Οστεοαρθρίτιδα: Φαρμακευτική και μη φαρμακευτική θεραπεία

Θάνος Κουτρούμπας

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Περίληψη

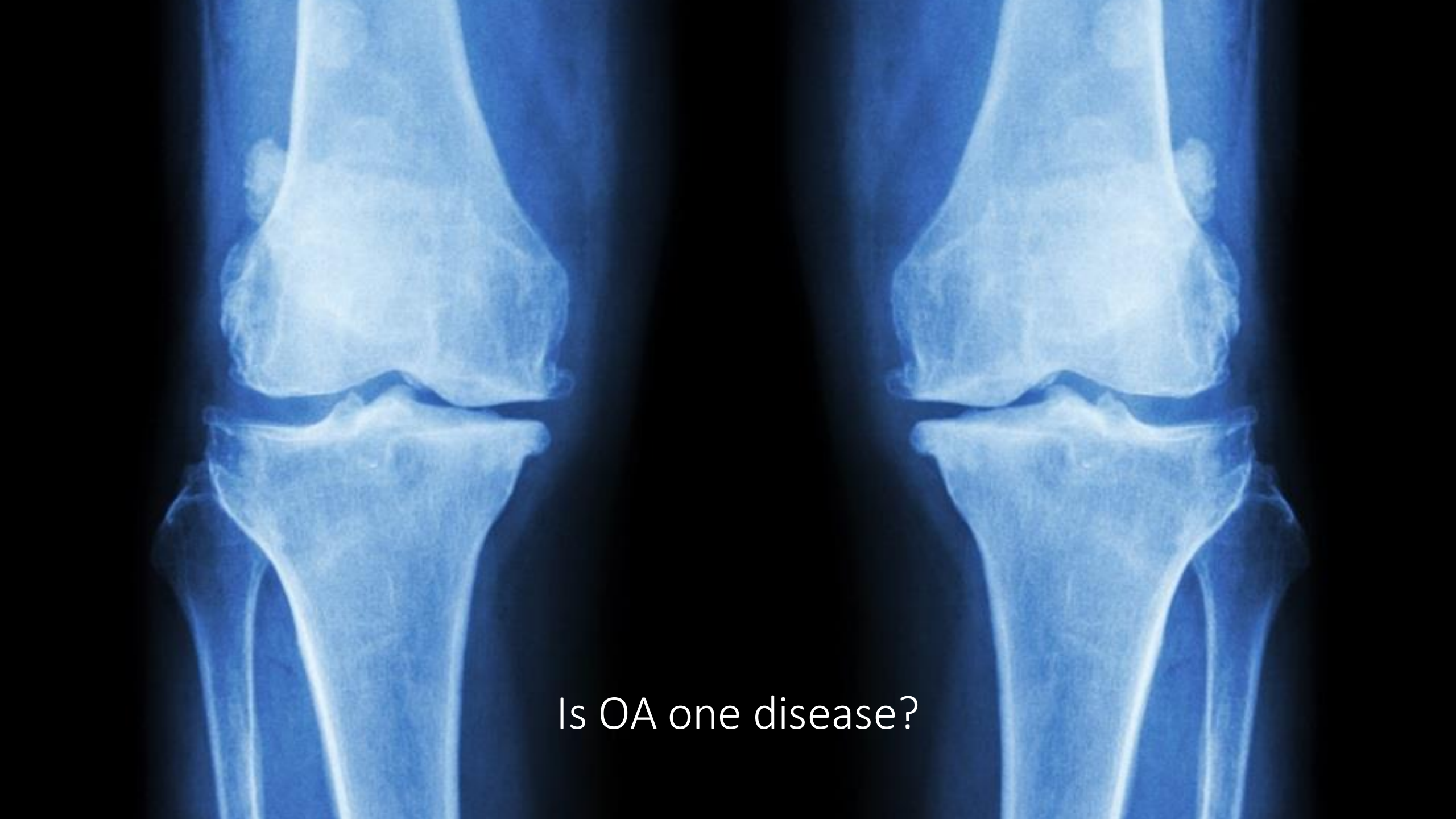
ΟΑ: μία "ιδιόρυθμη" πάθηση

Ιδιαιτερότητες μελετών στην ΟΑ

Θεραπευτικές επιλογές:

Φαρμακευτικές επιλογές

Μη φαρμακευτικές επιλογές (άσκηση- απώλεια βάρους)



Is OA one disease?

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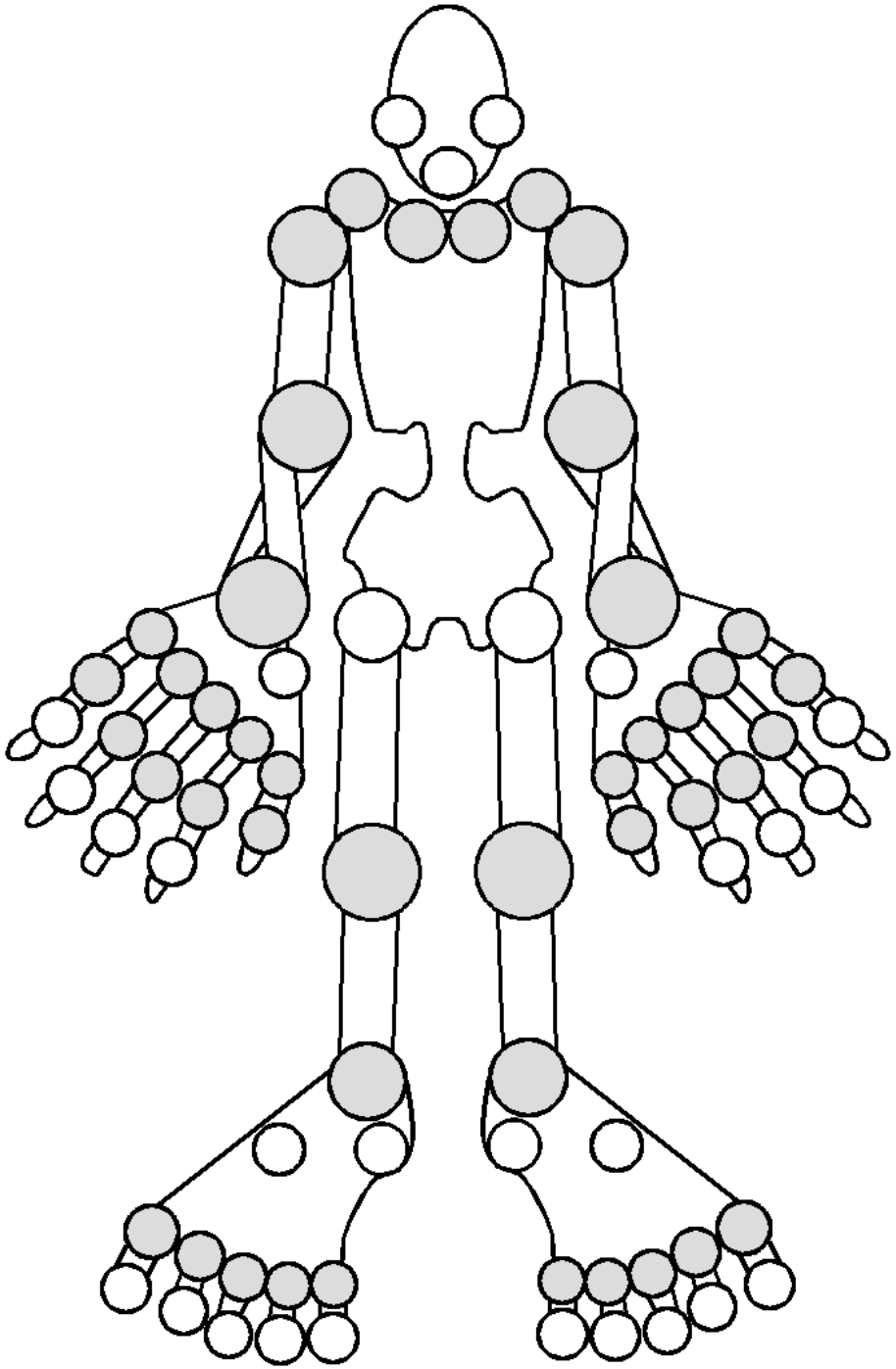

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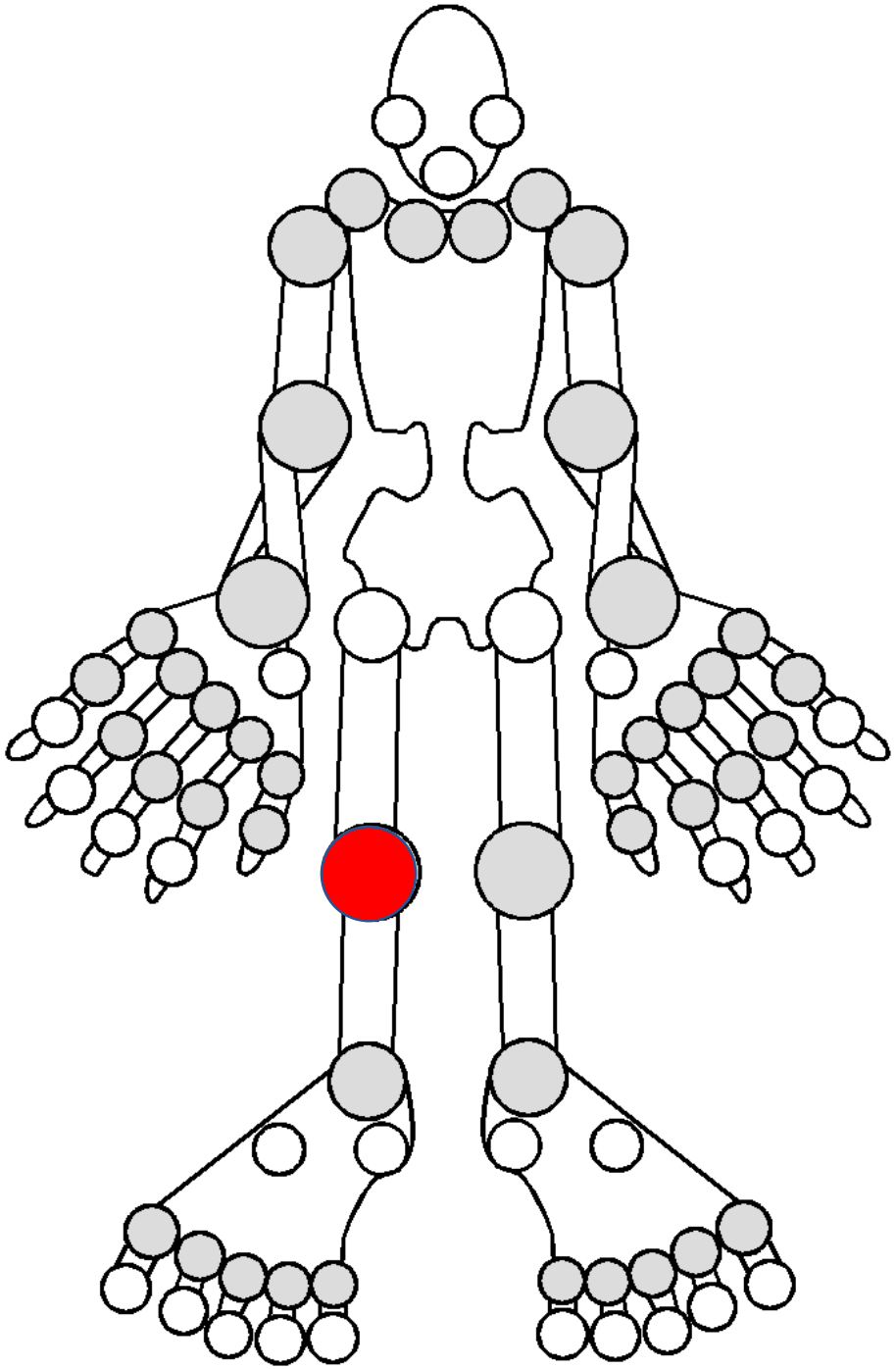

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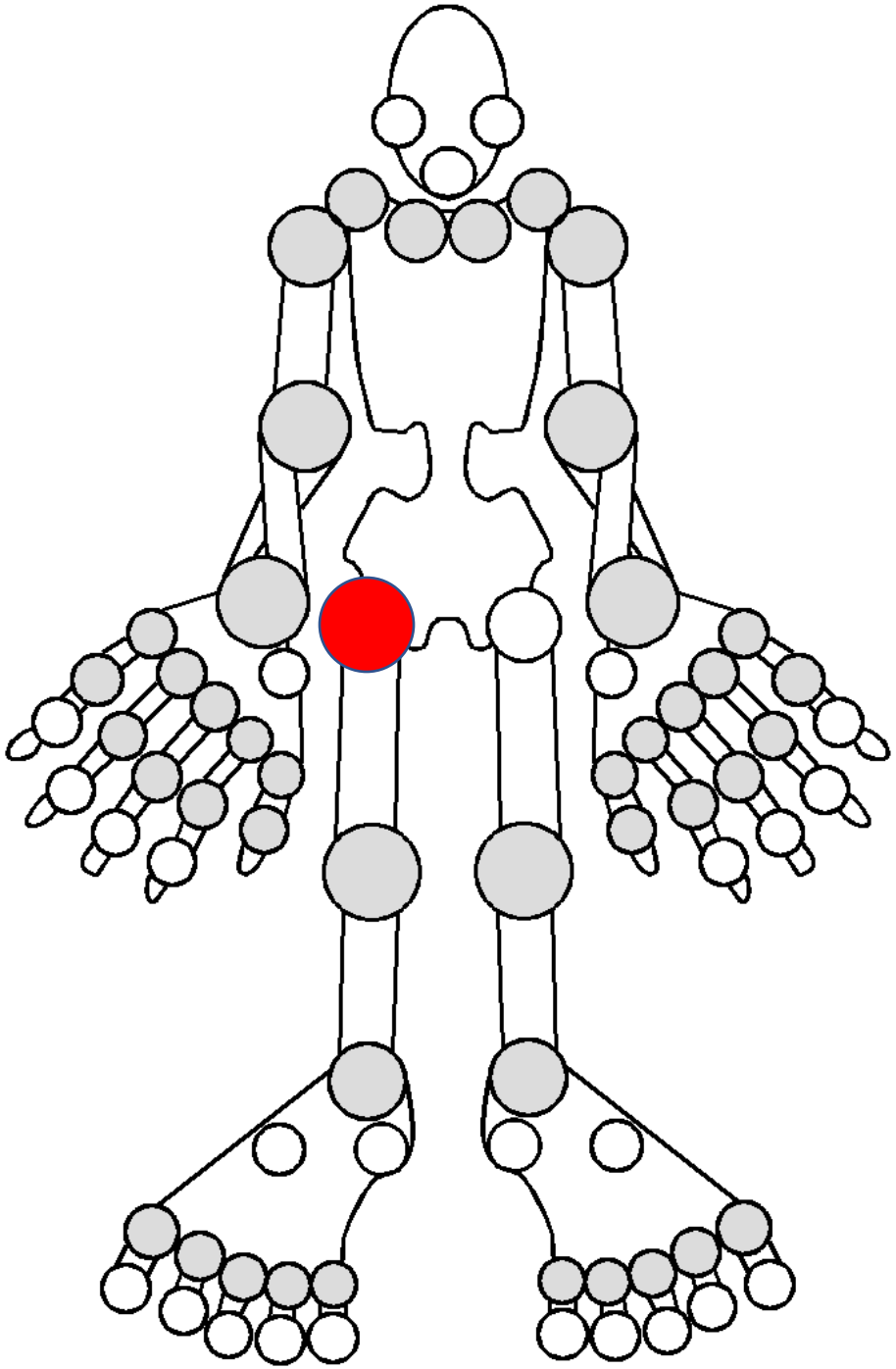

