, 0.19 to 0.86; group-based, ES, 95% CI 0.58, 0.19 to 0.50; and, home, ES, 95% CI 0.28, 0.17 to 0.38) compared with education, telephone calls, waiting list, relaxation, ultrasound, hot-packs or no treatment. In patients with hip and/or knee OA, water-based exercise was found to significantly reduce pain (ES, 95% CI 0.19, 0.04 to 0.35) and improve function (ES, 95% CI 0.26, 0.11 to 0.42) compared with education, telephone calls or no intervention. Home-based exercise was found to be as effective as water-based exercise in one small RCT in people with hip OA. Water-based exercise can include swimming and/or different types of exercise programmes. Since the different modes of delivery are equally effective, the person’s preference, findings of the initial assessment and local availability should determine the choice of mode of delivery in clinical practice.

The literature suggests that pacing of activity and/or integrating physical activity into daily living as part of a comprehensive exercise regimen is more effective in people with hip or knee OA or with knee pain than usual care or written information, but not compared with standardised exercise or a pharmacy review.

This recommendation suggests the need for an increase in the intensity and/or duration of exercise over time. This is based on the literature, where most strength training exercise programmes evaluated in people with knee OA included dynamic exercises with progression over time. Moreover, in one study comparing progressive and non-progressive approaches in people with knee OA, the former was found to reduce pain more effectively. General recommendations for dosage and progression of exercise in older people and people with chronic disease are aerobic moderate-intensity training for at least 30 min/day or up to 60 min for greater benefit, and progressive strength training involving the major muscle groups at least 2 days/week at a level of moderate to vigorous intensity (60–80% of one repetition maximum) for 8–12 repetitions. These recommendations emphasise that in people with chronic disease who do not reach the recommended level, they should be as physically active as their abilities and condition allow.

Exercise regimen
Before considering the evidence for specific exercises in hip and knee OA, it should be noted that although exercise has been shown to reduce pain in patients with hip OA, overall there is a lack of information to support treatment effects of exercise in hip OA. The LOE for the recommendation of different types of exercise in people with hip OA therefore could not be graded. For knee OA, however, high-quality research evidence has reported that exercise reduces pain and improves
physical function. Results for the effect of exercise on quality of life are inconsistent.90—92 95 99 102 104 105 Research about strengthening exercises in knee OA shows that both specific quadriiceps strengthening exercises or strength training for the lower limb reduce pain effectively (ES, 95% CI 0.29, 0.06 to 0.51 and 0.53, 0.27 to 0.79, respectively) and improve physical function (ES, 95% CI 0.24, 0.06 to 0.42 and 0.58, 0.27 to 0.88, respectively).67 The literature on strength training in people with knee OA in most cases describes dynamic exercises, whereas research on isometric exercises is sparse.95 Hip strengthening exercises have been poorly evaluated in people with hip OA.103 However, in people with medial thibiofemoral knee OA, hip strengthening exercises reduced knee pain and improved physical function.106

Aerobic training (walking) is effective in reducing pain (ES, 95% CI 0.48, 0.15 to 0.45) and improving physical function (ES, 95% CI 0.35, 0.11 to 0.58) in patients with knee OA.37

The evidence for mixed exercise programmes, including strengthening, aerobic and flexibility components, in patients with knee OA is conflicting.97—108 One type of exercise has not been shown to be better than another (strength, aerobic or mixed exercises).57 107 108

The group reached consensus that mixed programmes should be recommended. However, it was noted that with mixed programmes the minimal requirements to improve or maintain muscle strength, aerobic capacity and/or joint range of motion need to be met, as some reports suggest that mixed programmes may be less effective than focused programmes.108

This recommendation states that initial instruction is required, but that in the longer term the person should integrate exercise into daily life. This part of the recommendation is substantiated by studies showing that the number of supervised sessions influences outcome in people with knee OA.97 Twelve or more directly supervised sessions have been shown to be more effective than a smaller number on pain (ES 0.46, 95% CI 0.32 to 0.60 vs ES 0.28, 95% CI 0.16 to 0.40, p=0.03) and physical function (ES 0.45, 95% CI 0.29 to 0.62 vs ES 0.25, 95% CI 0.09 to 0.37, p=0.02).87

In addition, it was noted that research evidence is growing for tai chi and yoga. Though not included in the literature review, tai chi has been found to be effective for the reduction of pain in patients with hip or knee OA, with ES ranging from 0.28 to 1.67.108

