Experts Propose IA Pain Management Scheme

BY SHARON WORCESTER

FROM THE ANNUAL EUROPEAN CONGRESS OF RHEUMATOLOGY

A newly developed evidence-based set of recommendations and an algorithm for pharmacotherapy-based pain management in inflammatory arthritis achieved a high level of agreement among a multinational panel of rheumatologists who constitute the 2010 3e Initiative, according to Dr. Samuel Whittle.

The 3e (Evidence, Expertise, Exchange) Initiative is a multinational collaboration that aims to promote evidence-based medicine in rheumatology.

For recommendations that address pain management by pharmacotherapy in inflammatory arthritis (IA), 89 of 453 rheumatologists from 17 countries who were involved in the initiative developed a list of 10 top clinical questions regarding medical treatment for IA pain.

Based on a systematic literature review performed for each question – ultimately including data from 167 relevant studies – rheumatologists from each country that was represented developed a set of national recommendations, and then multinational recommendations were formulated and assessed for agreement, reported Dr. Whittle of the Queen Elizabeth Hospital near Adelaide, Australia.

The panel made 11 recommendations in total. One of the original 10 questions was addressed by two separate systematic reviews. Six of the recommendations address the role of different analgesic medications, including combination therapy; two address pain-medication safety in patients with gastrointestinal, hepatic, renal, and cardiac comorbidities; one addresses pain measurement scales; one addresses pain management during the preconception period, pregnancy, and lactation; and one addresses the safety of analgesics in combination with methotrexate.

The level of agreement on the recommendations by the panel members ranged from 8.5 to 9.3 (mean, 8.9) on a 1- to 10-point scale.

"Although this level of agreement is quite high, it is not a particularly surprising finding," said Dr. Alexandra Colebatch, one of the authors of the report. Previous recommendations from the 3e initiative have had a mean level of agreement of 8.7 (range, 7.4-9.1) (Ann. Rheum. Dis. 2011;70:15-24) and 8.7 (range, 7.8-9.4) (Ann. Rheum. Dis. 2011;70:388-9).

As for the algorithm developed for the pharmacologic management of pain, most (75%) of the rheumatologists said it was in accordance with their current practice, whereas 20% reported that it would change their practice, according to Dr. Whittle.

In addition to the main treatments to use in this patient population, the algorithm lists several points to consider, including type of pain, residual inflammation, comorbidities, patient preference, and addictive potential, and also includes adjuvant therapeutic options (such as tricyclic antidepressants and neuromodulators) to consider in these patients.

The evidence-based nature of these recommendations and the related algorithm, as well as the level of support demonstrated by the 3e initiative panel, suggest that they will have great utility in clinical practice, he concluded.

The full recommendations and algorithm paper will be published soon, Dr. Colebatch said; 3e has previously addressed the investigation and follow-up of undifferentiated peripheral IA, and the use of methotrexate in rheumatic disorders with a focus on rheumatoid arthritis, she noted.

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Dr. Samuel Whittle discussed the proposed 3e recommendations with senior reporter Heidi Splete.

The panel's 11 recommendations for pharmacotherapy pain management in IA are the following:

► In patients with IA, pain should be measured routinely using one of the following validated scales: visual analogue scale, numerical rating scale, or verbal rating scale. In addition, consider multidimensional measures or site-specific tools.

► Paracetamol is recommended for the treatment of persistent pain in patients with IA.

► Systemic glucocorticoids are not recommended for the routine management of pain in patients with IA in the absence of signs and symptoms of inflammation.

► In the treatment of pain in IA, tricyclic antidepressants and neuromodulators may be considered for use as adjuvant treatment; muscle relaxants and benzodiazepines aren't recommended.

► Weak opioids may be used for short-term treatment of pain in patients with IA when other therapies have failed or are contraindicated; long-term use may be considered and should be regularly reviewed. Strong opioids should be used only in exceptional cases.

► In patients with an inadequate response to paracetamol or NSAID monotherapy, the addition of a drug with a different mode of action could be considered; combination of two or more NSAIDs should not be used.

► NSAIDs should be used at the lowest effective dose, either continuously or on demand, according to clinical circumstances.

► Existing guidance regarding the safety of pain pharmacotherapies during preconception, pregnancy, and lactation should be applied.

► In the management of patients with IA, methotrexate can be used safely in combination with standard doses of paracetamol and/or NSAIDs (excluding anti-inflammatory doses of aspirin).

► In patients with gastrointestinal comorbidities, paracetamol should be considered first. NSAIDs in combination with proton pump inhibitors (PPI), or coxibs with or without PPI, may be used with caution. In the presence of liver disease, standard precautions for use of NSAIDs and other analgesics should be applied.

► In patients with IA plus preexisting hypertension or cardiovascular or renal disease, paracetamol should be used first; NSAIDs (including coxibs) should be used with caution.

The 3e initiative is supported by an unrestricted educational grant from Abbott. Neither Dr. Whittle nor any co-authors on this study had additional disclosures to report. ■

To watch an interview with Dr. Whittlew, scan this QR code with a smartphone.

Arthritis Complicated by Obesity Further Hinders Activity

BY FRANCES CORREA

FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION

Obesity makes it even less likely that a patient with arthritis is going to exercise, according to findings from two surveys conducted by the Centers for Disease Control and Prevention.

Arthritis is a common comorbidity of obesity. Approximately one-third (35.6%) of adults with self-reported obesity were also affected by physician-diagnosed arthritis, judging from the combined results of the surveys, which were performed in 2007 and 2009.

The combination of arthritis and obesity resulted in a more sedentary lifestyle: 22.7% of obese adults with arthritis were physically inactive, compared with 16.1% with arthritis alone, 13.5% with obesity alone, and 9.4% with neither condition (MMWR 2011;60:614-8).

The state-based, random-digit–dialed telephone survey included a total of 789,460 adults from 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. These surveys are part of a series conducted by the CDC to examine the affects of arthritis and comorbid conditions. Previous studies looked at arthritis comorbidity with diabetes and heart disease. CDC researcher Kamil Barbour, Ph.D., said in an interview that results show that patients with chronic conditions are less likely to be physically active if they also have arthritis.

In an editor's note, the CDC report observed: "Arthritis and obesity are common chronic conditions affecting an estimated 50 million and 72 million U.S. adults, respectively. The findings in this report indicate that these conditions co-occur commonly (one in three adults with obesity also has arthritis) and might hinder the management of both conditions by limiting physical activity. Among adults with both obesity and arthritis, the adjusted likelihood of physical inactivity was 44% higher compared with that of adults with obesity but without arthritis; all state-specific estimates were consistent with these results. These findings suggest that among many persons with obesity, arthritis might be an additional barrier to physical activity."

Dr. Barbour said that numerous barriers involved in arthritis can hinder people's ability to be active, beyond just being obese. The findings of these surveys should encourage doctors to consider the patient's full range of difficulties when making recommendations to engage in exercise, he added.

"We want to make [physicians] aware that they should look beyond obesity and any of the current conditions that [patients] may have, and look at the arthritis-specific barriers and kind of tailor their interventions toward addressing these [barriers]."

Dr. Barbour said the CDC will be using this information to augment community physical activity programs through the CDC Arthritis Program. The programs include EnhanceFitness, the Arthritis Foundation Exercise Program, and the Arthritis Foundation Walk With Ease programs, as well as self-management education programs.

Dr. Barbour and the other researchers who conducted and reported the study all work for the CDC. ■