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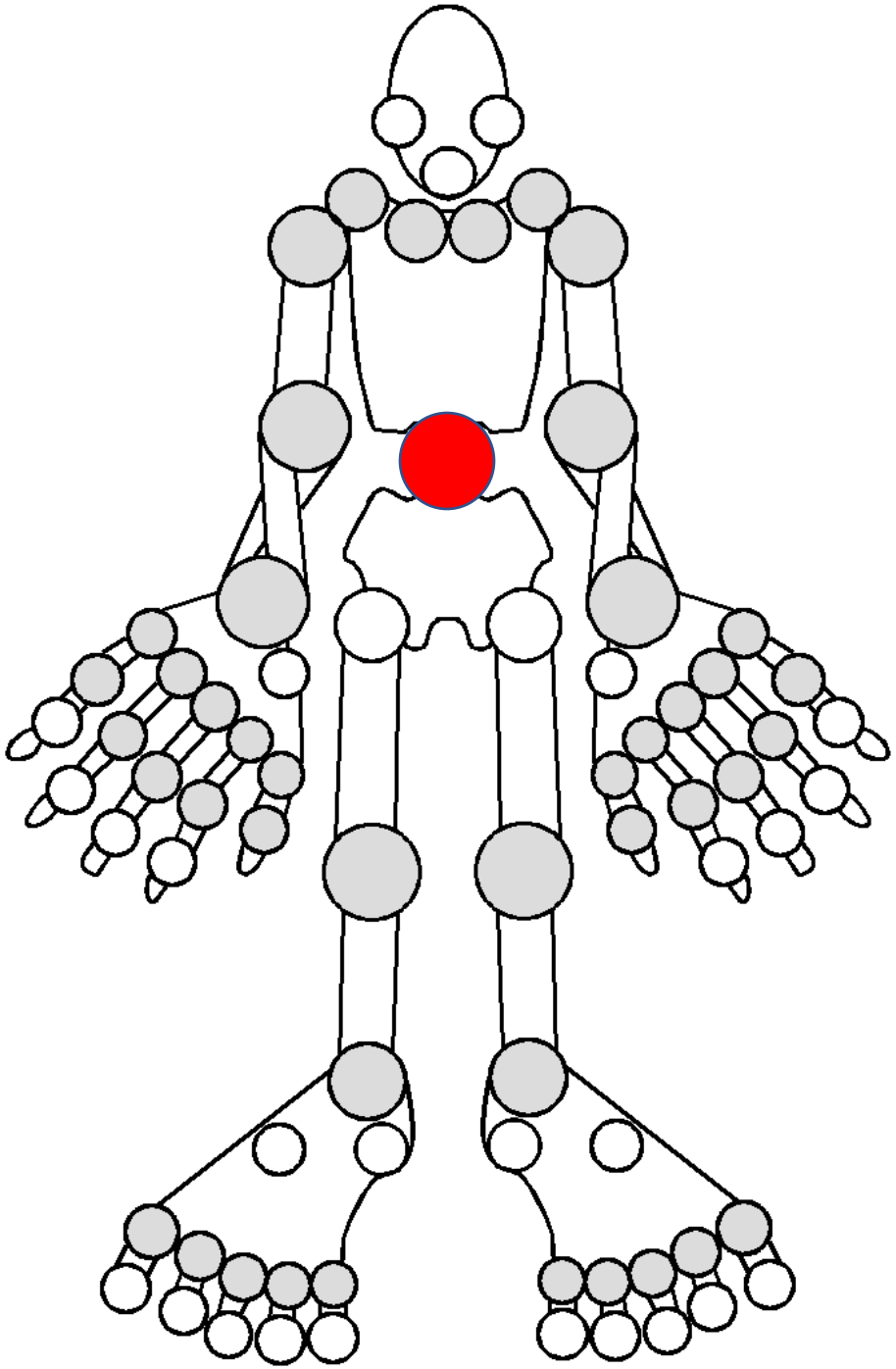

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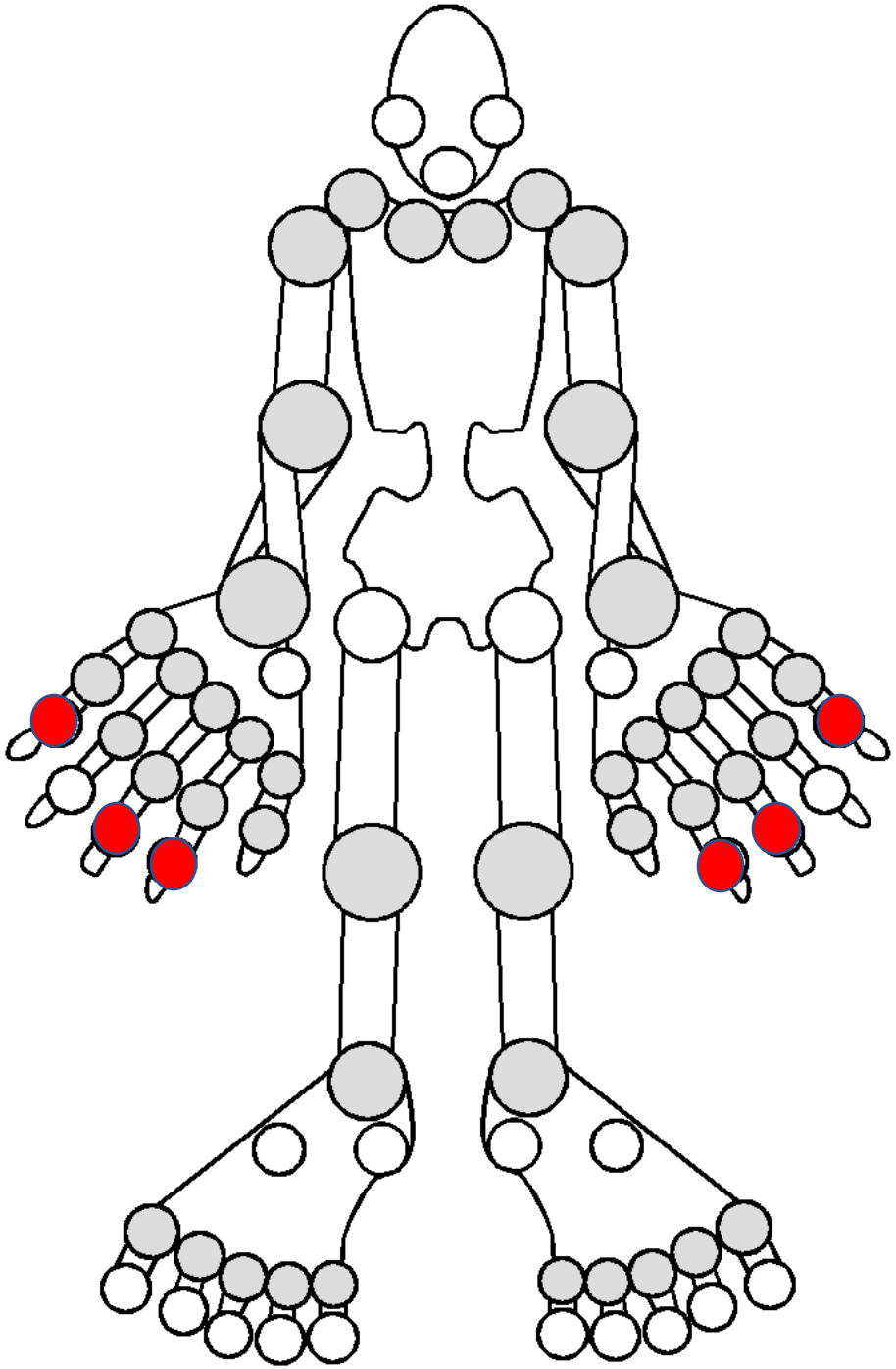

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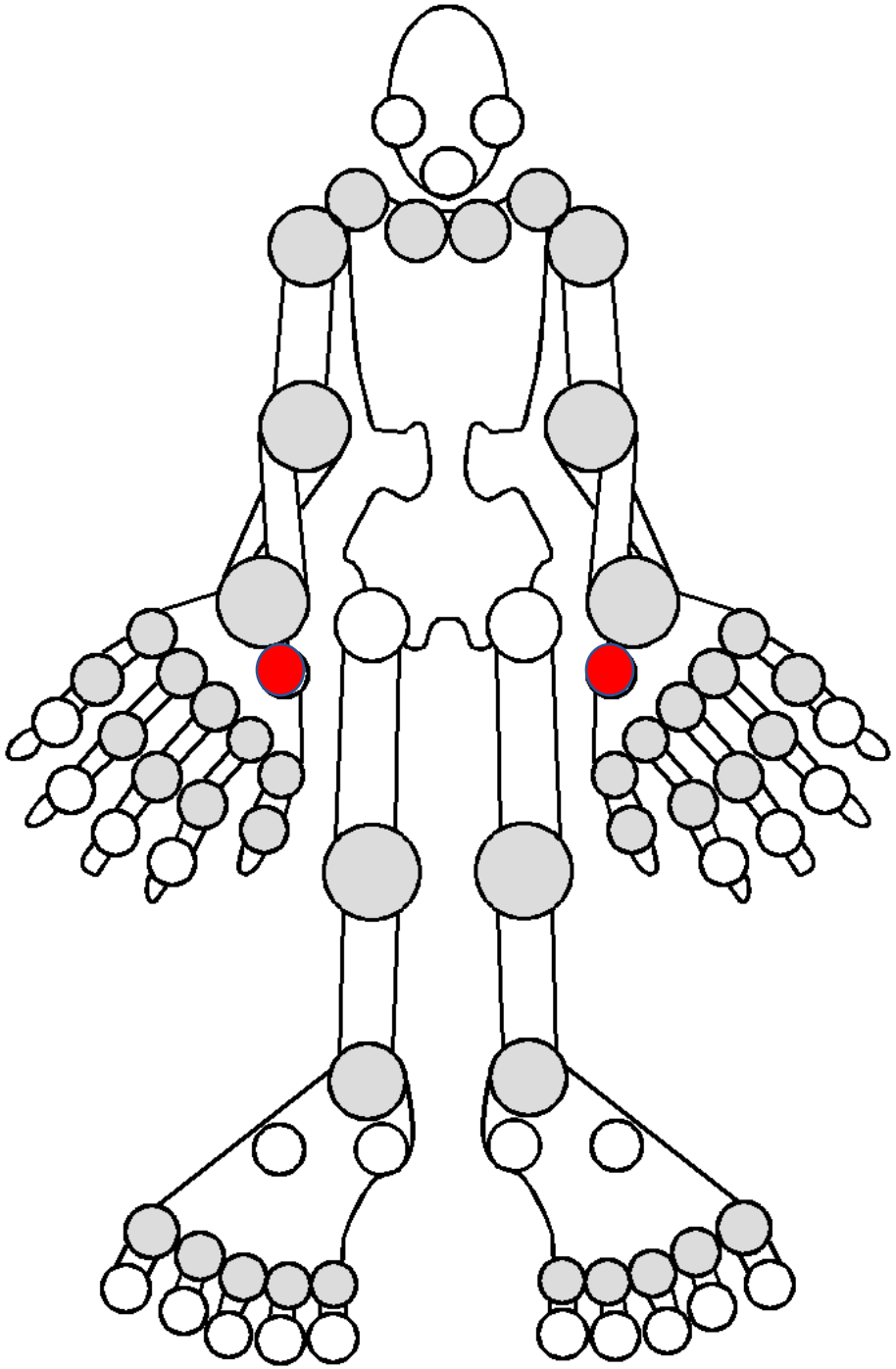

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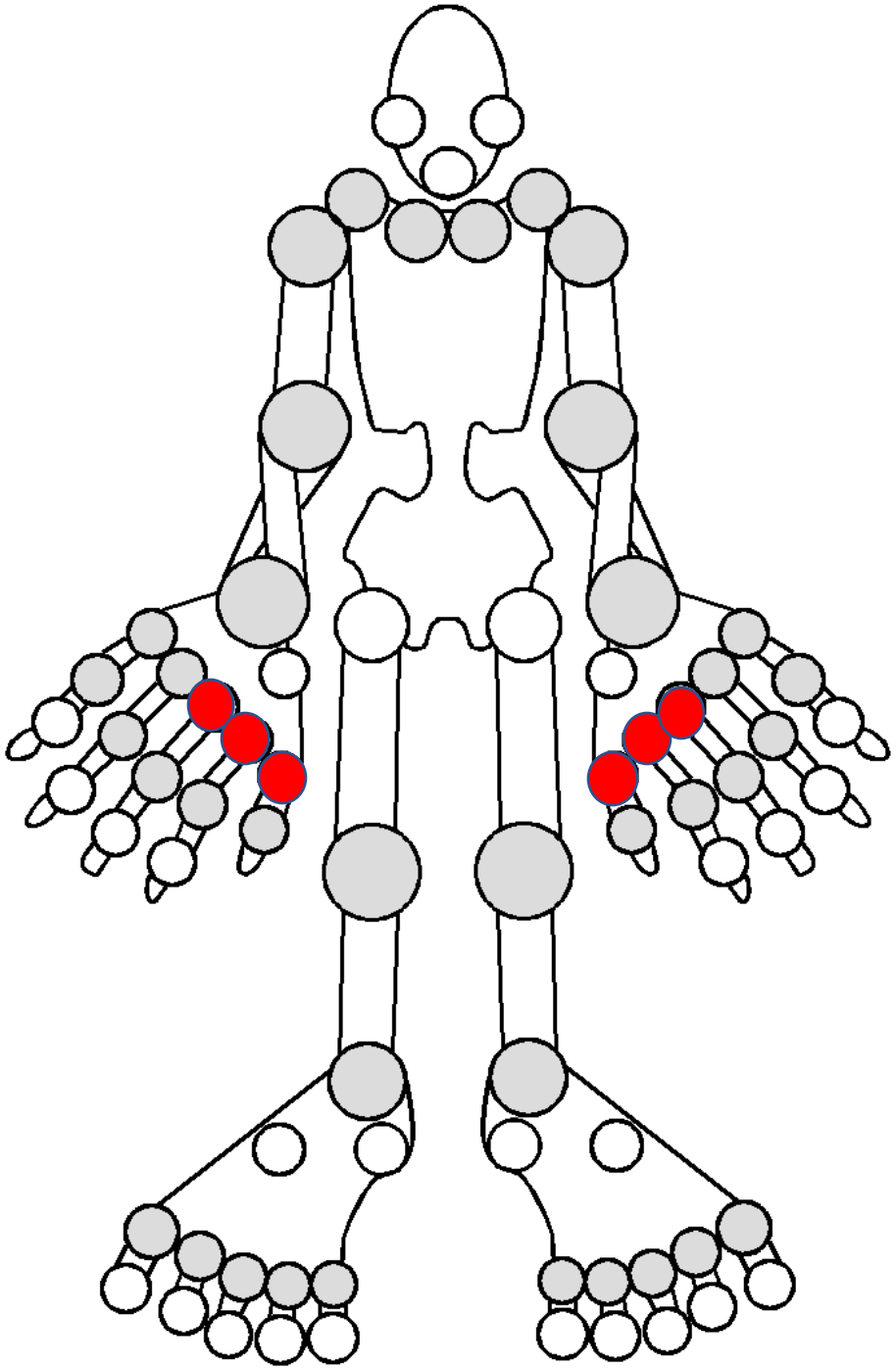

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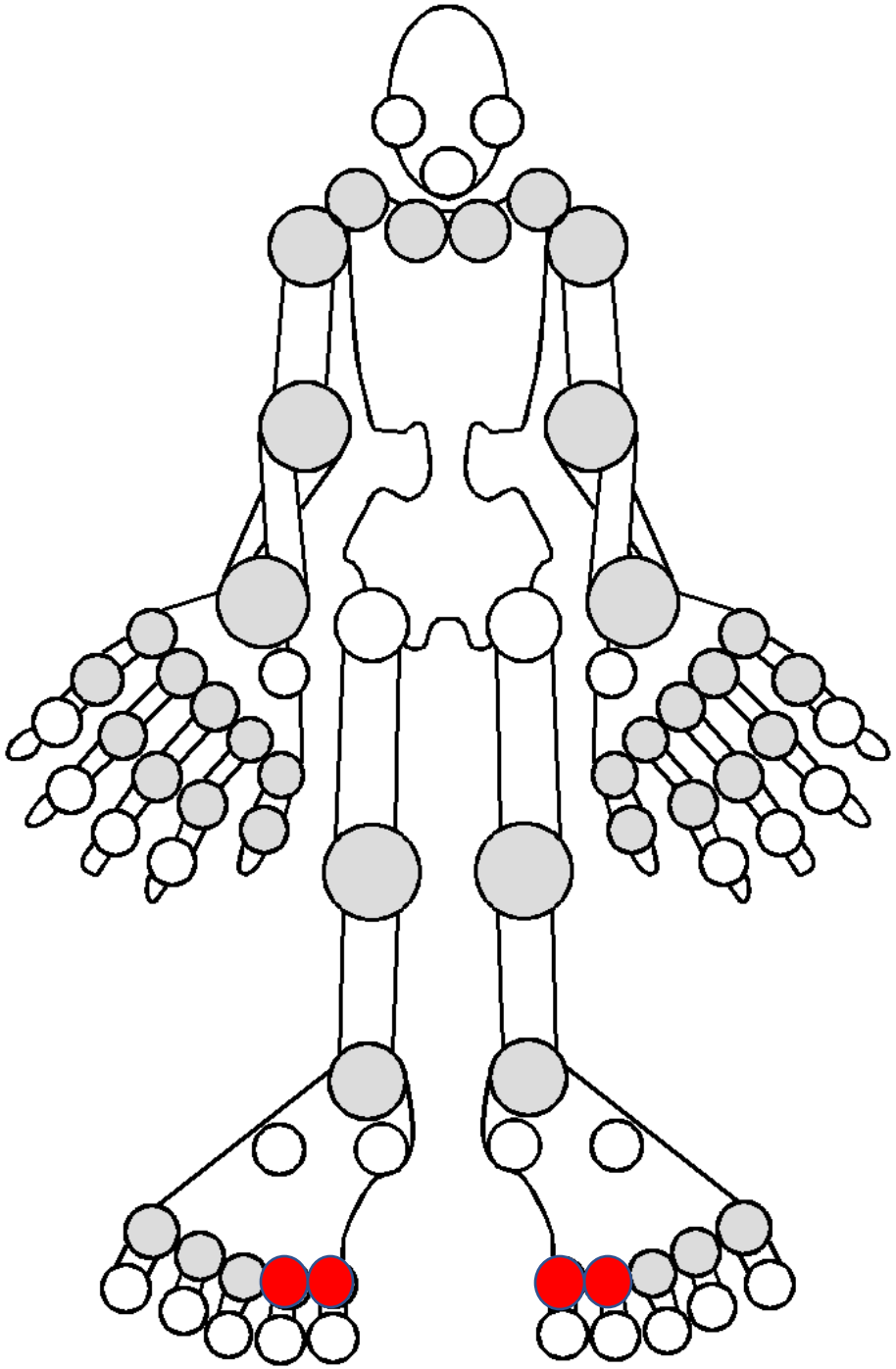