Education on weight loss

In recommendation 8, the principles of education about weight management are included. The recommendation is mainly supported by the literature in knee OA, as no evidence to support the effect of weight loss in patients with hip OA is available. However, being overweight or obese has been shown to be associated with hip OA (OR=1.11, 95% CI 1.07 to 1.16).33

In patients with knee OA, the effectiveness of weight-loss programmes on body weight, pain and/or physical function was demonstrated in programmes delivered as weekly supervised sessions for a range of 8 weeks to 2 years.54 60 109—113 The effects on pain, function and weight loss from attending weight-loss programmes were small but significant (ES, 95% CI, pain 0.20, 0.00 to 0.39; physical function 0.25, 0.04 to 0.42; mean weight loss, 95% CI, 6.1 kg, 4.7 to 7.6).105 The interventions included strategies on how to reduce calorie intake by meal plans, reduce fat and sugar, reduce portion size, meal replacements, and comprised behavioural modifications, self-monitoring, weight-loss goals and maintaining body weight in participants who had reached their goals and/or exercises for some of them.54 60 109—112 Overall, the evidence from RCTs for the maintenance of achieved weight loss after the interventions have ended is absent in people with hip and knee OA.

In general, in overweight or obese populations, healthy eating, limiting fat and salt intake, eating at least five portions of fruit and vegetables a day, being physically active for at least 30 min/day and elements such as self-monitoring, explicit weight-loss goals, and motivational interviewing have all been suggested to promote weight loss and that regular follow-up over 4 years helps in maintenance of the weight loss.65 114—118 Weight-loss programmes in older obese people that included explicit weight-loss goals showed mean changes in weight of −4.0 kg (95% CI −7.3 to −0.7), which was significantly more than programmes without explicit weight-loss goals (mean change, 95% CI, −1.3 kg, −2.9 to 0.3).65 To achieve a structured meal plan with a balanced combination of low calorie and sufficient vitamin and mineral intake, meal replacement bars or powders can be an addition to healthy eating.54 60 109 110 Though not included in the literature review, it has been suggested that bariatric surgery should be part of comprehensive weight management in people with hip or knee OA who are morbidly obese, and could help reduce weight and joint pain.119 120

Footwear

Although research evidence is scant, the group was unanimous in its view that the use of appropriate footwear should be recommended in patients with hip or knee OA. Shoes may help through different mechanisms, such as acting as shock absorbers or controlling foot pronation.121 122 Appropriate shoes implies no raised heel, thick, shock-absorbing soles, support for the arches of the foot and a shoe size big enough to give a comfortable space for the toes.121—123

In patients with hip OA there is no evidence to support the effect of specific shoes or insoles on pain or function. In patients with knee OA, the use of shoes with shock-absorbing insoles for 1 month reduced pain and improved physical function in a pre–post test design.124 No differences in knee pain from the use of specialised shoes (unstable Masai technology shoe or variable-stiffness shoe) compared with conventional athletic shoes have been seen, but reduced pain was seen in both groups over time.125 126 In addition, decreased knee joint loads were found when specialised mobility shoes were used.121

The literature on the effectiveness of the use of lateral wedged insoles in patients with medial knee OA found no significant effect on pain or function.121 127 128 There is no support for whether one type of insole would be better than another,129 and adverse effects including foot-sole pain, low-back pain and popliteal pain have been reported.121 128 129 In light of evidence for no clinical effects of the use of lateral wedged insoles and the report of adverse effects, the group rejected the recommendation (table 2, 9b).

Assistive technology and adaptations at home and/or at work

The frequent use of assistive technology and the high satisfaction rates with its use indicate that walking aids, assistive technology and adaptations are important and useful for people with hip or knee OA.130—133 There are, however, no clinical trials to substantiate elements in this proposition, except for the use of a cane in patients with knee OA.134 However, the group was unanimous in its view that in all patients with hip or knee OA walking aids, assistive technology and adaptations at home and/or at work should be considered systematically and recurrently. The group noted that the value of some of these interventions is so obvious and has an immediate effect
in individual cases that further research into the effectiveness of specific devices or adaptations can hardly be expected. Cross-sectional studies show that walking aids, assistive technology and adaptations at home and/or work are important and often used by people with hip or knee OA. Most people with severe hip (63%) or knee pain (90%) reported the use of walking aids. In people with arthritis, a mean of 9.9 devices has been reported to be in use and the satisfaction rate for all categories of device was more than 87%. Moreover, unmet needs for new assistive technology to help perform activities that individuals could not do were identified. Having access to a walking aid or other assistive technologies can be a help and provide security for individuals with constant or fluctuating symptoms. The group found that future observational studies on the use, satisfaction from and suggestions for new technology or improvements of existing technology are needed.

