

key points

SELECTED BY

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Osteoarthritis has become a major chronic pain condition.

It affects more than 10% of adults and accounts for almost 10% of health service resources. The impact of osteoarthritis is amplified by underuse of effective muscle strengthening exercises and a focus on often less effective and poorly tolerated analgesic therapies. Although traditionally considered to be primarily a disease of cartilage, there is now ample evidence that typical clinical osteoarthritis involves multiple tissue pathologies.

Increased BMI is associated with a higher incidence

of knee osteoarthritis. Anatomical abnormalities such as valgus alignment or previous joint trauma including meniscectomy, anterior cruciate ligament rupture and fracture through the joint are also associated with increased incidence of osteoarthritis.

Pain is the main presenting symptom. However, we still

have a poor understanding of the causes of pain in osteoarthritis. In patients aged 45 or over the diagnosis should be made clinically without investigations if the patient has activity-related joint pain in addition to early morning joint stiffness lasting less than 30 minutes.

Patient education in the form of both verbal and

written information about osteoarthritis and its management (for example, patient leaflets from Arthritis Research UK) is key. Non-pharmacological therapies including targeted muscle strengthening, aerobic exercise, weight loss if overweight, aids and orthotic devices are integral in the long-term management of osteoarthritis. Strategies to improve adherence to exercise or muscle strengthening activities are a major priority. Muscle strengthening and aerobic exercise have been shown to improve joint pain and function. Weight loss not only improves joint pain and function but has a myriad of other health benefits, reducing the incidence of lifestyle associated diseases such as cardiovascular disease and type 2 diabetes, and mechanical stress on the joints.

Conventional analgesia provides variable benefit to

patients with osteoarthritis. Pharmacological management should be tailored to the individual and depends on factors such as pain severity and time of day when pain is most troublesome. Topical capsaicin has also been found to be cost effective in comparison with placebo in the treatment of hand or knee osteoarthritis. Patients with osteoarthritis should be supported with non-surgical core treatments for at least three months prior to referral for consideration of joint surgery. There is no evidence to support the use of scoring tools to identify which patients are eligible for referral for orthopaedic surgery. Arthroscopy with debridement is not useful for most patients with knee osteoarthritis.