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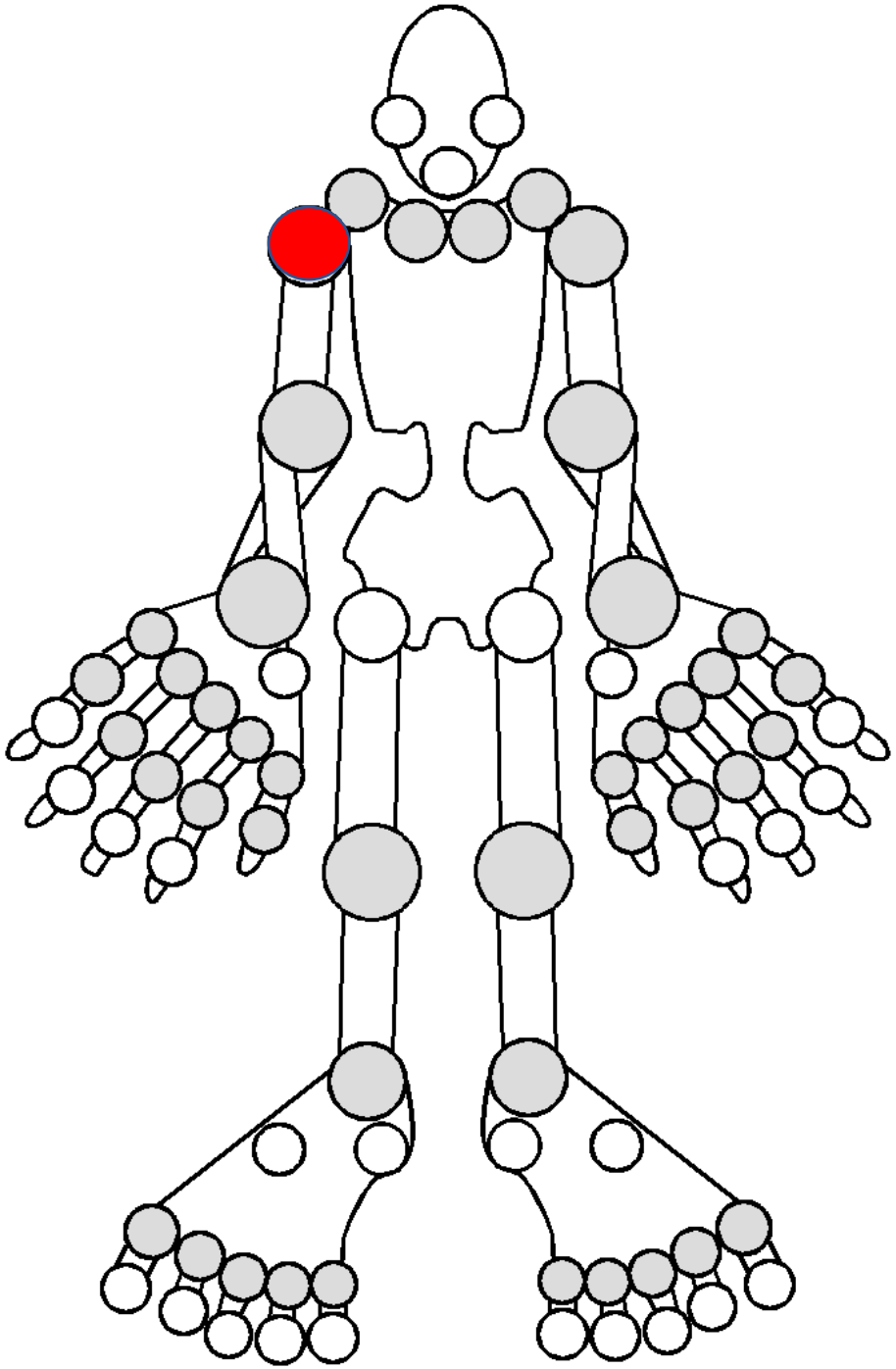

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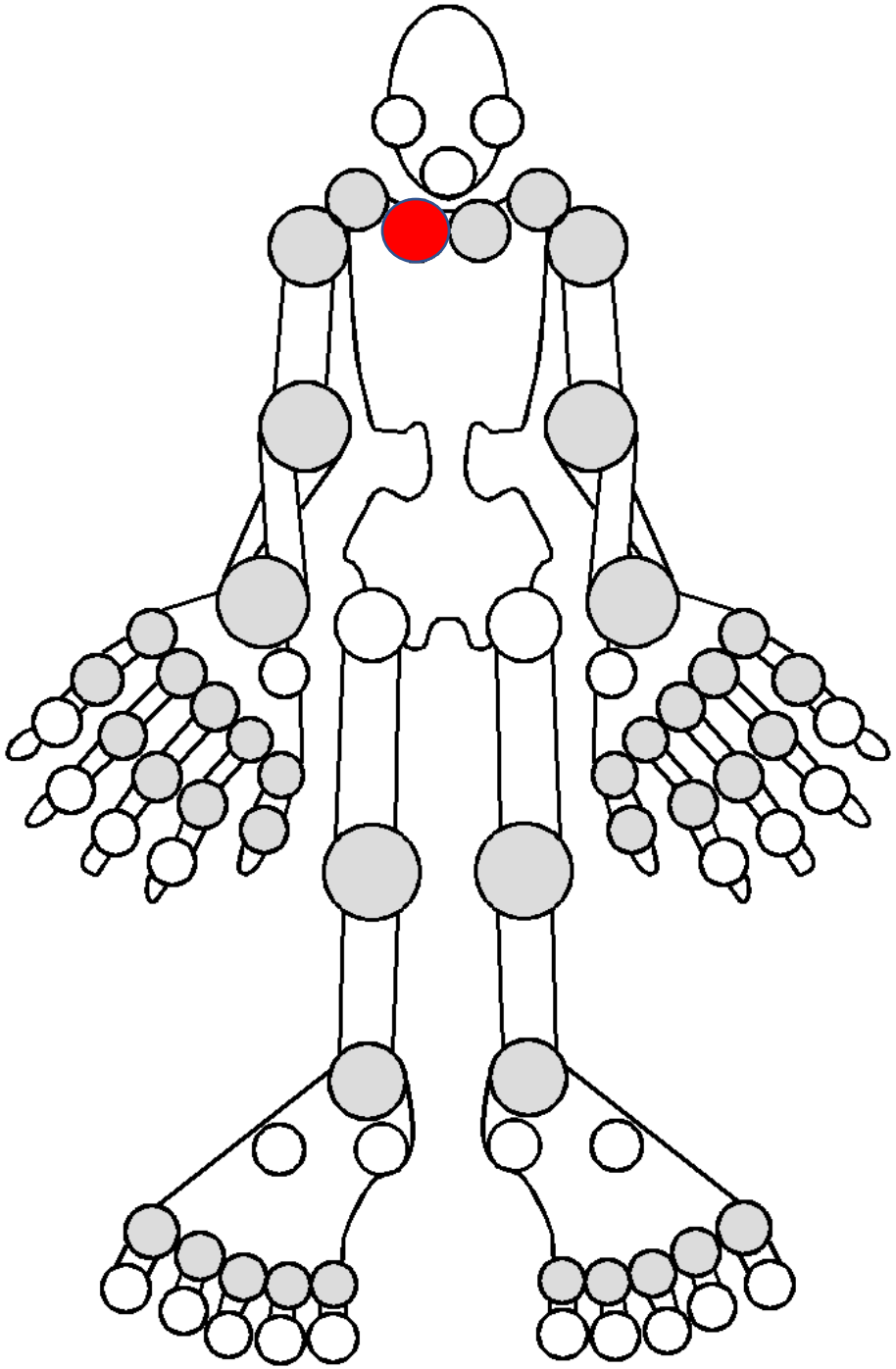
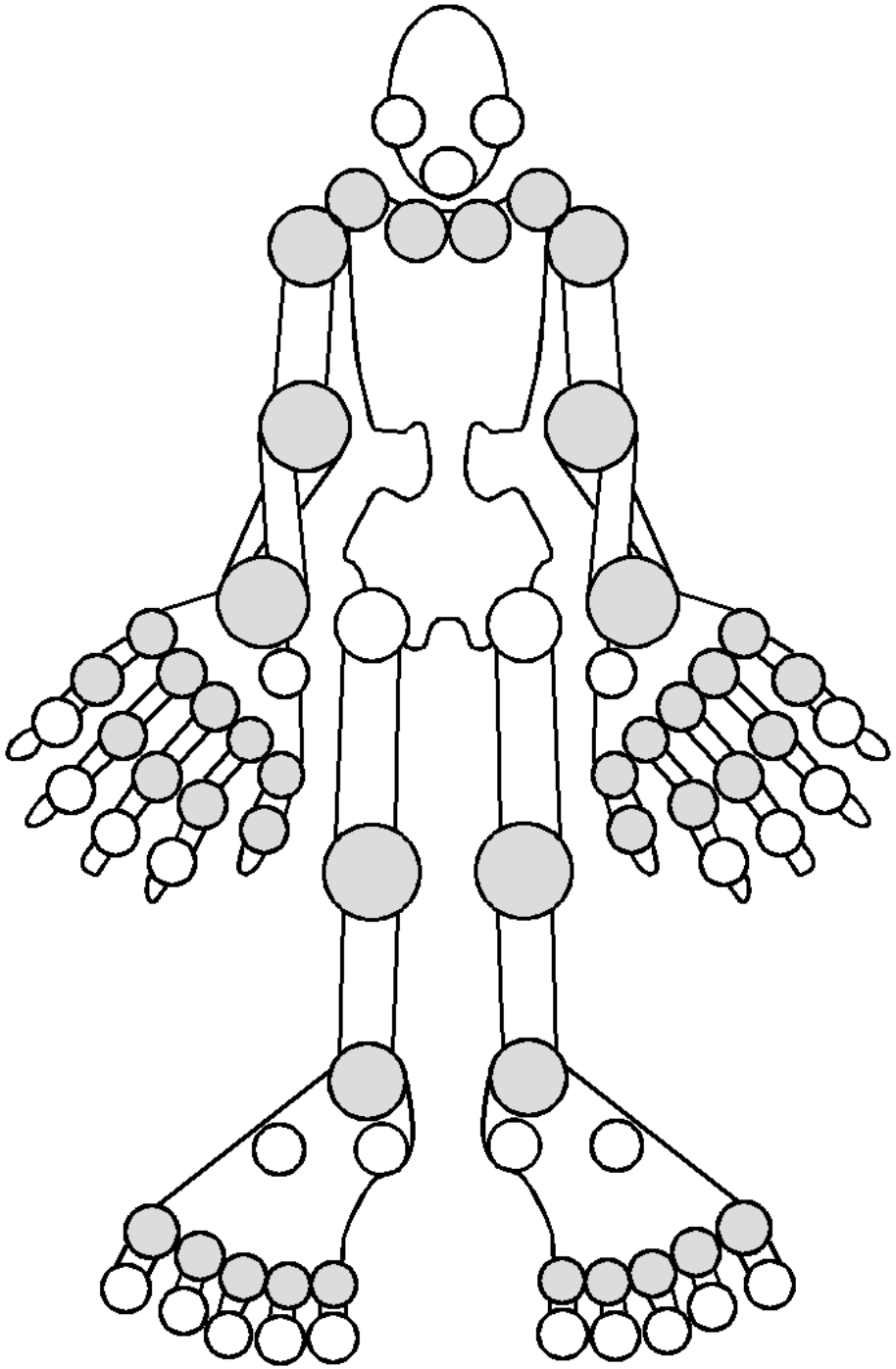


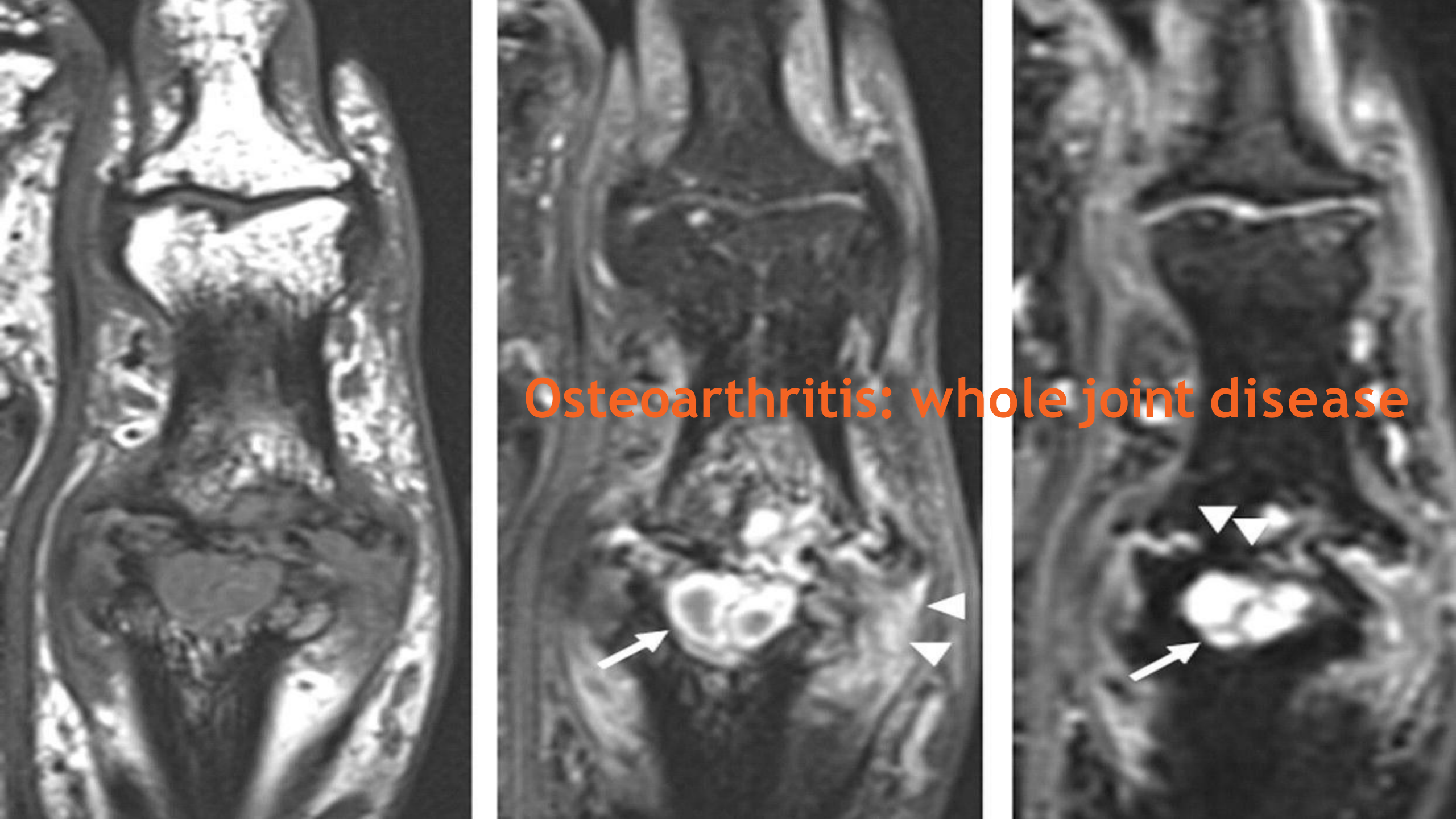
Is OA one disease?