Management of work ability
Recommendation 11 deals with the effectiveness of work-related interventions. The proportion of employed people who have work disability due to OA is substantial. Although there are known occupational risk factors for knee OA and its progression—for example, heavy work, knee squatting or bending, lifting and specific sports, there are no studies to support the effect of vocational rehabilitation on pain, physical function or quality of life specifically in patients with hip or knee OA. One study in patients with peripheral OA found that a specialist-run, protocol-based early intervention significantly reduced the number of days of sick leave compared with standard primary care. The intervention was administered by a rheumatologist and comprised three main elements: education, protocol-based clinical management and administrative duties. The educational part included information about the condition, reassurance that serious disease was not present, self-management, exercises, ergonomic care, booklets, optimal level of physical activity and early return to work. Descriptive studies have found that environmental factors, such as having access to public transport or a car for mobility outside home are facilitators and that the absence of these is associated with limitations to daily activity. Some elements in this recommendation may have to be adapted to the country in which they are executed, since availability and accessibility of services in the healthcare and social security system may vary greatly. The group concluded that there is a clear paucity of research evidence for work-related interventions in people with hip and knee OA.

DISCUSSION
Eleven recommendations for the core non-pharmacological management of people with hip and knee OA were developed based on research evidence and expert consensus. While the 11 evidence-based recommendations are not exhaustive and do not include all existing non-pharmacological treatments, they cover the main principles of non-pharmacological management. The selected recommendations support a patient-centred, multidisciplinary approach rather than a discipline-specific approach. There was a considerable body of evidence underlying the recommendations, with systematic reviews and/or RCTs available for most. It is worth noting, however, that overall the research evidence for hip OA was poorer than for knee OA, limiting conclusions about the effectiveness of non-pharmacological interventions in this patient group. Moreover, most trials found in the literature review used pain or physical function as the primary outcome and surprisingly few included quality-of-life outcome measures. Mental health, physical independence, autonomy and social participation have been reported as important domains by people with OA and older adults. Given these observations, the task force recommends that future research should include well-powered studies to evaluate the effect of core non-pharmacological treatments specifically in people with hip OA, moderators of effect and the inclusion of quality-of-life measurements that reflect physical, mental and social health in their evaluation. Several RCTs found in the systematic literature review compared two non-pharmacological interventions and found no significant differences in pain or physical function between them. This does not mean that the interventions were ineffective, but that neither was better than the other. For example, a well-powered RCT compared a behavioural graded activity intervention with education and exercise following the Dutch physiotherapy guideline for patients with hip and/or knee OA and found no differences between groups. Nevertheless, both groups showed improvements in pain and physical function over time. Moreover, it was found that non-pharmacological interventions often consisted of combinations of different treatments, with the combinations varying largely between studies. This hampered comparisons between studies and also the ability to define the effect of the individual components, so that the underpinning of every specific element in some of the recommendations proved to be difficult. Hence, the aim of developing detailed recommendations could not always be fulfilled. However, compared with previous recommendations, the current recommendations are more specific. They provide substantiated and more detailed recommendations about content (for patient education, exercise, weight reduction and combined treatment), frequency (at least 12 sessions, activity pacing and follow-ups) and mode of delivery (1:1, group-based or home exercise) than previously published recommendations. In addition, principles for optimising long-term adherence and effect are described. The optimal exercise volume (‘dose’) could not be substantiated. Exercise volume is difficult to investigate as it includes exercises performed at a gym or at the physiotherapy clinic and the total amount of exercise performed in daily life. Exercise volume therefore varies widely between individuals. The matter of timing lacks research evidence and the topic was included in the research agenda. Furthermore, the effect sizes for several non-pharmacological interventions reported in the literature were generally relatively low. It should be noted, however, that the costs of these interventions are generally limited, and the occurrence of adverse effects is low. The results of the LOE in addition to the traditional determination of the LOE are therefore important, as this reflects the experts’ interpretation of all the above-mentioned aspects. Limitations to the methodological quality of the systematic literature review were that only one person (LF) extracted data from the literature. According to the assessment of multiple systematic reviews, at least two independent data extractors are recommended. However, the research fellow (LF) presented and discussed all results with the conveners (JWB, KBH, TPMVV) and the extracted data were, thereafter, reviewed by experts in the committee. Another limitation was that, owing to limited time and resources, no scoring of the methodological quality of the systematic reviews or individual trials included in the literature review was done. Also, owing to limited resources, some potential healthcare providers playing a role in the management of hip and knee OA, such as the podiatrist or rehabilitation specialist, were not represented in the task force.
Recommendation

