

A newsletter by primary care practitioners on behalf of Arthritis Research UK | **Spring 2010** | No 29

Editorial

Never has so much information been so accessible to so many. In not much more than the time it takes for you to read this issue of Synovium it is possible (with an Athens password) to scan the contents pages of the latest issues of the leading rheumatology journals, identify the articles of relevance to you as a primary care physician and save them to your own virtual library. Or you can sign up to online newsletters that do this job for you. And if you don't know what things like low-level lasers are then Wikipedia will oblige. Although we know from the editorial inbox how much Synovium is appreciated there really is far more developing knowledge out there than we have space to include, so don't wait for the next issue – start surfing yourself!

Adrian Dunbar

Nobody does it better!

It is generally accepted that specialists in high-volume centres deliver the best care. This has been demonstrated for surgical and other invasive procedures and in acute illness, for example myocardial infarction. However, a review recently published in the *International Journal for Quality in Health Care* comparing treatment outcomes in 3 chronic diseases – rheumatoid arthritis, diabetes mellitus and cystic fibrosis – in 22 studies published between 1987 and 2008¹ found no evidence to suggest that care in specialist centres was superior to care provided by primary care generalists.

1. Post PN, Wittenberg J, Burgers JS. Do specialized centers and specialists produce better outcomes for patients with chronic diseases than primary care generalists? A systematic review. *Int J Qual Health Care* 2009 Dec; 21(6):387-96.

Laser treatment for neck pain

Neck pain is a pain in the neck. It is common, often persistent, and responds poorly to medication. So it is encouraging to read that a relatively novel, non-invasive treatment shows evidence of effectiveness. A systematic review and meta-analysis of 16 randomised controlled trials of low-level laser therapy (LLLT)¹ yielded 820 patients, for whom data was pooled. LLLT was found to reduce pain immediately after treatment in acute neck pain and up to 22 weeks after completion of treatment in patients with chronic neck pain. Low-level laser – or cold laser – is yet to be established as a medical treatment but, according to Wikipedia, papers are appearing at the rate of around 25 per month, mainly investigating treatment of musculoskeletal disorders. We will be watching.

1. Chow RT, Johnson MI, Lopes-Martins RA, Bjordal JM. Efficacy of low-level laser therapy in the management of neck pain: a systematic review and meta-analysis of randomised placebo or active-treatment controlled trials. *Lancet* 2009 Dec 5;374(9705):1897-908.

Cancer risk after anti-TNF treatment

There is always the concern with powerful immunosuppressive treatments that the short-term benefit might be at the price of increased long-term risk of malignant disease. So it is comforting to read that in a Swedish study following 6366 patients with rheumatoid arthritis treated with the anti-TNF drugs infliximab, adalimumab and etanercept¹ no increased risk of cancer was observed in 6 years of follow-up compared with patients on other therapies or not taking medication. Six years is not long in the timeline of a disease like rheumatoid arthritis and clearly much longer observation is needed, but this is encouraging information for patients.

1. Askling J, van Vollenhoven RF, Granath F et al. Cancer risk in patients with rheumatoid arthritis treated with anti-tumor necrosis factor alpha therapies: does the risk change with the time since start of treatment? *Arthritis Rheum* 2009 Nov;60(11):3180-9.

Intra-articular steroid or hyaluronan injections for OA knee

Given that NICE guidelines (www.nice.org.uk/cg59) have recommended steroid but not hyaluronan injections for knee osteoarthritis, a review of studies comparing these two treatments¹ is timely. Pooled data from 7 randomised trials involving over 600 patients revealed that steroids were more effective in relieving pain at 2 weeks, that the two treatments were equally effective at 4 weeks, and that at 8, 12 and 26 weeks hyaluronan was more effective. Hyaluronan injections are significantly more expensive than steroid injections and, as they are typically administered in a course of 3 injections given at weekly intervals, are heavy on appointment time. They appear safe and have fewer potential adverse effects or interactions with other medication. Does the longer duration of effectiveness justify the extra cost – given that it would appear that an equal or greater number of steroid injections might be needed to produce the same duration of symptom relief? Might a single – larger-dose – injection of hyaluronan be just as effective?