Different risk factors
Different clinical associations
Different genetics
Multiple phenotypes (even for the same site)
Different treatment response



Μία νόσος- πολλαπλές παθολογίες

Λέπτυνση του χόνδρου
Υμενίτιδα
Ενδοαρθρική συλλογή υγρού
Οστεόφυτα
Υποχόνδριες κύστες
Οστικές διαβρώσεις
Οστικό οίδημα
Βλάβες μηνίσκων
Βλάβες συνδεσμικών στοιχείων


Osteoarthritis: whole joint disease

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 FEBRUARY 23, 2006 VOL. 354 NO. 8

Glucosamine, Chondroitin Sulfate, and the Two in Combination for Painful Knee Osteoarthritis

Daniel O. Clegg, M.D., Domenic J. Reda, Ph.D., Crystal L. Harris, Pharm.D., Marguerite A. Klein, M.S., James R. O'Dell, M.D., Michele M. Hooper, M.D., John D. Bradley, M.D., Clifton O. Bingham III, M.D., Michael H. Weisman, M.D., Christopher G. Jackson, M.D., Nancy E. Lane, M.D., John J. Cush, M.D., Larry W. Moreland, M.D., H. Ralph Schumacher, Jr., M.D., Chester V. Oddis, M.D., Frederick Wolfe, M.D., Jerry A. Molitor, M.D., David E. Yocum, M.D., Thomas J. Schnitzer, M.D., Daniel E. Furst, M.D., Allen D. Sawitzke, M.D.,

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James
Micha
Larry W.
Jerry A. Molito

CONCLUSIONS

Glucosamine and chondroitin sulfate alone or in combination did not reduce pain effectively in the overall group of patients with osteoarthritis of the knee. Exploratory analyses suggest that the combination of glucosamine and chondroitin sulfate may be effective in the subgroup of patients with moderate-to-severe knee pain. (ClinicalTrials.gov number, NCT00032890.)

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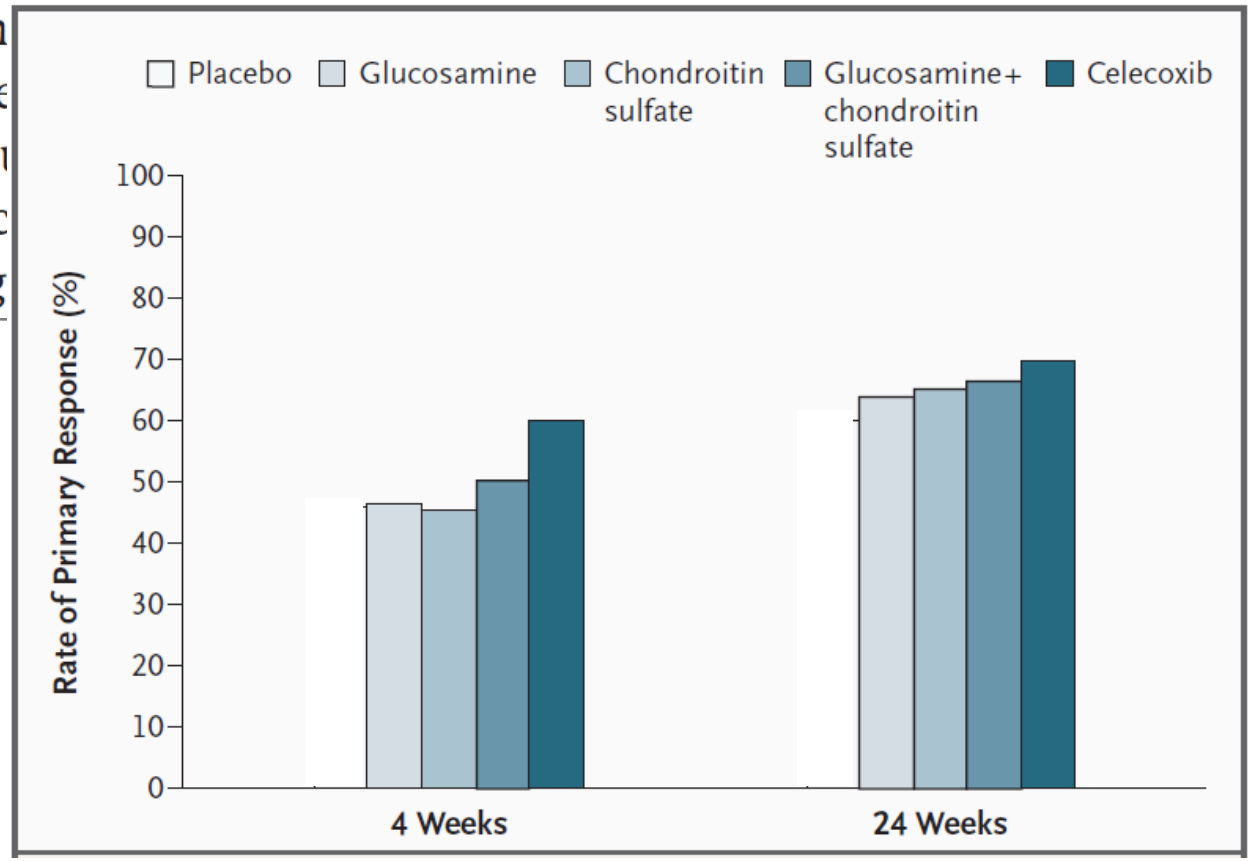

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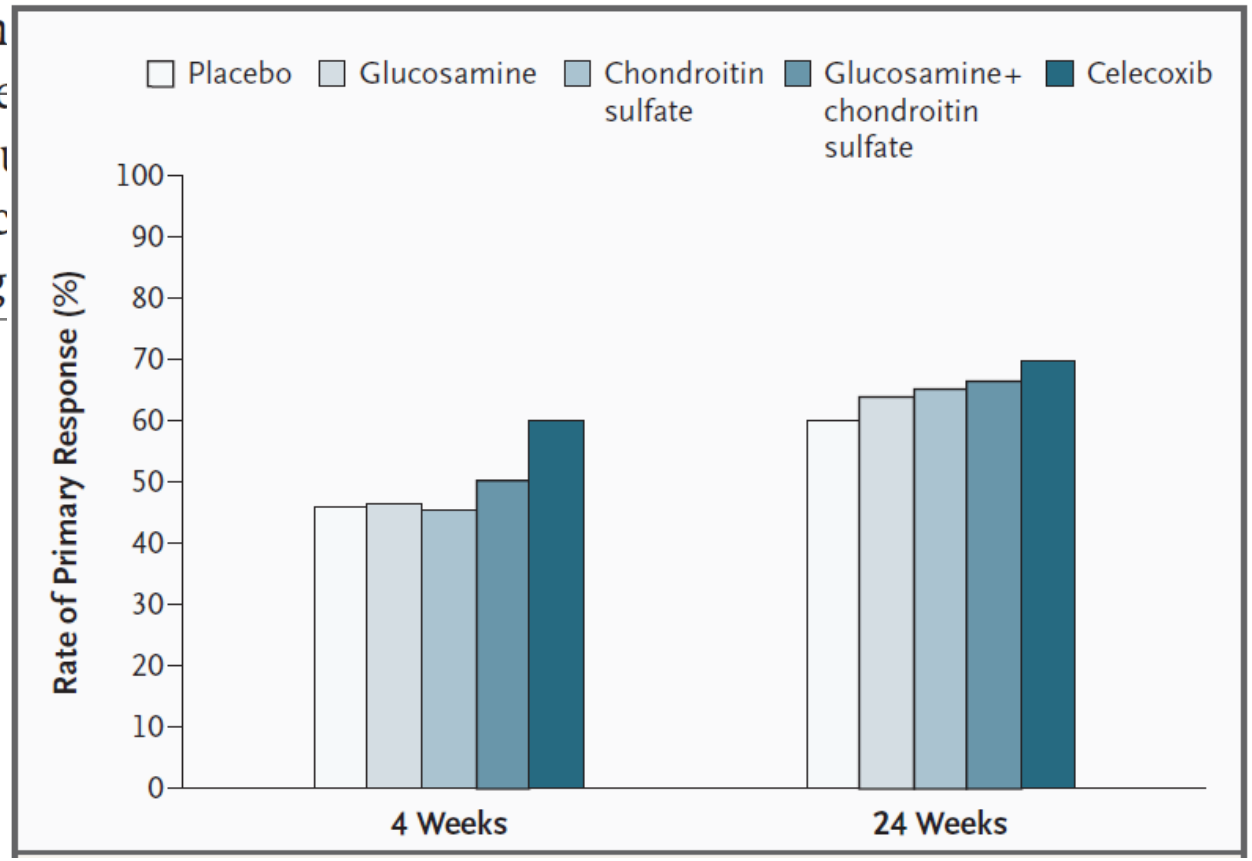


Placebo is a powerful drug in OA…

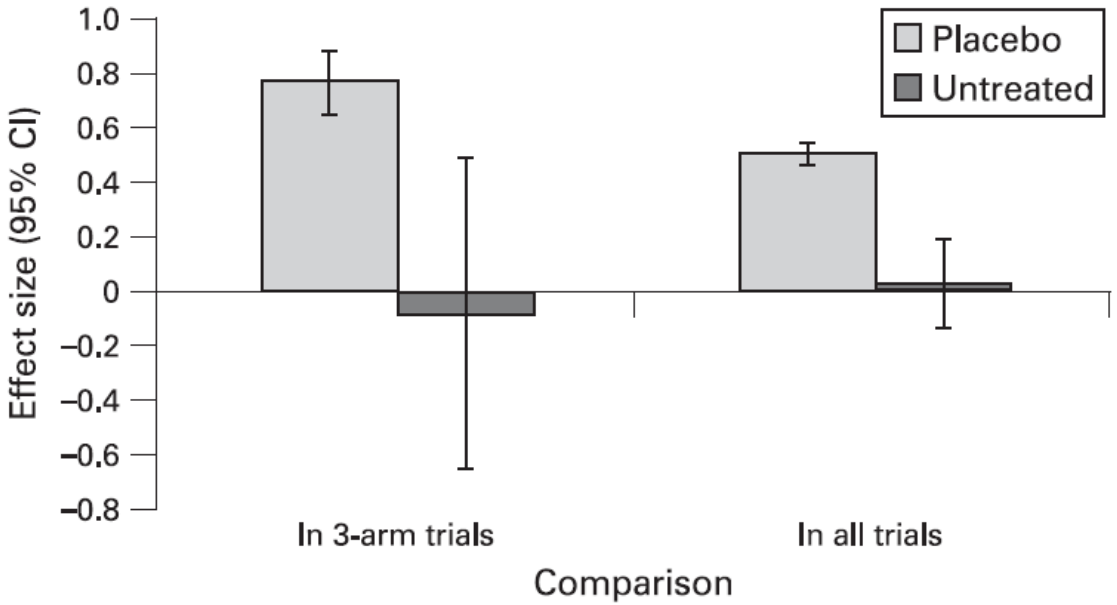
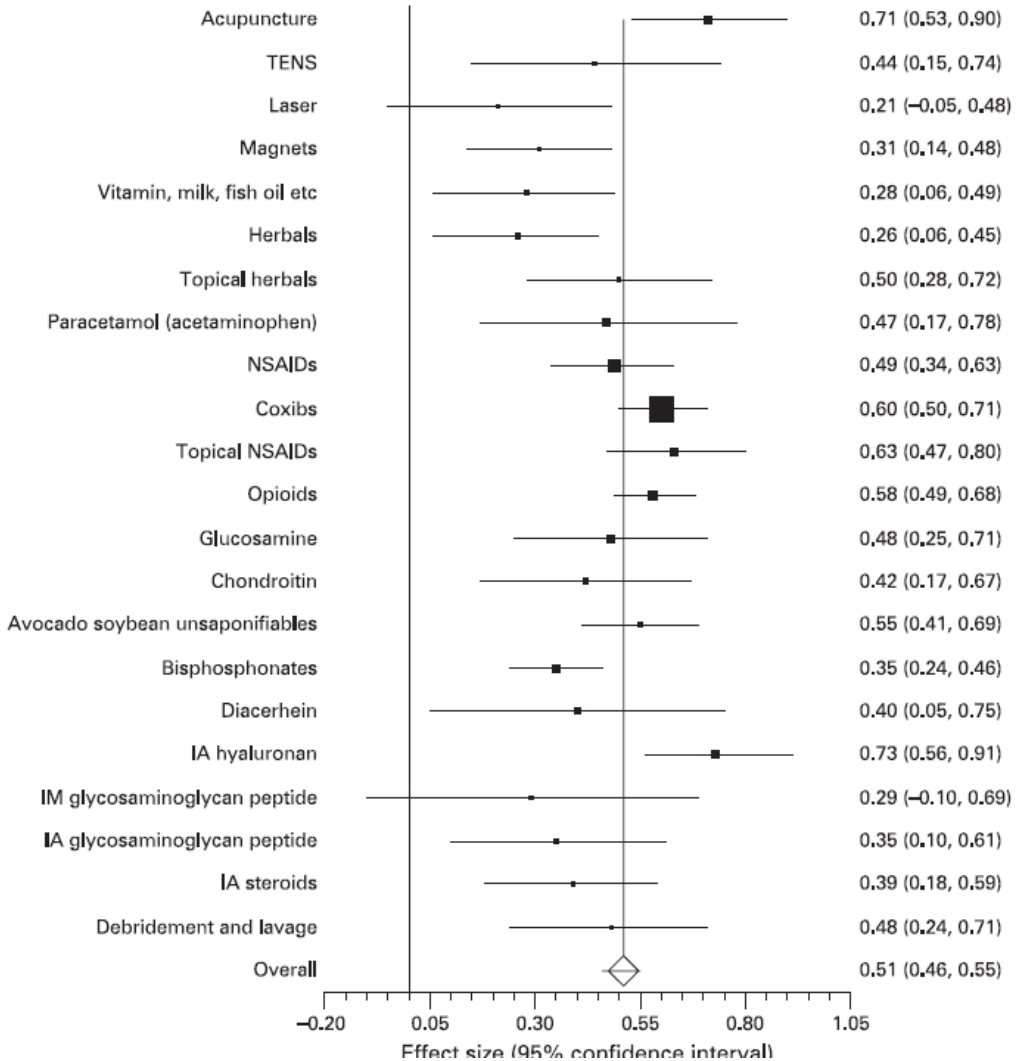


Figure 3 Effect size between placebo and untreated control. In three-arm trials: direct comparison between placebo and untreated control within the three trials that included placebo and untreated control, In all trials: indirect comparison between all placebo (n = 193) and all untreated control (n = 14) from different trials.

Zhang, Ann Rheum Dis 2008

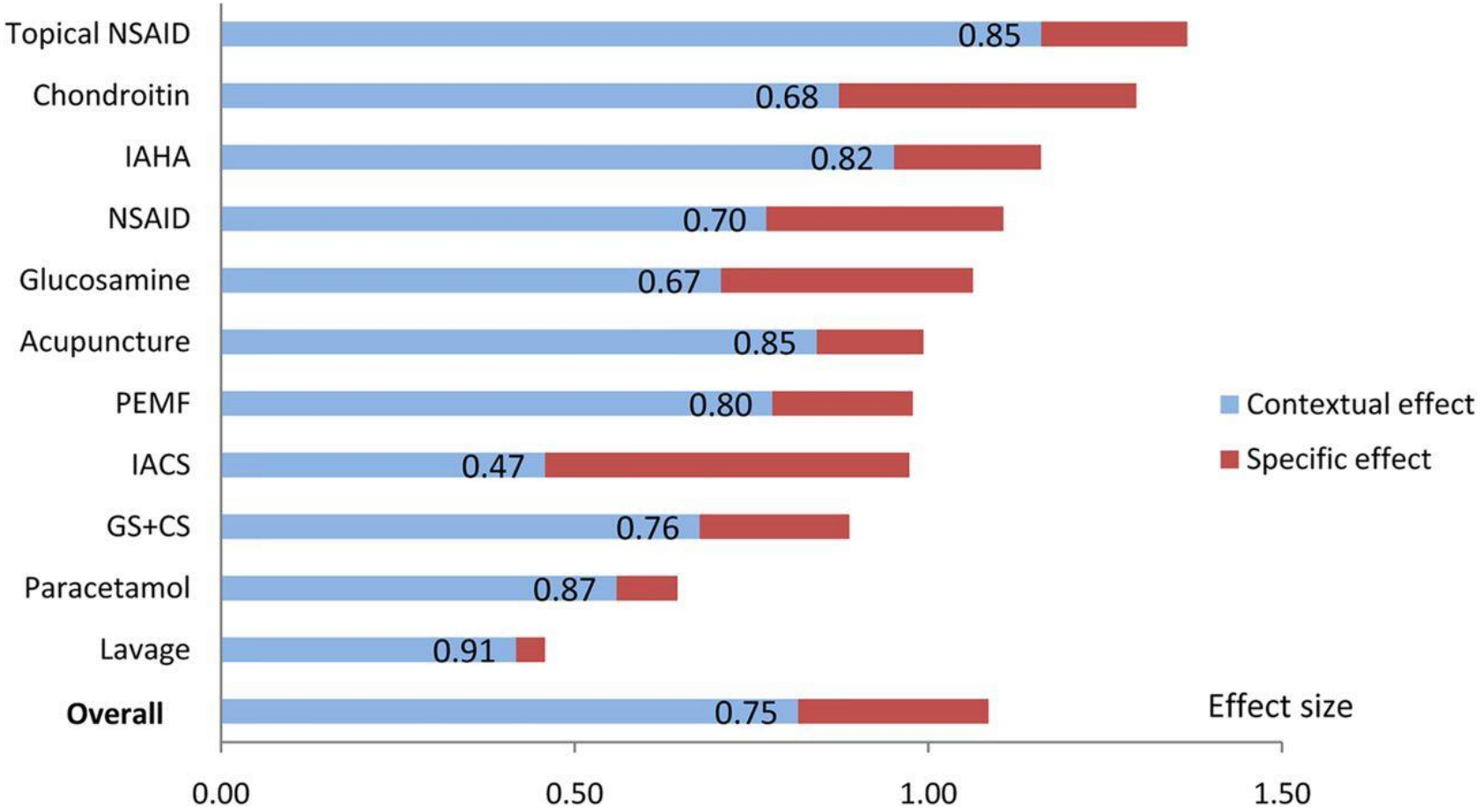
Placebo is a powerful drug in OA…

Figure 4 Placebo effect for pain categorised according to active treatment. IA, intra-articular; IM, intramuscular; NSAID, non-steroidal anti-inflammatory drug; TENS, transcutaneous electrical nerve stimulator.