To obtain a broad consensus and practical applicability of the recommendations, the task force had an inclusive and multidisciplinary approach. Nine different professional disciplines and people with OA were included in the committee. The task force followed a procedure similar to that used for other management recommendations, such as for the general management of OA, rheumatoid arthritis and ankylosing spondylitis, but is the first with such an inclusive approach. It has been strongly recommended that a minimum of two patient research partners with the relevant disease are included in development of recommendations. The participation of the people with OA in this task force was successful, with their experiential knowledge ensuring that clinical relevance was integrated throughout the process.

Finally, the task force reached consensus on a research and educational agenda, with general topics including the definition and nomenclature for non-pharmacological and non-surgical management and the need for more knowledge on their effectiveness in hip OA. Specific needs for additional research and/or education included the optimisation of tailoring of treatment and the mode of delivery, the long-term effects of lifestyle interventions, vocational rehabilitation and footwear, the measurement of adherence and participation and the conduct of studies with a sufficient sample size. An important subject regarding education pertained to lifestyle interventions, highlighting the need for educational activities not only for health-care providers, but also for people with OA and the public.

Author affiliations
National Resource Center for Rehabilitation in Rheumatology, Diakonhjemmet Hospital, Oslo, Norway
1Department of Rheumatology and Clinical Immunology, University Medical Center Utrecht, Utrecht, The Netherlands
2Department of Rheumatology, Patient Panel, Diakonhjemmet Hospital, Oslo, Norway
3Department of Rheumatology, The Parker Institute, Copenhagen University Hospital at Frederiksberg, Copenhagen, Denmark
4Department of Nutrition, Exercise and Sports, University of Copenhagen, Copenhagen, Denmark
5Division of Musculoskeletal Disease, University of Leeds, and NIHR Leeds Musculoskeletal Biomedical Research Unit, Leeds, UK
6Academic Rheumatology, University of Nottingham, Nottingham, UK
7Department of Clinical and Health Psychology, Utrecht University, Utrecht, The Netherlands
8Centre for Health Sciences Research, University of Salford, Salford, UK
9Department of Orthopaedics, Clinical Sciences Lund, University of Lund, Lund, Sweden
10Research Unit for Musculoskeletal Function and Physiotherapy, Institute of Sports Science and Clinical Biomechanics, University of Southern Denmark, Odense, Denmark
11Department of Orthopaedics and Traumatology, University of Southern Denmark, Odense, Denmark
12Arthritis Research UK Primary Care Centre, Keele University, Keele, UK
13Faculty of Physiotherapy, University of Studies of Milan, Milan, Italy
14Nurse Consultant Rheumatology, Minerva Health Centre, Preston, UK
15Institute of Rheumatology and Clinic of Rheumatology, First Medical Faculty, Charles University, Prague, Czech Republic
16Cyprus League Against Rheumatism, Cyprus, Cyprus
17Department of Rheumatology, Centro Hospitalar Universitario de Coimbra, Coimbra, Portugal
18Rheumatology Department, Alicantí General and University Hospital, Alicante, Spain
19Università degli Studi di Ferrara Casa di Curà SM Maddalena, Ferrara, Italy
20Department of Orthopaedics, Leiden University Medical Center, Leiden, The Netherlands

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Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES
Recommendation


