Response to Letter to the Editor entitled “Comments on ‘OARSI guidelines for the non-surgical management of knee osteoarthritis’”

We thank Prof. du Souich for commending the 2014 guidelines for the management of knee OA for taking into account the role of co-morbidities in its treatment recommendations\(^1\) and wholeheartedly share his views on the importance of considering co-morbidities and the risk of drug–drug interactions in those with multiple morbidity. Indeed, our decision to formulate treatment guidelines more tailored to patient characteristics was predicated on these important issues. Prof. du Souich’s emphasis on safety in treating at-risk individuals resonates with our own view, and, taken together with reliable data supporting their effectiveness, is the basis for our emphasis on non-pharmacological interventions for patients in the high risk group, namely strength training and aerobic exercise (land-based or water-based), weight management, biomechanical interventions, and self-management and education.

The paucity of reliable data to support the effectiveness of pharmacological treatments, and concerns about safety, resulted in only intra-articular corticosteroids, COX-2 inhibitors and duloxetine receiving designations of ‘appropriate’. As Prof. du Souich points out, all pharmaceuticals carry some risk, and so implementation of our recommendations ultimately remains a shared decision between the prescribing physician and the patient, taking into account individual characteristics and preferences.

Prof. du Souich advocates for incorporation of chondroitin sulfate and glucosamine sulfate into the knee OA treatment guidelines for at-risk individuals, a view based on the undisputed safety profile of these products, and also selected efficacy data. However, the OARSI recommendations are a synthesis of the best available evidence in the context of all available treatment alternatives, by health professionals with diverse expertise. An ‘uncertain’ designation does not mean that an intervention, e.g. glucosamine or chondroitin, should not be used. Individual clinicians and patients might reasonably choose to use such treatments; they should however do this cognizant of the strength of the underpinning evidence.

The development of guidelines requires a tremendous effort in synthesizing a large evidence base that is continually expanding. As such, one of the main objectives should be to highlight evidence-gaps and stimulate dialog, which Prof. du Souich has kindly provided. Such areas include the management of OA in patients with multiple morbidities and the approach to balancing benefits and harms. When pharmacological treatment is indicated, we agree with Prof. du Souich’s statement that, ‘clinicians should be advised to start symptomatic treatment with the drugs with the [smallest] potential to harm the patient’. Nevertheless, non-pharmacological modalities should be preferred and proposed first to the patient, considering the patient’s preference.

Conflict of interest
Full disclosure statements from all authors are shown in Appendix 1 of the OARSI Guidelines for the Non-Surgical Management of Knee Osteoarthritis. These disclosures were reviewed by the OARSI Ethics Committee. No potential conflicts of interest were identified that should have precluded any member of the committee from participating in that critical appraisal. No OAGDG members are employees of any pharmaceutical or medical device company. OAGDG members were recused from voting on select treatments where potential conflicts arose, as described in the report Methods. Corporate members of OARSI are also listed in Appendix 1 of the guidelines report.

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