Zhang, Ann Rheum Dis 2008

75% of pain reduction is attributed to placebo/contextual effects



Zou, Ann Rheum Dis 2016

Clinical practice guidelines
Evidence-based recommendations

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Arthritis & Rheumatology
Vol. 72, No. 2, February 2020, pp 220–233
DOI 10.1002/art.41142

2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee

Sharon L. Kolasinski,[1] Tuhina Neogi,[2] Marc C. Hochberg,[3] Carol Oatis,[4] Gordon Guyatt,[5] Joel Block,[6] Leigh Callahan,[7] Cindy Copenhaver,[8] Carole Dodge,[9] David Felson,[2] Kathleen Gellar,[10] William F. Harve Gillian Hawker,[12] Edward Herzig,[13] C. Kent Kwoh,[14] Amanda E. Nelson,[7] Jonathan Samuels,[15] Carla Daniel White,[16] Barton Wise,[17] Roy D. Altman,[18] Dana DiRenzo,[19] Joann Fontanarosa,[20] Gina Giradi, Mariko Ishimori,[21] Devyani Misra,[2] Amit Aakash Shah,[22] Anna K. Shmagel,[23] Louise M. Thoma,[7] Marat Turgunbaev,[22] Amy S. Turner,[22] and James Reston[20]

Osteoarthritis and Cartilage

OSTEOARTHRITIS RESEARCH SOCIETY INTERNATIONAL

OARSI guidelines for the non-surgical management of knee, hip, and polyarticular osteoarthritis

R.R. Bannuru † *, M.C. Osani †, E.E. Vaysbrot †, N.K. Arden ‡ §, K. Bennell ‖, S.M.A. Bierma-Zeinstra ¶ #, V.B. Kraus ††, L.S. Lohmander ‡‡, J.H. Abbott §§, M. Bhandari ‖‖, F.J. Blanco ¶¶ ##, R. Espinosa ††† ‡‡‡, I.K. Haugen §§§, J. Lin ‖‖‖, L.A. Mandl ¶¶¶, E. Moilanen ###, N. Nakamura ††††, L. Snyder-Mackler ‡‡‡‡, T. Trojian §§§§, M. Underwood ‖‖‖‖ ¶¶¶¶, T.E. McAlindon †

AAOS Clinical Practice Guideline Summary

AAOS Clinical Practice Guideline Summary: Management of Osteoarthritis of the Knee (Nonarthroplasty), Third Edition

Robert H. Brophy, MD
Yale A. Fillingham, MD

ABSTRACT

Management of Osteoarthritis of the Knee (nonarthroplasty) Evidence-Based Clinical Practice Guideline is based on a systematic review of

APPROPRIATE USE CRITERIA: MANAGEMENT OF OSTEOARTHRITIS OF THE KNEE (NON-ARTHROPLASTY) AUC (2022)

Endorsed by: AAHKS, AANA

INDICATION PROFILE

PROCEDURE RECOMMENDATIONS

Function-Limiting Pain

- ◯ Function-Limiting Pain that is intermittent and predictable
- ◯ Function-Limiting Pain that is constant
- ◯ Function-Limiting Pain that is constant with intense intermittent unpredictable episodes

Pattern of Arthritic Involvement

- ◯ Arthritic Involvement predominantly in one weight bearing compartment
- ◯ Arthritic Involvement predminantly in two or three compartments
- ◯ Arthritic Involvement isolated in patellofemoral compartment

Imaging (Joint Space Most Involved Compartment) and Range of Motion

- ◯ Minimal Joint Space Narrowing (KL 0-1)
- ◯ Mild to Moderate Joint Space Narrowing (KL 2-3) with full range of extension/flexion
- ◯ Mild to Moderate Joint Space Narrowing (KL 2-3) with lack of full range of extension (> 5-degree flexion contracture) and/or flexion (< 110 degrees)
- ◯ Severe Joint Space Narrowing (KL 4)

Mechanical Symptoms Compatible with Meniscal Tear or Loose Body

- ◯ Mechanical Symptoms Present
- ◯ Mechanical Symptoms Absent

Age (Including Patient Activity Level and Physiologic Status)

- ◯ Young
- ◯ Middle-Aged
- ◯ Elderly

SUBMIT

https://www.orthoguidelines.org/go/auc/auc.cfm?auc_id=225073

APPROPRIATE USE CRITERIA: MANAGEMENT OF OSTEOARTHRITIS OF THE KNEE (NON-ARTHROPLASTY) AUC (2022)

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SUBMIT

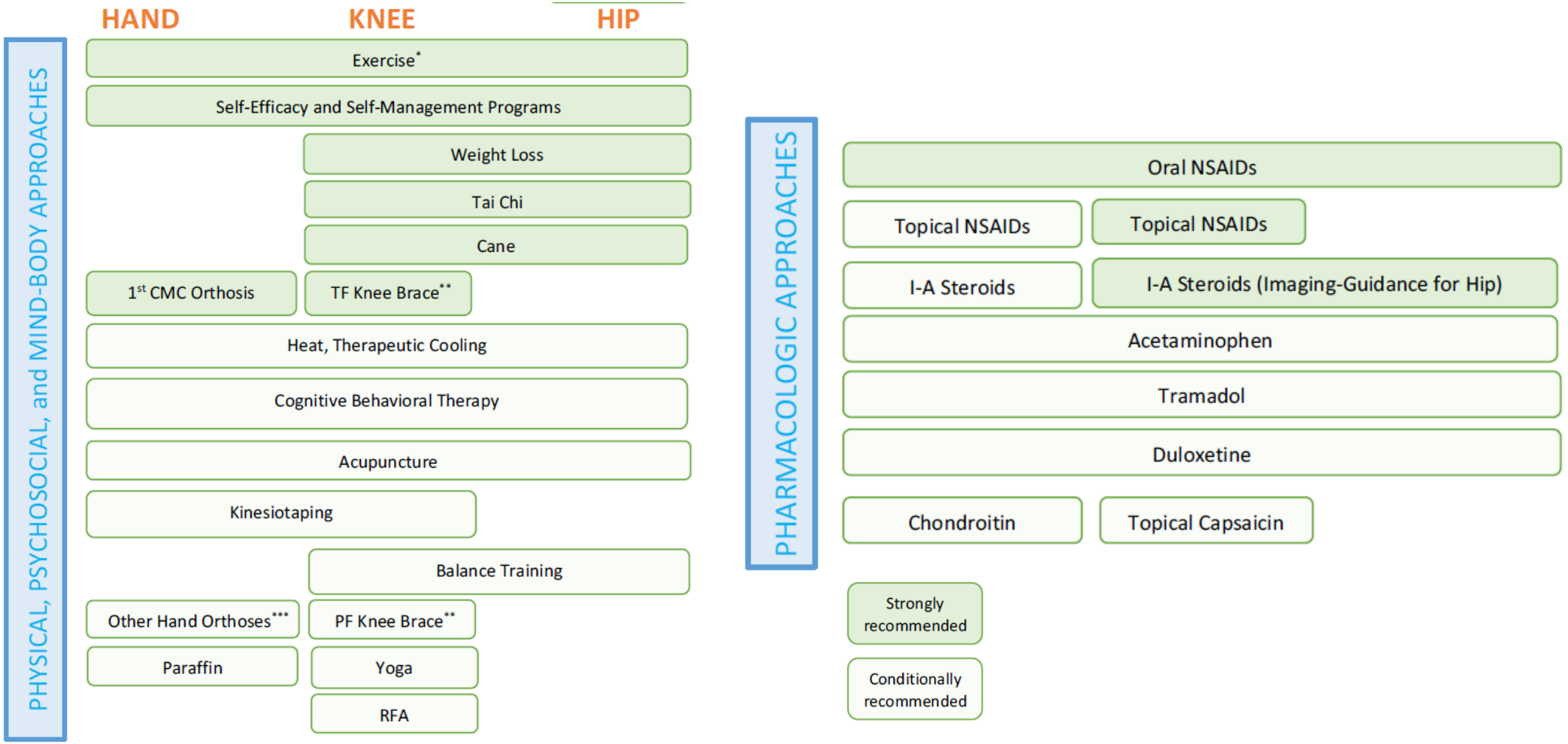
PROCEDURE RECOMMENDATIONS

✓	**Self-Management Programs (unsupervised exercise, tai chi, weight loss, aerobic walking)**	8
✓	**Prescribed Physical Therapy (Supervised Exercise, manual therapy, neuromuscular training, etc.)**	8
✓	**Hinged Knee Brace and/or Unloading Brace, Assistive Devices (e.g., cane, walker)**	7
✓	**NSAID or Acetaminophen**	
✓	**Intraarticular Corticosteroids**	8
✗	**Arthroscopic Partial Meniscectomy or Shaving**	3
✗	**PRP**	3

E-MAIL RESULTS | PRINT | COPY

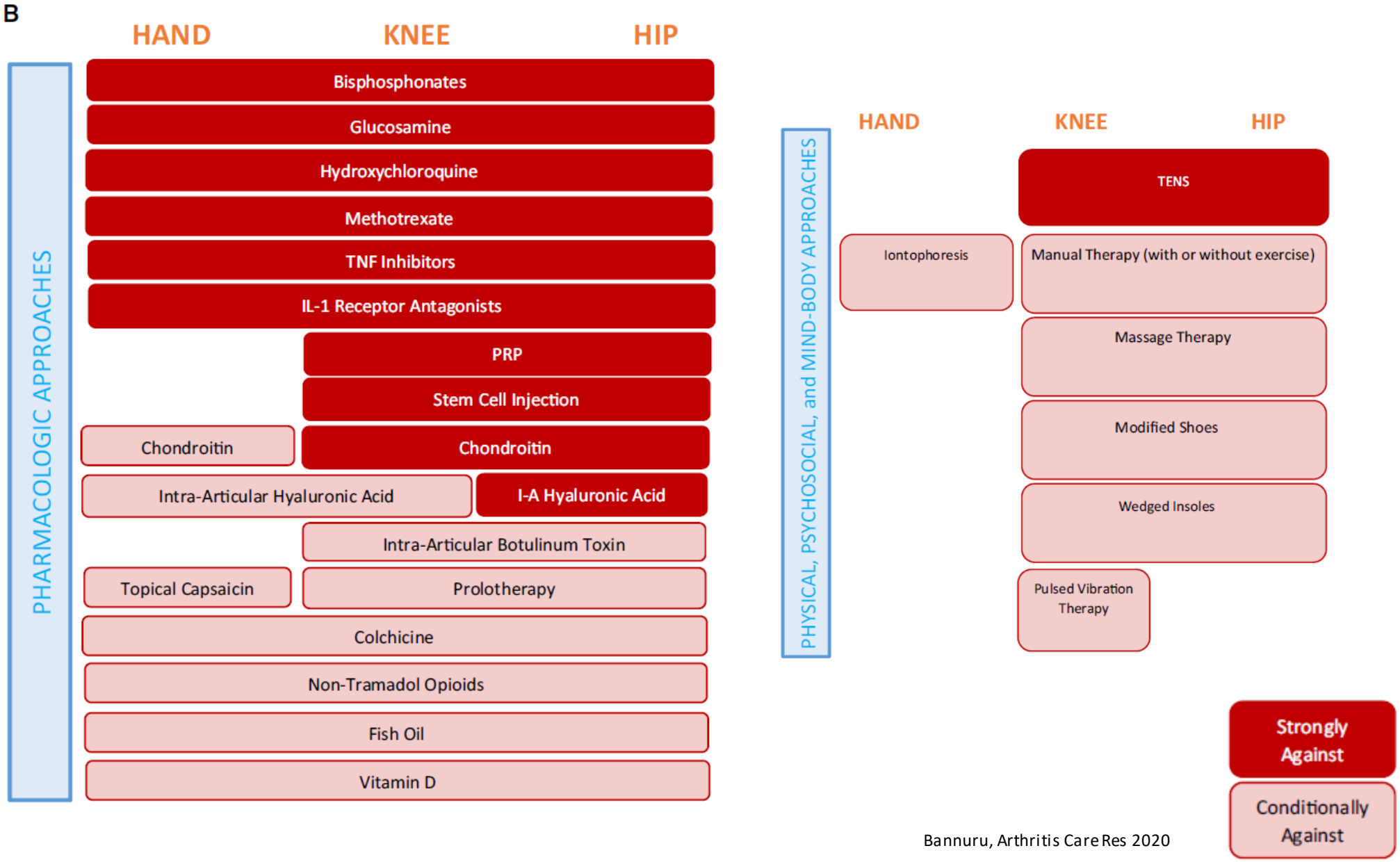
https://www.orthoguidelines.org/go/auc/auc.cfm?auc_id=225073

ACR guidelines (2019)



Bannuru, Arthritis Care Res 2020

ACR guidelines (2019)



Bannuru, Arthritis Care Res 2020

Table 2. Recommendations for the pharmacologic management of osteoarthritis of the hand, knee, and hip

Intervention	Joint		
	Hand	Knee	Hip
Topical nonsteroidal antiinflammatory drugs			
Topical capsaicin			
Oral nonsteroidal antiinflammatory drugs			
Intraarticular glucocorticoid injection			
Ultrasound-guided intraarticular glucocorticoid injection			
Intraarticular glucocorticoid injection compared to other injections			
Acetaminophen			
Duloxetine			
Tramadol			
Non-tramadol opioids			
Colchicine			
Fish oil			
Vitamin D			
Bisphosphonates			
Glucosamine			
Chondroitin sulfate			
Hydroxychloroquine			
Methotrexate			
Intraarticular hyaluronic acid injection	(First carpometacarpal)		
Intraarticular botulinum toxin			
Prolotherapy			
Platelet-rich plasma			
Stem cell injection			
Biologics (tumor necrosis factor inhibitors, interleukin-1 receptor antagonists)			

Strongly recommended
Conditionally recommended
Strongly recommended against
Conditionally recommended against
No recommendation