Appendix

Expert consensus on propositions

Before the first task force meeting, a general literature search of practice guidelines, overviews of systematic reviews and evidence-based recommendations was undertaken to obtain an overview of current recommendations and addressed treatment modalities in people with hip or knee OA. For this purpose, the databases Medline, Embase, Pedro, CINAHL, OTseekers, PsychInfo, AMED, G-I-N and The Cochrane Database of systematic reviews were searched up to March 2011. After removing duplicates, 984 hits were retrieved and after excluding recommendations on pharmacological or surgical treatment or other diagnoses than OA, 31 studies remained. The 31 studies addressed 30 different non-pharmacological treatment modalities. The results were presented at the first task force meeting. All addressed treatment modalities and potential topics for propositions were discussed. After the first meeting, the experts were asked to contribute independently with 10 propositions about non-pharmacological management and its content. Experts’ consensus was achieved using the Delphi technique. In total, five Delphi rounds, facilitated by the convenor, were performed by e-mail. All members of the task force, except for the convenor and the research fellow, responded during each round. The preliminary literature review as well as the first Delphi rounds included propositions covering different aspects of non-pharmacological treatment, for example thermal modalities, Transcutaneous Electric Nerve Stimulation, acupuncture, manual therapy and traction. Consensus on 11 propositions was reached in the 5th Delphi round concerning the topics; initial assessment, individualised treatment, comprehensive care, principles of life style changes, patient education, exercise, and weight loss, footwear, assistive technology, and vocational rehabilitation.

Systematic literature search

A systematic literature search was undertaken by the research fellow (LF) supported by her mentors (JWJB, KBH and TPMVV), using Medline (In-Process & Other Non-Indexed Citations 1948-), Embase (1980-), AMED (1985-), PsychINFO (1806-), CINAHL (1981-), Cochrane Database of Systematic Reviews (2005-), Database of Abstracts of Reviews of Effects (1994-), Cochrane Central Register of Controlled Trials (1898-), and PEDro (1929-). The search comprised a general and proposition-specific searches and were all performed up to
February 2012. The general search combined a search query for hip or knee OA with a search query for study design. Study designs of interest were; systematic review/meta-analysis, randomised controlled trial (RCT)/ controlled trial (CT), or observational studies. Systematic reviews were included if they had undertaken a literature search of at least two databases, were of a time frame of more than one year and presented at least one meta-analysis of RCTs. Effect-sizes presented in the results derived from the latest systematic review containing the largest number of studies. Propositions that were not substantiated by at least one meta-analysis of RCT’s were followed by a proposition-specific search for RCT/CT’s. If the propositions still was not substantiated, a proposition-specific search for observational studies was performed. RCTs were included if they described a random allocation procedure and presented between group comparisons. The general search queries and proposition-specific search queries for Medline are included in Table S1-2; these were adapted for the other databases. Part I, II and III (Table S1-2) were combined with “and” as appropriate. The extraction procedures are presented in Figures S1-12. Studies were included if they: a. evaluated the effect of non-pharmacological treatment related to the propositions; b. used clinical outcomes (pain, physical function, quality of life) or other outcomes relevant to the proposition (adherence, activity level, weight, sick-leave); c. concerned persons diagnosed with hip or knee OA or with persisting knee pain, if 45 years or older. In case of a mixed sample, studies were included if they provided a separate analysis for people with hip and/or knee OA or if the majority of included persons were diagnosed with hip or knee OA. Reviews, dissertations, case-reports, editorials, commentaries, meeting abstracts, and protocols were excluded. For every recommendation, all results obtained by the research fellow were discussed with the convenor and co-applicants. If needed, the extracted data were then reviewed by a committee member and any additional data known by the member could be included.
**Table S1** General search queries for Medline. These were adapted for other databases.