A very recent study from France² suggests it might be. In a randomised controlled trial 253 patients were allocated to receive 6 ml of hyaluronan (hylan G-F 20) – equal to three times the usual single injection – or placebo. Pain relief and functional capacity were assessed at 4, 8, 12, 18 and 26 weeks and found to be significantly improved after hyaluronan – although a significant placebo response was also noted. Another question to which we don't yet know the answer is whether there might be a case for injecting both steroids and hyaluronan at the same time.

1. Bannuru RR, Natov NS, Obadan IE, Price LL, Schmid CH, McAlindon TE. Therapeutic trajectory of hyaluronic acid versus corticosteroids in the treatment of knee osteoarthritis: a systematic review and meta-analysis. *Arthritis Rheum* 2009 Dec 15;61(12):1704-11.

2. Chevalier X, Jerosch J, Goupille P et al. Single, intra-articular treatment with 6 ml hylan G-F 20 in patients with symptomatic primary osteoarthritis of the knee: a randomised, multicentre, double-blind, placebo controlled trial. *Ann Rheum Dis* 2010 Jan;69(1):113-9.

The cost of osteoarthritis

One of those studies where the figures make the brain dizzy was recently published in *Arthritis and Rheumatism*.¹ The study uses data from health insurance claims to calculate the medical costs of osteoarthritis (OA) in the United States. (Remember this is based on people who are able to afford health insurance – and, as President Obama announced in 2009, almost 50 million Americans can't.) Over 27 million Americans were estimated by the National Arthritis Data Workgroup to be suffering from OA, and this study found that annual medical costs attributable to OA were a staggering \$185.5 billion. It is predicted that by 2030, 67 million people in the USA – or 25% of the adult population – will suffer from OA.

Given that it is unlikely that medical care will become any cheaper over the next 20 years (or that people will die at a younger age), the potential medical care costs will be truly mind-boggling. Of course, this is the USA and medical care is very much more expensive than in the UK; however, the predicted demographics for life expectancy, obesity and sedentary lifestyles appear to be indicating rapid increase in the prevalence of OA here too. Given the economic climate and expectations of a significant period of austerity, life is going to be difficult for OA sufferers unless we can achieve significant improvement in prevention strategies and find treatments to delay progression.

1. Kotlarz H, Gunnarsson CL, Fang H, Rizzo JA. Insurer and out-of-pocket costs of osteoarthritis in the US: evidence from national survey data. *Arthritis Rheum* 2009 Dec;60(12):3546-53.

In praise of... 'NHS Evidence – musculoskeletal'

Synovium readers may also enjoy and find useful the e-newsletter of the 'NHS Evidence – musculoskeletal' specialist collection, and indeed their website library where you may sign up for the newsletter. In the January 2010 newsletter there is another and larger review of the evidence for the effectiveness of the nutraceuticals glucosamine and chondroitin in slowing the progression of osteoarthritis. (And we know how much interest glucosamine generates among Synovium readers from the volume of emails in the editorial inbox.) The results – limited evidence for glucosamine sulphate, little or inconsistent evidence for other glucosamine salts and chondroitin – are similar to those we have previously reported from manufacturer-sponsored trials in non-UK populations. There is also a review of the efficacy of opiate drugs in relieving the pain of osteoarthritis of the knee and hip: modest benefits and significant adverse effects, no great differences in either benefits or adverse effects between different opiates or modes of delivery (oral or transdermal) – in other words, best avoided.

Sign up at <http://www.library.nhs.uk/musculoskeletal/>.

Calling all musculoskeletal GPwSIs!

Arthritis Research UK is compiling a national database of GPs with Special Interests working in the fields of musculoskeletal medicine, rheumatology and orthopaedics, for the purposes of educational development and peer support.

If you are interested in being included in the database please send your contact details to:
f.mawer@arthritisresearch.uk.org