Bannuru, Arthritis Care Res 2020

Guidelines: critique

Clin Orthop Relat Res (2022) 480:1-3
DOI 10.1097/CORR.0000000000002068

Clinical Orthopaedics and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

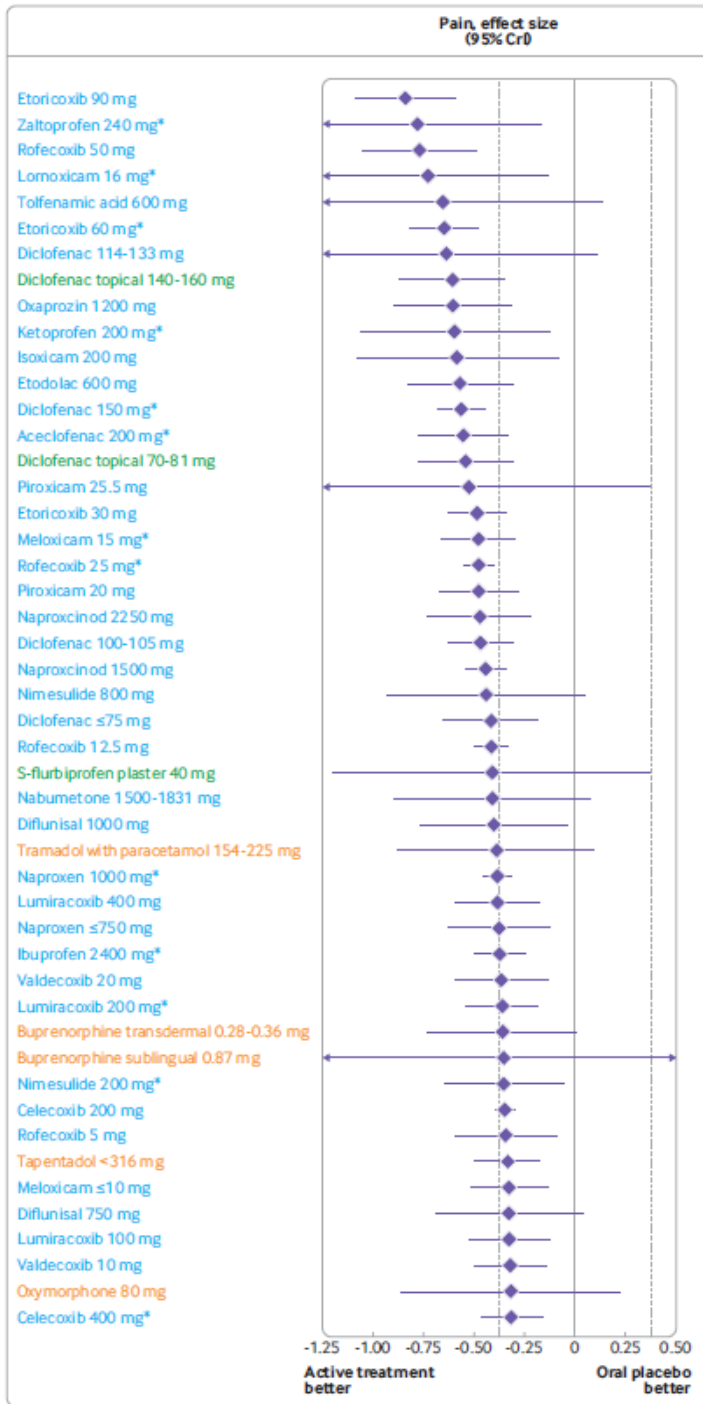
Editorial

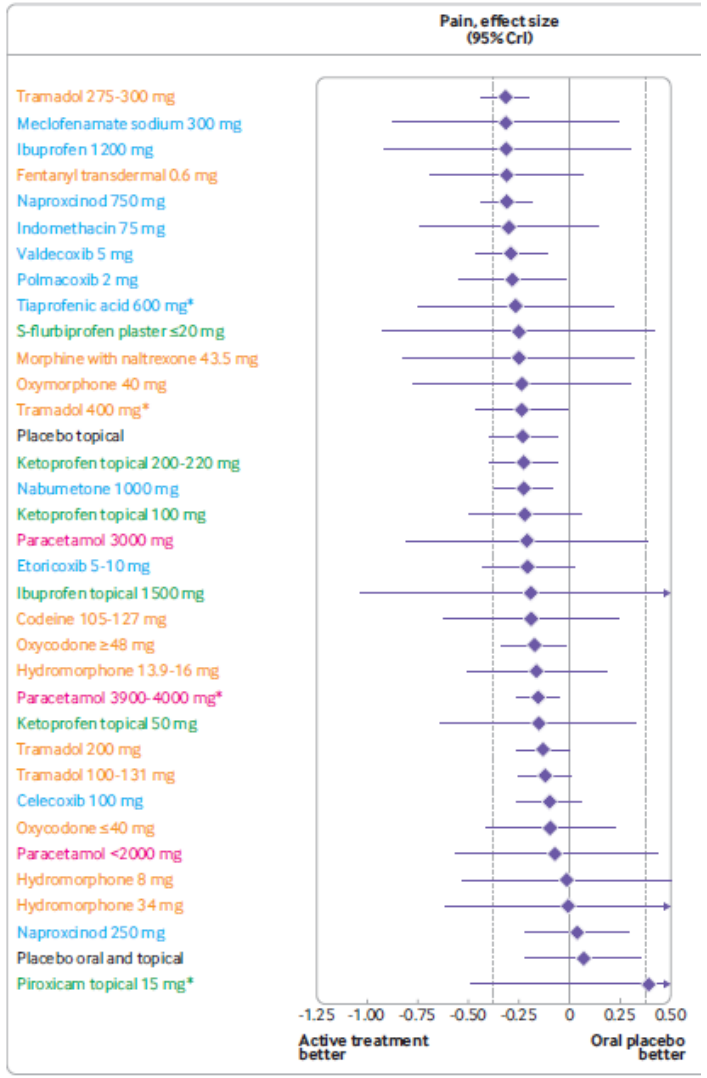
Published online: 25 November 2021

Editorial: The New AAOS Guidelines on Knee Arthroscopy for Degenerative Meniscus Tears are a Step in the Wrong Direction

Seth S. Leopold MD[1]

Guidelines: critique



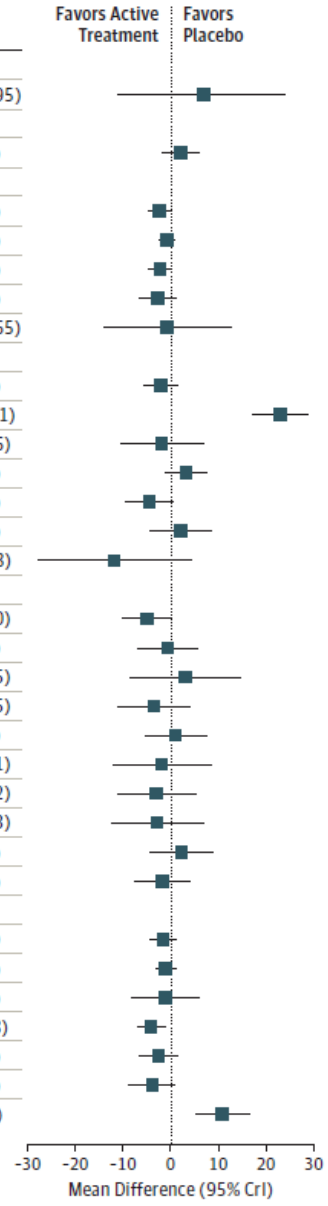


Da Costa, BMJ 2022

Guidelines: critique

Figure 2. Forest Plot for the Estimates of Long-term Treatment Effects of Interventions on Knee Pain

Type of Intervention	No. of Trials	No. of Patients	Mean Difference (95% CrI)
Analgesics			
Acetaminophen	1	27	7.00 (-10.86 to 23.95)
Antioxidants			
Vitamin E	1	59	2.13 (-1.66 to 5.96)
Bone-acting agents			
Calcitonin	1	695	-2.25 (-4.58 to 0.08)
Risedronate	3	2087	-0.77 (-2.48 to 0.90)
Strontium ranelate	1	899	-2.11 (-4.51 to 0.29)
Vitamin D	2	310	-2.73 (-6.50 to 0.99)
Zoledronic acid	1	29	-0.64 (-14.14 to 12.65)
Intra-articular hyaluronate and corticosteroid injections			
Hyaluronic acid	12	1051	-1.97 (-5.56 to 1.53)
Betamethasone	1	98	23.04 (17.16 to 28.71)
Methylprednisolone	1	60	-1.90 (-10.57 to 6.96)
Triamcinolone	2	103	3.30 (-1.05 to 7.64)
Hyaluronic acid plus betamethasone	1	35	-4.45 (-9.57 to 0.64)
Hyaluronic acid plus methylprednisolone	1	169	2.20 (-4.19 to 8.61)
Hyaluronic acid plus triamcinolone	1	16	-11.79 (-27.72 to 4.18)
Nonsteroidal anti-inflammatory drugs			
Celecoxib	3	690	-4.93 (-10.23 to 0.30)
Diclofenac	5	1090	-0.58 (-6.81 to 5.54)
Etofenamate	1	29	3.18 (-8.48 to 14.75)
Etoricoxib	2	780	-3.40 (-10.92 to 4.05)
Indomethacin	1	202	1.07 (-5.38 to 7.47)
Licofelone	1	147	-1.82 (-12.19 to 8.51)
Naproxen	4	659	-2.98 (-11.21 to 5.22)
Nimesulide	1	183	-2.76 (-12.28 to 6.83)
Rofecoxib	2	979	2.25 (-4.37 to 8.82)
Tiaprofenic acid	1	307	-1.67 (-7.58 to 4.11)
Symptomatic slow-acting drugs in osteoarthritis and putative disease-modifying agents			
Chondroitin sulfate	5	731	-1.47 (-4.21 to 1.27)
Cindunistat	1	971	-0.94 (-3.10 to 1.22)
Diacerein	1	85	-1.07 (-8.13 to 5.94)
Glucosamine sulfate	2	207	-4.07 (-6.99 to -1.18)
Glucosamines	3	325	-2.54 (-6.59 to 1.55)
Glucosamines plus chondroitin sulfate	2	280	-3.85 (-8.72 to 0.87)
Sprifermin	1	122	10.86 (5.28 to 16.48)



Estimates are expressed on a 0 to 100 scale. Point estimates refer to the posterior mean. The bars indicate 95% credibility intervals (CrIs).

Gregori, JAMA 2018

Management of osteoarthritis

Explain that:
- osteoarthritis is diagnosed clinically and usually does not need imaging to confirm diagnosis
- management is guided by symptoms and physical function
- the core treatments are therapeutic exercise and weight management, alongside information and support.

Exercise

- For all people with osteoarthritis, offer therapeutic exercise tailored to their needs (for example, local muscle strengthening, general aerobic fitness).
- Consider supervised therapeutic exercise sessions.
- Advise people it may initially cause pain or discomfort but long-term adherence to an exercise plan will benefit the joints, reduce pain and improve function.
- Consider combining therapeutic exercise with an education programme or behaviour change approaches in a structured treatment package.

Weight management

For people who are living with overweight or obesity:
- advise them that weight loss will improve quality of life and physical function, and reduce pain
- support them to choose a weight loss goal
- explain that any weight loss is likely to be beneficial, but losing 10% is likely to be better than 5%.

For guidance and information on weight management, including interventions for weight loss, see NICE's topic page on obesity.

Information and support

- Tailor information to the person's individual needs and ensure it is in an accessible format.
- Advise where people can find further information on:
  - the condition and information that challenges common misconceptions
  - specific types of exercise
  - managing their symptoms
  - how to access additional information and support
  - benefits and limitations of treatment.

Manual therapy
Only consider for hip and knee osteoarthritis and alongside therapeutic exercise.

Devices
Consider walking aids for lower limb osteoarthritis.

Do not offer:
- acupuncture or dry needling
- electrotherapy treatments
- insoles, braces, tape, splints or supports routinely.

Pharmacological management

If needed, use:
- alongside non-pharmacological treatments and to support therapeutic exercise
- the lowest effective dose for the shortest possible time.

Review with the person whether to continue treatment. Base frequency of reviews on clinical need.

- Offer a topical non-steroidal anti-inflammatory drug (NSAID) for knee osteoarthritis.
- Consider a topical NSAID for other osteoarthritis-affected joints.

Consider an oral NSAID if topical medicines are ineffective or unsuitable and offer a gastroprotective treatment alongside.

Do not offer:
- paracetamol or weak opioids routinely, unless:
  - used infrequently for short-term pain relief
  - all other treatments are ineffective or unsuitable
- glucosamine
- strong opioids
- intra-articular hyaluronan injections.

Consider intra-articular corticosteroid injections for short-term relief when other pharmacological treatments are ineffective or unsuitable or to support therapeutic exercise.

Referral for joint replacement

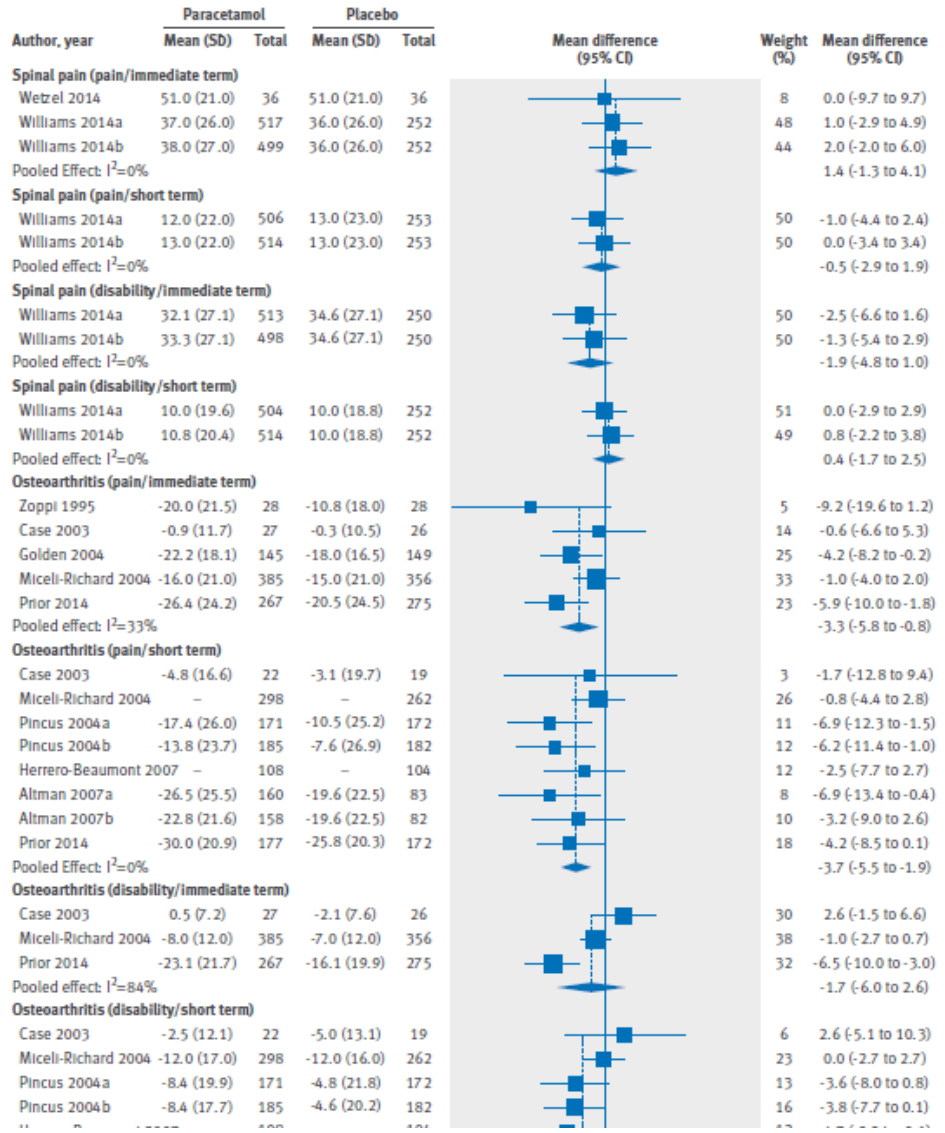
Consider referring people with hip, knee or shoulder osteoarthritis for joint replacement if:
- joint symptoms are substantially impacting their quality of life **and**
- non-surgical management is ineffective or unsuitable.

Do not exclude people from referral for joint replacement because of age, sex or gender, smoking, comorbidities, or overweight or obesity.

This is a summary of the recommendations on managing osteoarthritis in NICE's guideline on osteoarthritis in over 16s: diagnosis and management

NICE National Institute for Health and Care Excellence

Acetaminophen for OA: does it work?