<table>
<thead>
<tr>
<th>General search query</th>
<th>General search query</th>
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<tr>
<td><strong>Part I, Osteoarthritis</strong></td>
<td><strong>Part II, Study design</strong></td>
</tr>
<tr>
<td>OA</td>
<td>SR/ MA</td>
</tr>
<tr>
<td>1. Osteoarthritis/</td>
<td>1. exp Meta-Analysis as Topic/</td>
</tr>
<tr>
<td>3. osteoarthros$.tw.</td>
<td>3. quantitative review$.tw.</td>
</tr>
<tr>
<td>4. degenerative arthrit$.tw.</td>
<td>4. quantitative overview$.tw.</td>
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<td>5. arthrosis.tw.</td>
<td>5. statistical pool$.tw.</td>
</tr>
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<td>6. arthroses.tw.</td>
<td>6. data pool$.tw.</td>
</tr>
<tr>
<td>7. or/1-6</td>
<td>7. (meta analy$ or metaanaly$ or meta?analy$).tw.</td>
</tr>
<tr>
<td>8. Hip/</td>
<td>8. exp &quot;Review Literature as Topic&quot;/</td>
</tr>
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<td>10. hip$.tw.</td>
<td>10. Systematic review$.tw.</td>
</tr>
<tr>
<td>11. or/8-10</td>
<td>11. or/1-10</td>
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<tr>
<td>12. Knee/</td>
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<tr>
<td>13. knee$.tw.</td>
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<tr>
<td>14. exp Knee joint/</td>
<td>RCT/ CT</td>
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<td>15. or/12-14</td>
<td>1. randomized controlled trial.pt.</td>
</tr>
<tr>
<td>16. 11 or 15</td>
<td>2. controlled clinical trial.pt.</td>
</tr>
<tr>
<td>17. 7 and 16</td>
<td>3. randomized.ab.</td>
</tr>
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<td>19. Osteoarthritis, Knee/</td>
<td>5. drug therapy.fs.</td>
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<tr>
<td>20. coxitis.tw.</td>
<td>6. randomly.ab.</td>
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<tr>
<td>21. gonarthritis.tw.</td>
<td>7. trial.ab.</td>
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<tr>
<td>22. or/17-21</td>
<td>8. groups.ab.</td>
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<td></td>
<td>9. or/1-8</td>
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<td></td>
<td>10. (animals not (humans and animals)).sh.</td>
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<td>11. 9 not 10</td>
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<td>Obs.</td>
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<tr>
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<tr>
<td>2. cohort stud$.tw.</td>
<td></td>
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<tr>
<td>3. exp Prospective Studies/</td>
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<tr>
<td>8. exp Incidence/</td>
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<td>9. incidence.tw.</td>
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<tr>
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<td>16. retrospective stud$.tw.</td>
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<tr>
<td>17. exp Odds Ratio/</td>
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<tr>
<td>19. or/13-18</td>
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<tr>
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<tr>
<td>21. cross-sectional stud$.tw.</td>
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<tr>
<td>22. exp Prevalence/</td>
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<td>23. prevalence.tw.</td>
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<td>24. disease frequenc$.tw.</td>
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<td>25. or/20-24</td>
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<tr>
<td>26. 12 or 19 or 25</td>
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OA, osteoarthritis; SR, systematic review; MA, meta-analysis; RCT/CT, randomised controlled trial/controlled trial; Obs., observational studies.
Table S2 Proposition-specific search queries for Medline (proposition 1-11). These were adapted for other databases.

| 1 | Medical History Taking/medical history.tw. | 2 | Medical History Taking/medical history.tw. |
| 3 | exp Physical examination/examination.tw. | 4 | exp Physical examination/examination.tw. |
| 5 | assessment$.tw. | 6 | assessment$.tw. |
| 7 | measurement$.tw. | 8 | biopsychosocial.tw. |
| 9 | psychosocial.tw. | 10 | exp Holistic Health/ | 11 | exp Holistic Nursing/ |
| 12 | holistic.tw. | 13 | (comprehensive or thorough or full or complete).tw. |
| 14 | or/8-13 | 15 | exp "Activities of Daily Living"/activit$ of daily living.tw. |
| 16 | Examination.tw. | 17 | exp Disability Evaluation/ | 18 | disability$.tw. |
| 19 | ((limitation$ or reduce$ or restrict$) and activit$).tw. | 20 | ((limitation$ or reduce$ or restrict$) and physical function).mp. |
| 21 | or/15-20 | 22 | social behavior/ or exp social adjustment/ or exp social isolation/ or exp social environment/ |
| 23 | (social function$ or social behavior or social adjustment or social isolation or social environment).tw. | 24 | participation.tw. |
| 25 | exp Work/work.tw. | 26 | exp Work/work.tw. |
| 27 | Education.tw. | 28 | education.tw. |
| 29 | societ$ participation.tw. | 30 | exp Leisure Activities/ |
| 31 | leisure or recreation).tw. | 32 | or/22-31 |
| 33 | pain.tw. | 34 | exp Pain Measurement/ |
| 35 | exp Fatigue/fatigue.tw. | 36 | exp Fatigue/fatigue.tw. |
| 37 | exp Sleep Disorders/sleep.tw. | 38 | exp Sleep Disorders/sleep.tw. |
| 39 | exp Foot Joints/foot or feet).tw. | 40 | exp Foot Joints/foot or feet).tw. |
| 41 | "Range of Motion, Articular"/range of motion.tw. | 42 | "Range of Motion, Articular"/range of motion.tw. |
| 43 | Muscle Strength/muscle strength or muscular strength.tw. | 44 | Muscle Strength/muscle strength or muscular strength.tw. |
| 47 | alignment.tw. | 48 | exp Proprioception/proprioception.tw. |
| 49 | | 50 | joint position sense.tw. |
| 51 | Posture/ | 52 | Posture/posture.tw. |
| 53 | Comorbidity/comorbidity.tw. | 54 | Comorbidity/comorbidity.tw. |
| 57 | body mass index/ | 58 | or/1-9 |

