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Original article

Inadequate pain relief among patients with primary knee osteoarthritis

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ABSTRACT

Background: Despite the widespread treatments for osteoarthritis (OA), data on treatment patterns, adequacy of pain relief, and quality of life are limited. The prospective multinational Survey of Osteoarthritis Real World Therapies (SORT) was designed to investigate these aspects.

Objectives: To analyze the characteristics and the patient reported outcomes of the Portuguese dataset of SORT at the start of observation.

Methods: Patients ≥ 50 years with primary knee OA who were receiving oral or topical analgesics were eligible. Patients were enrolled from seven healthcare centers in Portugal between January and December 2011. Pain and function were evaluated using the Brief Pain Inventory (BPI) and WOMAC. Quality of life was assessed using the 12-Item Short Form Health Survey (SF-12). Inadequate pain relief (IPR) was defined as a score $>4/10$ on item 5 of the BPI.

Results: Overall, 197 patients were analyzed. The median age was 67.0 years and 78.2% were female. Mean duration of knee OA was 6.2 years. IPR was reported by 51.3% of patients. Female gender (adjusted odds ratio – OR 2.15 [95%CI 1.1, 4.5]), diabetes (OR 3.1 [95%CI 1.3, 7.7]) and depression (OR 2.24 [95%CI 1.2, 4.3]) were associated with higher risk of IPR. Patients with IPR reported worst outcomes in all dimensions of WOMAC ($p < 0.001$) and in all eight domains and summary components of SF-12 ($p < 0.001$).

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Conclusions: Our findings indicate that improvements are needed in the management of pain in knee OA in order to achieve better outcomes in terms of pain relief, function and quality of life.

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Alívio inadequado da dor em pacientes com osteoartrite de joelho primária

R E S U M O

Palavras-chave:

Osteoartrite de joelho
Alívio inadequado da dor
Qualidade de vida
Incapacidade
Desfechos relatados pelo paciente

Antecedentes: Apesar dos tratamentos muito difundidos para a osteoartrite (OA), dados sobre os padrões de tratamento, a adequação do alívio da dor e a qualidade de vida são limitados. O estudo multinacional prospectivo *Survey of Osteoarthritis Real World Therapies* (SORT) foi projetado para investigar esses aspectos.

Objetivos: Analisar as características e os desfechos relatados pelo paciente do conjunto de dados português do Sort no início da observação.

Métodos: Consideraram-se elegíveis os pacientes com 50 anos ou mais com OA de joelho primária que recebiam analgésicos orais ou tópicos. Os pacientes foram recrutados de sete centros de saúde de Portugal entre janeiro e dezembro de 2011. A dor e a função foram avaliadas pelo *Brief Pain Inventory* (BPI) e pelo WOMAC. A qualidade de vida foi avaliada com o 12-item *Short Form Health Survey* (SF-12). O alívio inadequado da dor (AID) foi definido como uma pontuação > 4/10 no item 5 do BPI.

Resultados: Foram analisados 197 pacientes. A idade média foi de 67 anos e 78,2% eram do sexo feminino. A duração média da OA de joelho foi de 6,2 anos. O AID foi relatado por 51,3% dos pacientes. O sexo feminino (*odds ratio* ajustado - OR 2,15 [IC 95% 1,1-4,5]), o diabetes (OR = 3,1 [IC 95% 1,3-7,7]) e a depressão (OR 2,24 [IC 95% 1,2-4,3]) estiveram associados a um maior risco de AID. Os pacientes com AID relataram piores desfechos em todas as dimensões do WOMAC ($p < 0,001$) e em todos os oito domínios e nos dois componentes sumários do SF-12 ($p < 0,001$).

Conclusões: Os resultados do presente estudo indicam que é necessário melhorar o manejo da dor na OA de joelho a fim de alcançar melhores desfechos em termos de alívio da dor, função e qualidade de vida.

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Introduction

Osteoarthritis (OA) is a highly prevalent and debilitating disorder which seriously limits both health and well-being, particularly in the elderly population.^{1,2} The economic burden of OA on subjects, their caregivers and society is considered quite high. In developed countries it may cost between 1.0% and 2.5% of gross domestic product.³

Approximately 13% of women and 10% of men aged 60 years and older have symptomatic knee OA. These proportions are likely to increase due to the aging of the population and the growing rate of obesity in the general population.⁴ Other factors are associated with a higher risk for the development and progression of knee OA such as female gender, previous knee trauma, bone density, muscle weakness, joint laxity and physically demanding occupations or activities.^{2,5}

The European League Against Rheumatism (EULAR) recommends that the clinical diagnosis of knee OA should be based on three symptoms (persistent knee pain, limited morning stiffness and reduced function) and three signs (crepitus, restricted movement and bone enlargement). The presence

of all these signs and symptoms increases the probability of radiographic knee OA to 99%.⁶

Pain is the most common symptom in knee OA and is the leading cause of disability due to this condition.² This symptom has also a diversity of psychological and social implications.

The clinical management of OA aims to relieve pain, maintain or improve joint function and prevent or delay disease progression and its consequences.^{7,8} Effective pain management relies on a broad range combination of non-pharmacological and pharmacological modalities.⁹ The pharmacological approaches and treatment modalities include paracetamol, NSAIDs, opioids, topical analgesics and intra-articular injection of corticosteroid.^{10,11} However, variability in treatment effectiveness, as well as tolerability, often requires trials of different treatment modalities to achieve adequate pain control. Treatment should be individualized according to patient symptoms, preferences, and the therapeutic agent's safety profile.¹² Despite its serious consequences, most patients with knee OA can be managed in the community and the primary care setting.^{7,13}

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