Author, year	Paracetamol Mean (SD)	Paracetamol Total	Placebo Mean (SD)	Placebo Total	Mean difference (95% CI)	Weight (%)	Mean difference (95% CI)
Spinal pain (pain/immediate term)							
Wetzel 2014	51.0 (21.0)	36	51.0 (21.0)	36		8	0.0 (-9.7 to 9.7)
Williams 2014a	37.0 (26.0)	517	36.0 (26.0)	252		48	1.0 (-2.9 to 4.9)
Williams 2014b	38.0 (27.0)	499	36.0 (26.0)	252		44	2.0 (-2.0 to 6.0)
Pooled Effect: I^2=0%							1.4 (-1.3 to 4.1)
Spinal pain (pain/short term)							
Williams 2014a	12.0 (22.0)	506	13.0 (23.0)	253		50	-1.0 (-4.4 to 2.4)
Williams 2014b	13.0 (22.0)	514	13.0 (23.0)	253		50	0.0 (-3.4 to 3.4)
Pooled effect: I^2=0%							-0.5 (-2.9 to 1.9)
Spinal pain (disability/immediate term)							
Williams 2014a	32.1 (27.1)	513	34.6 (27.1)	250		50	-2.5 (-6.6 to 1.6)
Williams 2014b	33.3 (27.1)	498	34.6 (27.1)	250		50	-1.3 (-5.4 to 2.9)
Pooled effect: I^2=0%							-1.9 (-4.8 to 1.0)
Spinal pain (disability/short term)							
Williams 2014a	10.0 (19.6)	504	10.0 (18.8)	252		51	0.0 (-2.9 to 2.9)
Williams 2014b	10.8 (20.4)	514	10.0 (18.8)	252		49	0.8 (-2.2 to 3.8)
Pooled effect: I^2=0%							0.4 (-1.7 to 2.5)
Osteoarthritis (pain/immediate term)							
Zoppi 1995	-20.0 (21.5)	28	-10.8 (18.0)	28		5	-9.2 (-19.6 to 1.2)
Case 2003	-0.9 (11.7)	27	-0.3 (10.5)	26		14	-0.6 (-6.6 to 5.3)
Golden 2004	-22.2 (18.1)	145	-18.0 (16.5)	149		25	-4.2 (-8.2 to -0.2)
Miceli-Richard 2004	-16.0 (21.0)	385	-15.0 (21.0)	356		33	-1.0 (-4.0 to 2.0)
Prior 2014	-26.4 (24.2)	267	-20.5 (24.5)	275		23	-5.9 (-10.0 to -1.8)
Pooled effect: I^2=33%							-3.3 (-5.8 to -0.8)
Osteoarthritis (pain/short term)							
Case 2003	-4.8 (16.6)	22	-3.1 (19.7)	19		3	-1.7 (-12.8 to 9.4)
Miceli-Richard 2004	–	298	–	262		26	-0.8 (-4.4 to 2.8)
Pincus 2004a	-17.4 (26.0)	171	-10.5 (25.2)	172		11	-6.9 (-12.3 to -1.5)
Pincus 2004b	-13.8 (23.7)	185	-7.6 (26.9)	182		12	-6.2 (-11.4 to -1.0)
Herrero-Beaumont 2007	–	108	–	104		12	-2.5 (-7.7 to 2.7)
Altman 2007a	-26.5 (25.5)	160	-19.6 (22.5)	83		8	-6.9 (-13.4 to -0.4)
Altman 2007b	-22.8 (21.6)	158	-19.6 (22.5)	82		10	-3.2 (-9.0 to 2.6)
Prior 2014	-30.0 (20.9)	177	-25.8 (20.3)	172		18	-4.2 (-8.5 to 0.1)
Pooled Effect: I^2=0%							-3.7 (-5.5 to -1.9)
Osteoarthritis (disability/immediate term)							
Case 2003	0.5 (7.2)	27	-2.1 (7.6)	26		30	2.6 (-1.5 to 6.6)
Miceli-Richard 2004	-8.0 (12.0)	385	-7.0 (12.0)	356		38	-1.0 (-2.7 to 0.7)
Prior 2014	-23.1 (21.7)	267	-16.1 (19.9)	275		32	-6.5 (-10.0 to -3.0)
Pooled effect: I^2=84%							-1.7 (-6.0 to 2.6)
Osteoarthritis (disability/short term)							
Case 2003	-2.5 (12.1)	22	-5.0 (13.1)	19		6	2.6 (-5.1 to 10.3)
Miceli-Richard 2004	-12.0 (17.0)	298	-12.0 (16.0)	262		23	0.0 (-2.7 to 2.7)
Pincus 2004a	-8.4 (19.9)	171	-4.8 (21.8)	172		13	-3.6 (-8.0 to 0.8)
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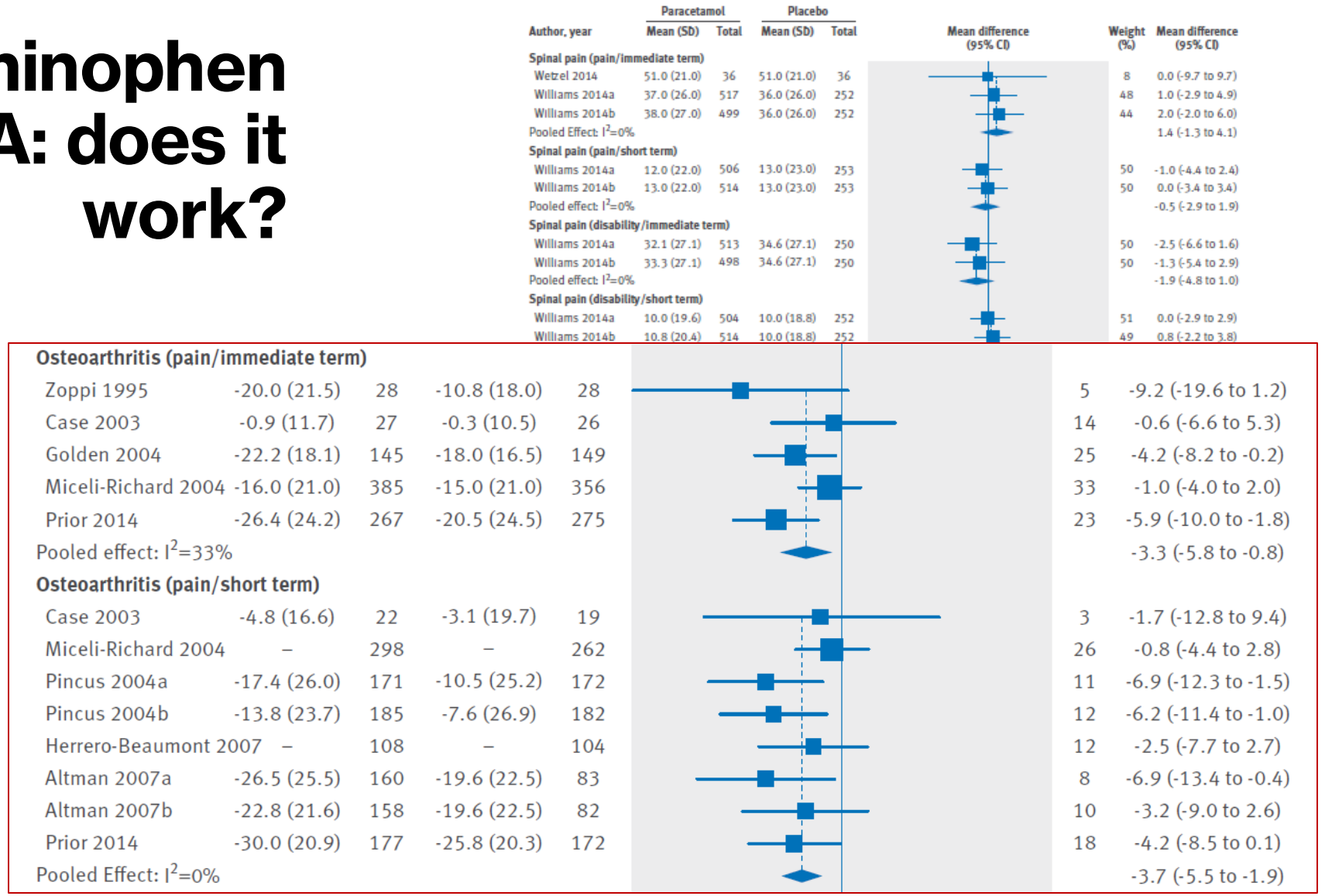
Machado, BMJ 2015

Acetaminophen for OA: does it work?



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Machado, BMJ 2015

Acetaminophen for OA: does it work?

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[3]Department of Clinical Pharmacology, St Vincent's Hospital and University of New South Wales, Sydney, NSW 2010, Australia
[4]School of Medical Sciences, Department of Medicine, University of New South Wales, Sydney, NSW 2033, Australia
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Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmj.h1225)

ABSTRACT

OBJECTIVE
To investigate the efficacy and safety of paracetamol (acetaminophen) in the management of spinal pain and osteoarthritis of the hip or knee.

DESIGN
Systematic review and meta-analysis.

DATA SOURCES
Medline, Embase, AMED, CINAHL, Web of Science, LILACS, International Pharmaceutical Abstracts, and Cochrane Central Register of Controlled Trials from inception to December 2014.

ELIGIBILITY CRITERIA FOR SELECTING STUDIES
Randomised controlled trials comparing the efficacy and safety of paracetamol with placebo for spinal pain (neck or low back pain) and osteoarthritis of the hip or knee.

DATA EXTRACTION
Two independent reviewers extracted data on pain, disability, and quality of life. Secondary outcomes were adverse effects, patient adherence, and use of rescue medication. Pain and disability scores were converted to a scale of 0 (no pain or disability) to 100 (worst possible pain or disability). We calculated weighted mean differences or risk ratios and 95% confidence intervals using a random effects model. The Cochrane Collaboration's tool was used for assessing risk of bias, and the GRADE approach was

ineffective for reducing pain intensity (weighted mean difference −0.5, 95% confidence interval −2.9 to 1.9) and disability (0.4, −1.7 to 2.5) or improving quality of life (0.4, −0.9 to 1.7) in the short term in people with low back pain. For hip or knee osteoarthritis there was "high quality" evidence that paracetamol provides a significant, although not clinically important, effect on pain (−3.7, −5.5 to −1.9) and disability (−2.9, −4.9 to −0.9) in the short term. The number of patients reporting any adverse event (risk ratio 1.0, 95% confidence interval 0.9 to 1.1), any serious adverse event (1.2, 0.7 to 2.1), or withdrawn from the study because of adverse events (1.2, 0.9 to 1.5) was similar in the paracetamol and placebo groups. Patient adherence to treatment (1.0, 0.9 to 1.1) and use of rescue medication (0.7, 0.4 to 1.3) was also similar between groups. "High quality" evidence showed that patients taking paracetamol are nearly four times more likely to have abnormal results on liver function tests (3.8, 1.9 to 7.4), but the clinical importance of this effect is uncertain.

CONCLUSIONS
Paracetamol is ineffective in the treatment of low back pain and provides minimal short term benefit for people with osteoarthritis. These results support the reconsideration of recommendations to use paracetamol for patients with low back pain and osteoarthritis of the hip or knee in clinical practice guidelines.

Machado, BMJ 2015

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Machado, BMJ 2015

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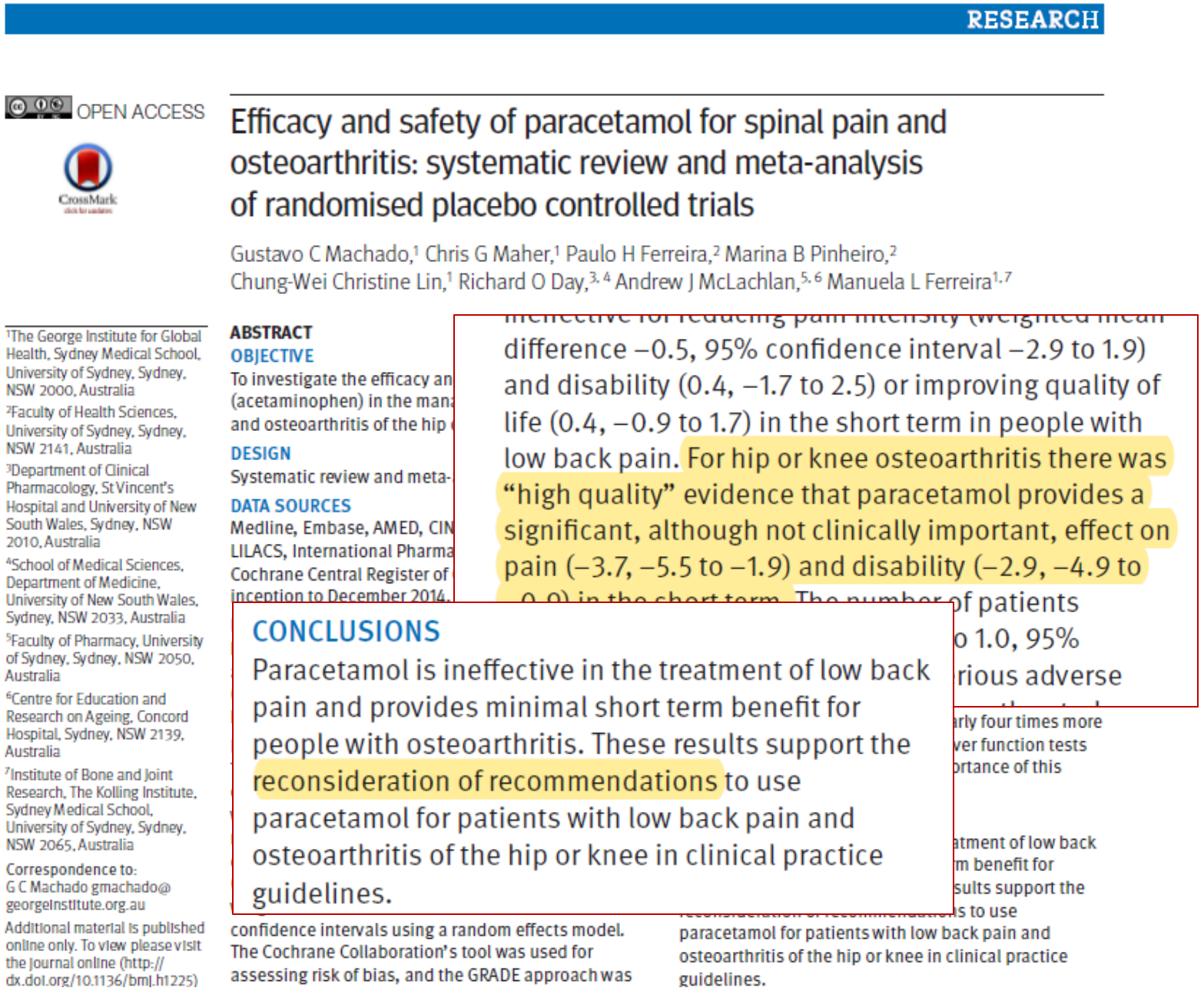

RESEARCH

OPEN ACCESS

Efficacy and safety of paracetamol for spinal pain and osteoarthritis: systematic review and meta-analysis of randomised placebo controlled trials

Gustavo C Machado,[1] Chris G Maher,[1] Paulo H Ferreira,[2] Marina B Pinheiro,[2] Chung-Wei Christine Lin,[1] Richard O Day,[3,4] Andrew J McLachlan,[5,6] Manuela L Ferreira[1,7]

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Machado, BMJ 2015

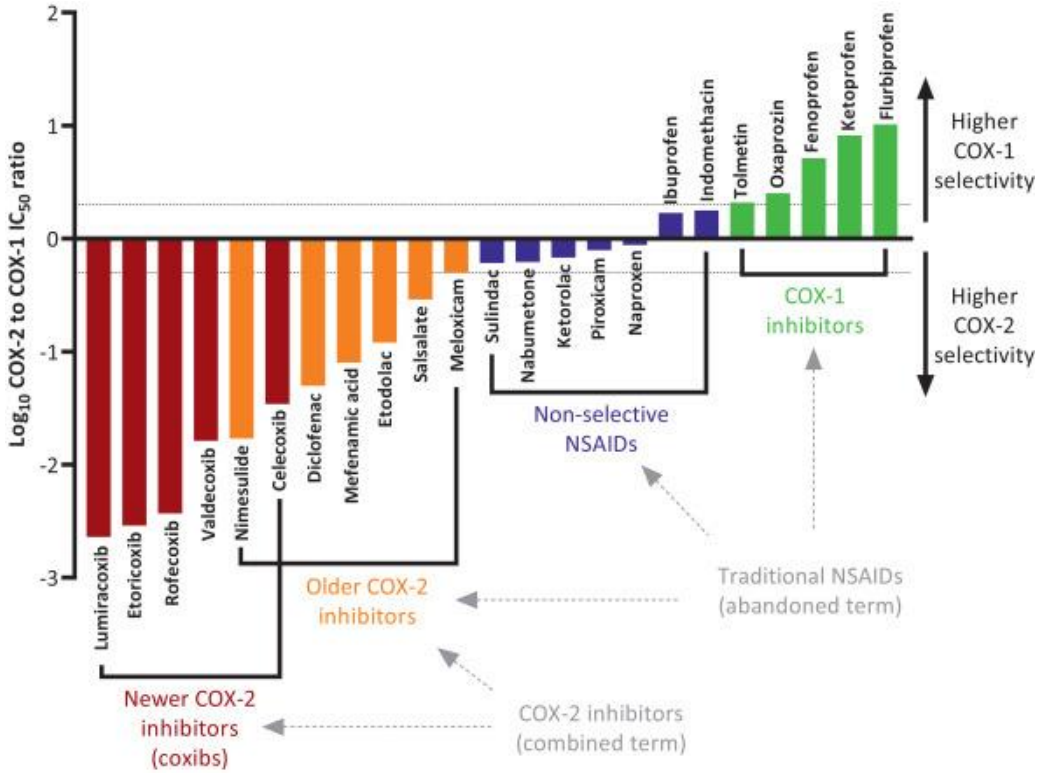
ΜΣΑΦ

Διαφορετικά προφίλ (εκλεκτικότητα COX-1 & COX-2)