4. Lifestyle$,tw. |
5. (goal or action plan).tw. |
6. (reinforcement or booster or adjustment or adherence).tw. |
7. (individual$ adj4 (treatment$ or therap$ or prorgram$ ro management$)).tw. |
8. (tailor$ adj4 (treatment$ or therap$ or prorgram$ ro management$)).tw. |
9. (target$ adj4 (treatment$ or therap$ or prorgram$ ro management$)).tw. |
10. or/1-9 |
11. exp Health Education/ |
12. Patient Education as Topic/ |
13. Self Care/ |
14. (health education or patient education or self care).tw. |
15. (self adj2 manage$).tw. |
16. (information or advice or counsel$).tw. |
17. or/1-6 |
18. exp Exercise Tolerance/ or exp Exercise/ or exp Exercise Therapy/ |
19. exercise.tw. |
20. physical activity.tw. |
21. or/1-3 |
22. (pacing or dose or progression or link$ or integrate or adhere$).tw. |
23. or/5 and 6 |
24. pain.tw. |
26. Fatigue.tw. |
27. Sleep Disorders/tw. |
28. or/3-13 |
29. Foot Joints/tw. |
31. Proprioception/tw. |
32. Posture/tw. |
33. Comorbidity/tw. |
34. Body Weight/tw. |
35. or/7-32 |
36. exp Diet/diet.tw. |
37. exp Health Promotion/ |
38. (nutrition adj2 education).tw. |
39. or/10-13 |
40. Health Promotion/tw. |
41. (meal or activity or individual or patient) adj2 (plan or goal)).tw. |
42. (eating adj2 (beavior$ or trigger$)).tw. |
43. (self adj3 (monitor$ or record$ or assess$))
58. body mass index.tw.
59. or/33-58
60. exp Emotions/
61. exp Depressive Disorder/
62. (emotion$ or depression or mood or fear or anxiety or affect or frustration or anger or loneliness or sadness).tw.
63. or/60-62
64. exp Motivation/
65. motivation$.tw.
66. exp Attitude to Health/
67. exp Health Behavior/
68. (health belief$ or health behavior or attitude to health).tw.
69. or/64-68
70. 21 or 32 or 63 or 69
71. 14 or 70

2 1. Individualized medicine/
2. individual$.tw.
3. (individual$ adj4 (treatment$ or therap$ or prorgram$ or management$)).tw.
4. (tailor$ adj4 (treatment$ or therap$ or prorgram$ or management$)).tw.
5. (target$ adj4 (treatment$ or therap$ or prorgram$ or management$)).tw.
6. exp Classification/
7. classif$.tw.
8. stratif$.tw.
9. categor$.tw.
10. or/1-9

10 1. Walkers/
2. walker$.tw.
3. (walking adj3 aids).tw.
4. (walking adj3 stick$).tw.
5. (walking adj3 frame$).tw.
6. self-help devices/ or wheelchairs/
7. assistive device$.tw.
8. crutch$.tw.
10. (height adj3 (bed$ or chair$ or seat$)).tw.
12. (adaptation$ adj3 work).tw.
13. (cane or canes).tw.
15. (handrail$ or (hand adj rail$)).tw.
17. (automatic adj gear).tw.
18. (car or cars or driving).tw.
19. occupational therapy/
20. or/1-20

3 1. exp health services/ or exp patient care/ or exp preventive health services/ or exp rehabilitation/
2. exp Patient Care Management/
3. (multidisciplinary or rehabilitation or complex intervention or package of care).tw.
4. ((multifaceted or multimodal or integrated or complex or combined) adj2 management).tw.
5. (education or information or advise).tw.
6. or/1-5

