

# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## INTERVENTIONAL PROCEDURES PROGRAMME

### Interventional procedure overview of magnetic resonance therapy for knee osteoarthritis

Osteoarthritis can develop in the knee when cartilage covering the ends of the bone becomes worn. This can cause pain, stiffness, swelling and difficulty walking. In this procedure, a magnetic resonance device is put over the knee. The device produces electromagnetic energy, stimulating the cartilage to heal. Treatments last about an hour and are given for 5 to 10 days in a row. The aim is to relieve the symptoms of osteoarthritis.

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## Abbreviations

Word or phrase	Abbreviation
Confidence interval	CI
Femoral condylar cartilage thickness	FCT
Femoral intercondylar area	FICA
Lateral femoral condyle	LFC
Magnetic resonance therapy	MRT
Medial femoral condyle	MFC
Mental component score	MCS
Molecular biophysical stimulation therapy	MBST
Not statistically significant	NS
Nuclear magnetic resonance	NMR
Osteoarthritis	OA
Physical component score	PCS
Short form 36	SF-36
Standard deviation	SD
Visual analogue scale	VAS
Western Ontario and McMaster Universities Arthritis Index	WOMAC

## Introduction

The National Institute for Health and Care Excellence (NICE) prepared this interventional procedure overview to help members of the interventional procedures advisory committee (IPAC) make recommendations about the safety and efficacy of an interventional procedure. It is based on a rapid review of the medical literature and professional opinion. It should not be regarded as a definitive assessment of the procedure.

## Date prepared

This overview was prepared in August 2020 and updated in April 2021.

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## Procedure name

- magnetic resonance therapy for knee osteoarthritis

## Professional societies

- British Orthopaedic Association
- British Association for Surgery of the Knee (BASK)
- British Society of Rheumatology
- Chartered Society of Physiotherapists (CSP).

## Description of the procedure

### Indications and current treatment

Osteoarthritis of the knee is the result of progressive deterioration of the articular cartilage and menisci of the joint, usually because of trauma and wear and tear. This leads to exposure of the bone surface. Symptoms include pain, stiffness, swelling and difficulty walking. Acute exacerbations of pain are common and usually self-limiting after 14 days. Only a small number of patients develop progressive symptoms needing treatment.

Treatment depends on the severity of the symptoms. Conservative treatments include analgesics and corticosteroid injections to relieve pain and inflammation, and physiotherapy and prescribed exercise to improve function and mobility. When symptoms are severe, surgery may be indicated: options include upper tibial osteotomy and unicompartmental or total knee replacement.

### What the procedure involves

Magnetic resonance therapy for osteoarthritis (MRT) is a non-invasive procedure that uses a special device to administer electromagnetic energy to an osteoarthritic joint. A range of devices with different physical designs are available. The aim is to relieve the symptoms and to improve the osteoarthritis by stimulating the cartilage cells.

MRT is done in an outpatient setting. During the procedure, the patient lies on the couch and a section of the MRT device slides over the knee. The device generates electromagnetic fields which are targeted to the cartilaginous tissue in the affected joint. The aim is to promote joint repair and relieve the symptoms of osteoarthritis. Each treatment lasts 60 minutes. Depending on the severity of the

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disease and MRT therapy device, a course of treatment typically consists of 5 to 10 treatment sessions on consecutive days.

## Outcome measures

### Lequesne index

The Lequesne index is a questionnaire used to evaluate the severity of the osteoarthritis. It has 5 questions relating to pain or discomfort, 1 question about the maximum distance walked, and 4 questions about activities of daily living. The total questionnaire is scored on a 0 to 24 scale. Lower scores indicate there is less functional impairment.

### Western Ontario and McMaster Universities Arthritis Index

The Western Ontario and McMaster Universities Arthritis Index (WOMAC) is an extensively used standardised questionnaire that is used to assess patients with osteoarthritis of the knee or hip. The questionnaire evaluates 3 domains: pain (score range 0 to 20); stiffness (score range 0 to 8) and physical function (score range 0 to 68). The total score ranges from 0 to 96 with lower scores indicating better outcomes.

## Efficacy summary

### Osteoarthritis symptoms

#### Lequesne osteoarthritis (OA) index

A scoping review showed that there seems to be a beneficial effect of MRT in the treatment of patients with OA in relation to joint function<sup>5</sup>.