Προφίλ ανεπιθύμητων ενεργειών

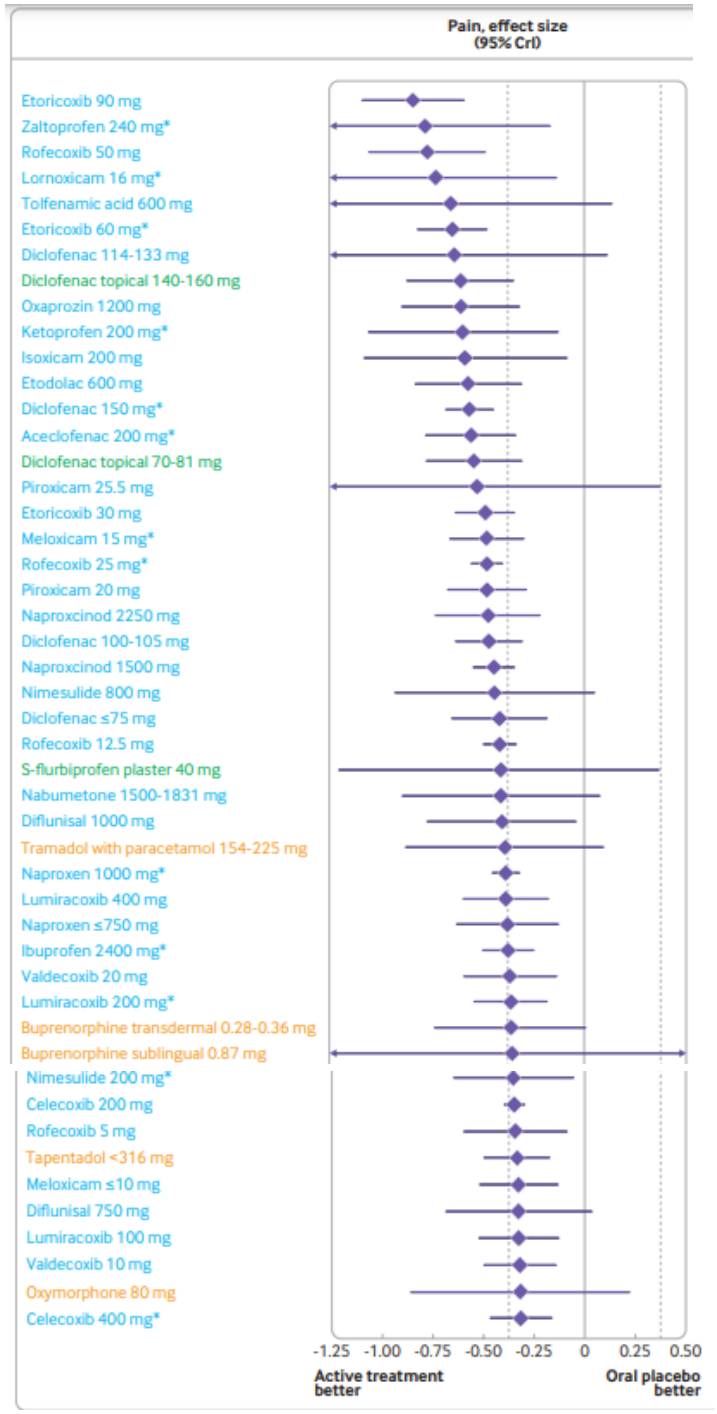
Προφίλ ασθενούς

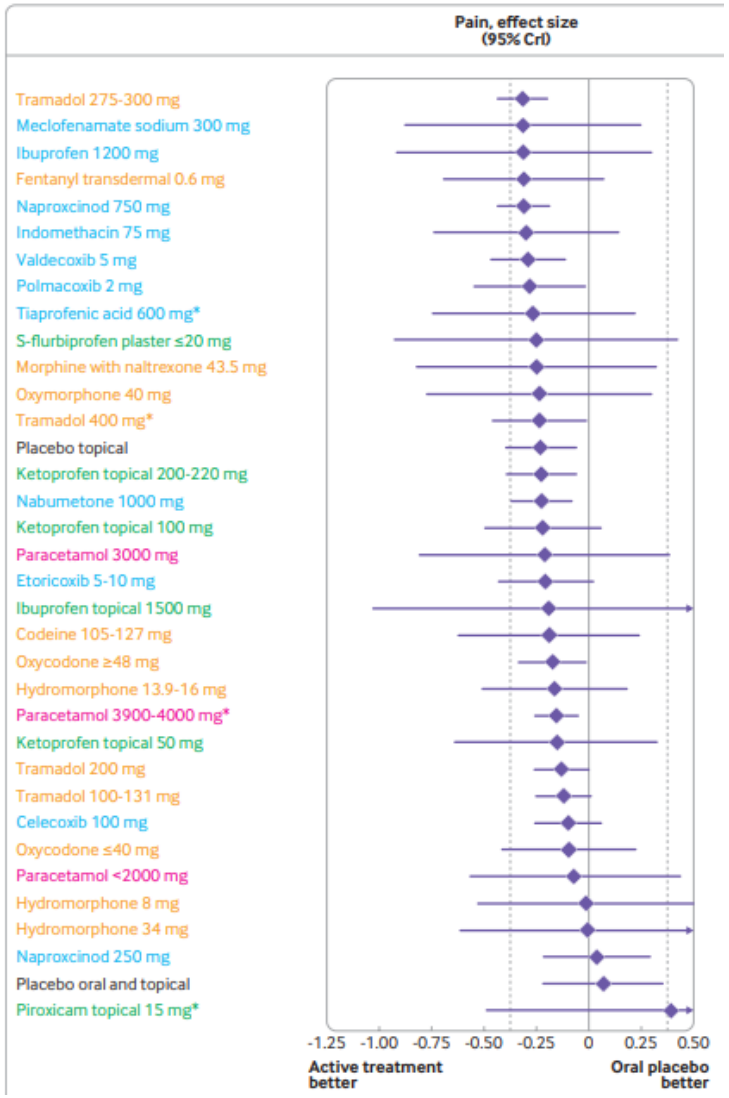
Εκλεκτικότητα COX-1/2



Bonnesen and Schmidt, Can J Cardiol 2021

NSAIDs: do they work in OA?





Da Costa, BMJ 2021

Χειρουργική θεραπεία

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Ολική αρθροπλαστική (total joint arthroplasty)

Ημιαρθροπλαστική (unicompartmental)

Οστεοτομίες (tibial osteotomy)

Αρθροσκοπική έκπλυση και καθαρισμός (lavage and debridement)

Μερική μηνισκεκτομή (partial meniscectomy)

Ολική αρθροπλαστική

Καλά αποτελέσματα

Πολλές τεχνικές

Χρόνος αναθεώρησης (revision)

Προεγχειρητική εκτίμηση κινδύνου

Προεγχειρητική προετοιμασία (απώλεια βάρους, ασκηση, φυσικοθεραπεία)

https://www.aaos.org/globalassets/quality-and-practice-resources/surgical-management-knee/smoak2cpg.pdf

Ολική αρθροπλαστική- διάρκεια ζωής εμφυτευμάτων

Ισχίο:
10 ετής επιβίωση του εμφυτεύματος: 95,6%
20-ετης επιβίωση του εμφυτεύματος: 85%

Γόνατο:
10 ετής επιβίωση του εμφυτεύματος: 96,1%
20-ετης επιβίωση του εμφυτεύματος: 89,7%

Bayliss, Lancet 2017

Μία κρίσιμη παράμετρος: η ηλικία

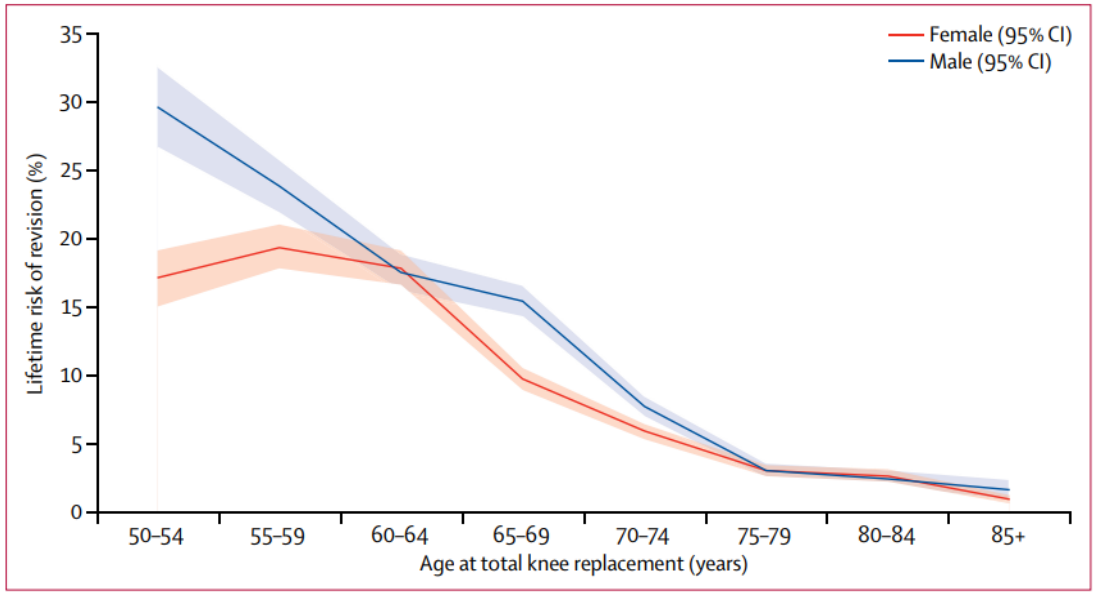


***Figure 2*: Lifetime risk of revision after total hip replacement**
Plot showing estimates of lifetime risk of total hip replacement revision against age at the time of total hip replacement primary surgery (in 5-year age bands) and stratified by sex (results adjusted for lost and censored population).

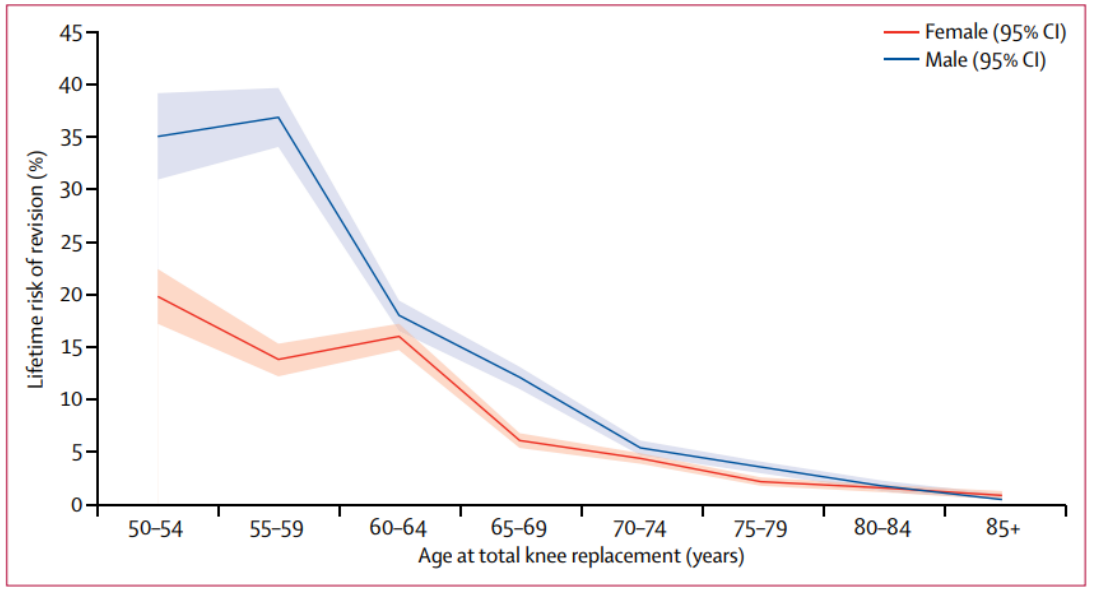


***Figure 3*: Lifetime risk of revision after total knee replacement**
Plot showing estimates of lifetime risk of total knee replacement revision against age at the time of primary total knee replacement surgery (in 5-year age bands) and stratified by sex (results adjusted for lost and censored population).

Bayliss, Lancet 2017

Ημιαρθροπλαστική (unicompartmental)

UNICOMPARTMENTAL VS. TOTAL KNEE ARTHROPLASTY

The practitioner can use unicompartmental arthroplasty vs total knee arthroplasty for patients with predominantly medial compartment osteoarthritis, as evidence reports improved patient reported and functional outcomes in the short term; however, long-term rates of revision in unicompartmental knee arthroplasty may be higher than total knee arthroplasty.

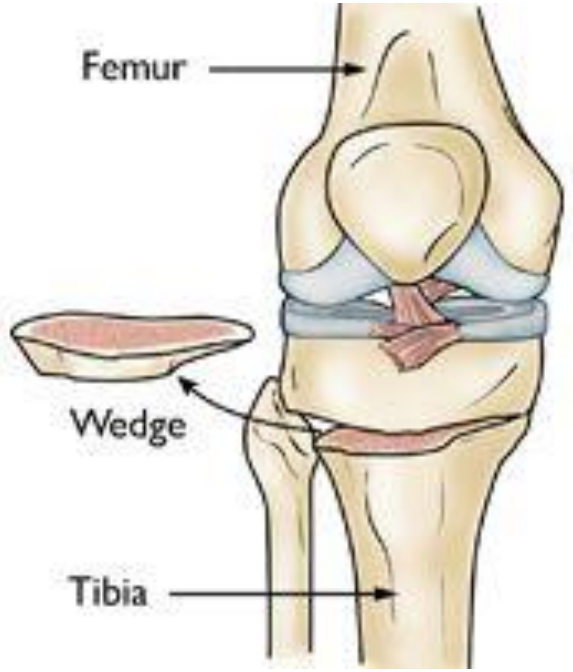
Strength of Evidence: Strong

Strength of Recommendation: Moderate ★★★☆ (downgraded)

Evidence from two or more "Moderate" quality studies with consistent findings, or evidence from a single "High" quality study for recommending for or against the intervention. Also, higher strength evidence can be downgraded to limited due to major concerns addressed in the EtD Framework.

https://www.aaos.org/globalassets/quality-and-practice-resources/surgical-management-knee/smoak2cpg.pdf

Οστεοτομία



https://journals.lww.com/jaaos/Fulltext/2022/05010/AAOS_Clinical_Practice_Guideline_Summary_.10.aspx

Οστεοτομία

Tibial Osteotomy

High tibial osteotomy may be considered to improve pain and function in properly indicated patients with unicompartmental knee osteoarthritis.

Strength of recommendation: Limited. ★★☆☆ (downgrade)

https://journals.lww.com/jaaos/Fulltext/2022/05010/AAOS_Clinical_Practice_Guideline_Summary_.10.aspx

Lavage and debribement

Lavage/Débridement

Arthroscopy with lavage and/or débridement in patients with a primary diagnosis of knee osteoarthritis is not recommended.

Strength of recommendation: Moderate. 

https://journals.lww.com/jaaos/Fulltext/2022/05010/AAOS_Clinical_Practice_Guideline_Summary_.10.aspx

Partial meniscectomy

Partial Meniscectomy

Arthroscopic partial meniscectomy can be used for the treatment of meniscal tears in patients with concomitant mild-to-moderate osteoarthritis who have failed physical therapy or other nonsurgical treatments.

Strength of recommendation: Moderate. 

https://journals.lww.com/jaaos/Fulltext/2022/05010/AAOS_Clinical_Practice_Guideline_Summary_.10.aspx

Συμπερασματα

Εξατομικευμένη προσέγγιση

("θετική" ανάλογα με την εστία, την βαρύτητα, την λειτουργική επιβάρυνση κλπ)

("αρνητική" ανάλογα με το προφίλ ασθενούς/ κίνδυνο τοξικότητας)

ΠΑυσίπονα (παρακεταμόλη/ ασθενή οπιοειδή)

ΜΣΑΦ

Ενδοαρθρικές ενεσεις (κορτικοειδή)

Συμπερασματα

Εμφαση στην μη φαρμακευτική θεραπεία:

- Ασκηση
- Φυσικοθεραπεία
- Απώλεια βάρους