11 1. exp Rehabilitation, Vocational/
2. vocation$.tw.
3. (occupational adj3 rehabilitation).tw.
4. exp Work/
5. work$.tw.
6. job$.tw.
7. career.tw.
8. exp Employment/
9. employment.tw.
10. exp Disability Evaluation/
11. or/1-10
Figure S1 General literature search combining the search query for osteoarthritis and meta-analysis.
osteoarthritis AND RCT/CT AND proposition 1
MEDLINE (936), AMED (139), Embase (1800), PsychINFO (36),
CINAHL (72), Cochrane Clinical Trials (1179), PEDro (108)
2260 hits after removing duplicates

2260 titles

EXCLUDED (n=2069)
- study design
- not OA
- not initial assessment
- animal

191 abstracts

EXCLUDED (n=187)
- study design
- pharmacological interventions
- post-hoc sub-group analyses

4 RCTs retrieved in full-text

TRACKING OF REFERENCE LISTS
1 RCT included

EXCLUDED (n=4)
- baseline data only
- not a comprehensive initial assessment
- pharmacology

1 RCT included

Figure S2 Proposition-specific search literature search for proposition 1.
osteoarthritis AND RCT/CT AND proposition 2

MEDLINE (842), AMED (64), Embase (1266), PsychINFO (19), CINAHL (19), Cochrane Clinical Trials (1345), PEDro (19)

2530 hits after removing duplicates

2530 titles

EXCLUDED (n=2467)
- study design
- not OA
- not non-pharmacological individualised interventions
- outcome
- animal

63 abstracts

EXCLUDED (n=50)
- study design
- surgery
- not individualised intervention

13 studies retrieved in full-text

TRACKING OF REFERENCE LISTS
3 RCT included

EXCLUDED (n=7)
- study design
- no separate analysis for OA
- not individualised intervention

9 RCTs included

Figure S3 Proposition-specific literature search for proposition 2
osteoarthritis AND RCT/CT AND proposition 3
MEDLINE (1254), AMED (157), Embase (2289), PsychINFO (17),
CINAHL (91), Cochrane Clinical Trials (2472), PEDro (90)

3068 hits after removing duplicates

3068 titles

EXCLUDED (n=2867)
- study design
- not OA
- intervention other than elements proposed in proposition 3 a-f

201 abstracts

EXCLUDED (n=152)
- study design
- intervention other than elements proposed in recommendation 3 a-f
- outcome

49 studies retrieved in full-text

TRACKING OF REFERENCE LISTS
0 RCT included

EXCLUDED (n=26)
- study design
- no analysis for OA
- interventions other than the comprehensive non-pharmacological management proposed in recommendation 3a-f
- no between group comparisons
- outcome
- double publication

23 RCTs included

Figure S4 Proposition-specific literature search for proposition 3.
Figure S5 Proposition-specific literature search for proposition 4.
ostearthritis AND RCT/CT AND proposition 5
MEDLINE (336), AMED (38), Embase (454), PsychINFO (19),
CINAHL (11), Cochrane Clinical Trials (423), PEDro (66)

815 hits after removing duplicates

815 titles

EXCLUDED (n=739)
- study design
- not OA
- interventions other than education

76 abstracts

EXCLUDED (n=50)
- study design
- interventions other than education

26 studies retrieved in full-text

TRACKING OF REFERENCE LISTS
1 RCT included

EXCLUDED (n=10)
- study design
- no separate analysis for OA
- interventions include both education and exercise

17 RCTs included

Figure S6 Proposition-specific literature search for proposition 5.
Figure S7 Proposition-specific literature search for proposition 6.
Figure S8 Proposition-specific literature search for proposition 8. Time limit April 2006 to February 2012.
**Figure S9** Proposition-specific search for proposition 9.
Figure S10. Proposition-specific literature search for proposition 10.
osteoaarthritis AND observational studies AND proposition 10
MEDLINE (131), AMED (3), Embase (131), PsychINFO (2),
CINAHL (86)
202 hits after removing duplicates

202 titles
EXCLUDED (n=185)
- study design
- not OA
- not investigating assistive technology

17 abstracts
EXCLUDED (n=8)
- biomechanics, work participation, PT referral
- study design

9 observational studies retrieved in full-text
EXCLUDED (n=5)
- no access to full text
- study design

4 observational studies included\textsuperscript{130-133}

\textbf{Figure S11} Proposition-specific literature search for proposition 10.
**Figure S12.** Proposition-specific search for proposition 11.