In a survey of 2,770 patients with knee OA, there was a statistically significant decrease in the mean global score for the Lequesne OA index from  $7.77 \pm 4.33$  before the procedure to  $6.62 \pm 3.92$  after the procedure,  $5.70 \pm 3.87$  at 3 months,  $4.97 \pm 3.86$  at 6 months and  $4.69 \pm 3.94$  at 12 months ( $p < 0.000001$ ). The statistically significant improvement was reported for each of the 3 components of the index (pain/complaints, walking distance and function,  $p < 0.000001$ ).<sup>1</sup>

#### WOMAC index

#### WOMAC-pain score

In a randomised controlled trial (RCT) of 97 patients with mild to moderate knee OA (49 patients who had MRT compared with 48 patients who had placebo

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therapy), there were statistically significant improvements from baseline in mean WOMAC-pain scores for both MRT and placebo at 2 and 12 weeks. For MRT, mean WOMAC-pain scores decreased from  $4.25 \pm 2.08$  to  $2.16 \pm 2.09$  at 2 weeks and to  $2.26 \pm 2.11$  at 12 weeks ( $p < 0.001$ ). For placebo therapy, mean WOMAC-pain scores decreased from  $4.08 \pm 2.09$  to  $2.16 \pm 2.36$  at 2 weeks and to  $2.50 \pm 2.09$  at 12 weeks ( $p < 0.001$ ). However, there were no statistically significant differences between MRT and placebo for the improvements in WOMAC-pain scores at 2 weeks ( $-2.09 \pm 2.15$  compared with  $-1.91 \pm 2.49$ ,  $p = 0.712$ ) and at 12 weeks ( $-1.98 \pm 2.13$  compared with  $-1.58 \pm 2.13$ ,  $p = 0.351$ ).<sup>2</sup>

#### WOMAC-stiffness score

In the RCT of 97 patients, there were statistically significant improvements from baseline in mean WOMAC-stiffness scores for both MRT and placebo at 2 and 12 weeks. For MRT, mean WOMAC-stiffness scores decreased from  $3.46 \pm 2.16$  to  $1.65 \pm 1.84$  at 2 weeks and to  $1.54 \pm 1.60$  at 12 weeks ( $p < 0.001$ ). For placebo therapy, mean WOMAC-stiffness scores decreased from  $2.96 \pm 2.38$  to  $1.69 \pm 2.02$  at 2 weeks and to  $1.84 \pm 1.94$  at 12 weeks ( $p < 0.001$ ). However, there were no statistically significant differences between MRT and placebo for the improvements in WOMAC-stiffness scores at 2 weeks ( $-1.81 \pm 2.12$  compared with  $-1.27 \pm 2.12$ ,  $p = 0.213$ ) and at 12 weeks ( $-1.92 \pm 2.20$  compared with  $-1.1 \pm 2.03$ ,  $p = 0.660$ ).<sup>2</sup>

#### WOMAC-physical function score

In the RCT of 97 patients, there were statistically significant improvements from baseline in mean WOMAC-physical function scores for both MRT and placebo at 2 and 12 weeks. For MRT, mean WOMAC-physical function scores decreased from  $4.27 \pm 2.02$  to  $2.31 \pm 1.90$  at 2 weeks and to  $2.48 \pm 2.09$  at 12 weeks ( $p < 0.001$ ). For placebo therapy, mean WOMAC-physical function scores decreased from  $3.88 \pm 2.36$  to  $2.34 \pm 2.28$  at 2 weeks and to  $2.25 \pm 1.77$  at 12 weeks ( $p < 0.001$ ). However, there were no statistically significant differences between MRT and placebo for the improvements in WOMAC-physical function scores at 2 weeks ( $-1.96 \pm 1.87$  compared with  $-1.54 \pm 2.56$ ,  $p = 0.361$ ) and at 12 weeks ( $-1.79 \pm 1.81$  compared with  $-1.63 \pm 2.32$ ,  $p = 0.700$ ).<sup>2</sup>

### Pain

The scoping review showed that there seems to be a beneficial effect of MRT in the treatment of patients with osteoarthritis of the knee in relation to improvement in pain<sup>5</sup>.

