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EDITORIAL

John Hickner, MD, MSc
Editor-in-Chief

4 pearls for treating musculoskeletal pain

Musculoskeletal complaints are one of the top reasons patients visit family physicians, with more than 24 million encounters per year.[1] Two articles in this month's issue of *JFP* discuss treatments for musculoskeletal pain.

The article by Drs. Stephen and Peter Carek (page 534) summarizes the value of specific exercises for hip and knee osteoarthritis (OA), chronic back pain, chronic shoulder pain, Achilles tendinitis, and lateral epicondylitis. This month's PURL (page 566) summarizes a negative randomized trial of treatment of knee OA with the popular over-the-counter combination of glucosamine and chondroitin. The findings? The group taking placebo actually had superior pain relief at 6 months!

Studies remind us to harness the placebo effect, rather than dismiss it.

What else works … and doesn't? You may find that the following 4 "pearls," taken from the literature, are also useful to know as you seek to manage patients' musculoskeletal pain.

Pearl #1. Don't use diazepam (valium) for acute low back pain. It doesn't improve pain or function for this back pain. One hundred fourteen patients with acute low back pain were randomized to naproxen 500 mg bid as needed plus either placebo or diazepam 5 mg, 1 or 2 tablets, every 12 hours prn. At 7 days, 32% of the diazepam group reported moderate to severe pain and 22% of the placebo group did.[2]

Pearl #2. Use naproxen alone when treating acute low back pain. Three hundred twenty-three patients with acute low back pain were randomized to receive naproxen 500 mg bid plus placebo; naproxen plus oxycodone/acetaminophen; or naproxen plus cyclobenzaprine.[3] At 7 days and 3 months, pain and function scores did not differ between groups.

Pearl #3. Don't inject knees with corticosteroids. Enroll these patients in exercise and walking programs, which do provide benefit. One hundred forty patients with moderately severe knee OA were randomized to saline or triamcinolone 40 mg intra-articular injections every 3 months for 2 years.[4] There was no difference in pain or function scores measured every 3 months and there was more cartilage degeneration in the triamcinolone group.

Pearl #4. Don't dismiss the placebo effect. Eighty-three patients with chronic low back pain were randomized to either continue their current pain medications or to continue their current pain medication plus a placebo tablet twice daily for 3 weeks.[5] They were told that placebos can have significant pain-relieving qualities. At 3 weeks, the patients taking placebo had less pain than those not taking placebo.

I'm not sure if we should start prescribing placebos, but this study is a strong reminder that we should harness the placebo effect, rather than dismiss it.

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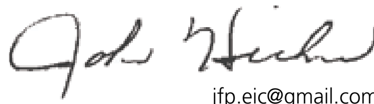

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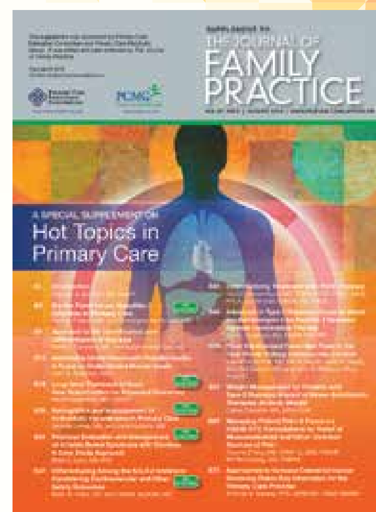

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