In the survey of 2,770 patients with knee OA, peak pain, pain on load and pain at rest scores measured on a visual analogue scale decreased statistically significantly after the 9 nuclear magnetic resonance (NMR) treatment sessions, IP overview: magnetic resonance therapy for knee osteoarthritis

with further reductions after 3, 6, and 12 months ( $p < 0.00001$ ). The pain frequency also decreased with all 3 types of pain, especially 6 and 12 months after NMR therapy. Pain on load diminished on a 10-part scale from 6 (daily) to 4 (once a week), the frequency of peak pain reduced to 'very little/only twice a month' (= 3), and pain at rest decreased to 'rare' to 'very rare' (as stated in the article). The number of patients who had no complaints during the night increased from 39% at baseline to 72% 12 months after NMR therapy. The percentage of patients without pain when walking increased from 24% to 48%. One year after treatment, 32% of patients could kneel or crouch down without any difficulty, while at baseline this was possible for only 15% of patients <sup>1</sup>

In the RCT of 97 patients, there were statistically significant improvements from baseline in mean VAS pain scores (from 0 [no pain] to 10 [worst pain]) for both MRT and placebo at 2 and 12 weeks. For MRT, mean VAS-pain scores decreased from  $6.36 \pm 2.24$  to  $3.76 \pm 3.16$  at 2 weeks and to  $3.75 \pm 3.14$  at 12 weeks ( $p < 0.001$ ). For placebo therapy, mean VAS-pain scores decreased from  $4.91 \pm 6.06$  to  $2.90 \pm 4.80$  at 2 weeks and to  $2.86 \pm 4.40$  at 12 weeks ( $p < 0.001$ ). However, there were no statistically significant differences between MRT and placebo for the improvements in VAS-pain scores at 2 weeks ( $-2.6 \pm 3.35$  compared with  $-1.63 \pm 3.35$ ,  $p = 0.160$ ) and at 12 weeks ( $-2.61 \pm 3.19$  compared with  $-1.85 \pm 3.42$ ,  $p = 0.263$ ). In the same study, there was no significant difference in paracetamol consumption between MRT and placebo during the study.<sup>2</sup>

In a case series of 39 patients, who had MBST for osteoarthritis of the knee, the intensity and frequency of the pain and the Lequesne index scores showed lower values at 4 years follow-up. The comparison of scores before and after therapy showed a clear increase in percentage of patients with no or low pain or no restriction with everyday activities. There was a positive effect on women, elderly and on patients who were not actively taking part in sport activities<sup>4</sup>.

### **Range of motion**

In the survey of 2,770 patients with knee OA, statistically significant improvements in the active range of motion were recorded 3 months after NMR therapy ( $p < 0.000001$ ), with a further enhancement of flexion and extension after 6 and 12 months. <sup>1</sup>

### **Quality of life**

The scoping review showed that there seems to be a beneficial effect of MRT in the treatment of patients with osteoarthritis of the knee in relation to quality of life<sup>5</sup>.

### **SF-36 physical component score**

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In the RCT of 97 patients, there were statistically significant improvements from baseline in mean SF-36 physical component scores (from 0 [worst quality of life] to 100 [best quality of life]) for both MRT and placebo at 2 and 12 weeks. For MRT, mean SF-36 physical component scores increased from  $29.79 \pm 8.53$  to  $39.14 \pm 10.82$  at 2 weeks and to  $39.06 \pm 12.47$  at 12 weeks ( $p < 0.001$ ). For placebo therapy, mean SF-36 physical component scores increased from  $33.09 \pm 9.40$  to  $35.85 \pm 43.10$  at 2 weeks and to  $37.89 \pm 44.91$  at 12 weeks ( $p < 0.001$ ). However, there were no statistically significant differences between MRT and placebo for the improvements in SF-36 physical component scores at 2 weeks ( $9.35 \pm 8.70$  compared with  $6.37 \pm 11.59$ ,  $p = 0.158$ ) and at 12 weeks ( $9.2 \pm 9.94$  compared with  $8.3 \pm 12.30$ ,  $p = 0.673$ ).<sup>2</sup>

#### SF-36 mental component score

In the RCT of 97 patients, there was a statistically significant improvement from baseline in mean SF-36 mental component scores (from 0 [worst quality of life] to 100 [best quality of life]) for MRT at 12 weeks only from  $49.80 \pm 12.38$  to  $54.50 \pm 10.16$  ( $p = 0.006$ ). For placebo therapy, the increase in mean SF-36 mental component scores was statistically significant at 2 weeks but not at 12 weeks:  $45.87 \pm 12.50$  compared with  $52.20 \pm 11.98$  ( $p = 0.002$  at 2 weeks). There were no statistically significant differences between MRT and placebo for the improvements in SF-36 mental component scores at 2 weeks ( $2.64 \pm 12.55$  compared with  $6.32 \pm 13.09$ ,  $p = 0.161$ ) and at 12 weeks ( $4.69 \pm 11.3$  compared with  $2.1 \pm 10.93$ ,  $p = 0.255$ ).<sup>2</sup>

#### Cartilage thickness

In the RCT of 97 patients, there were no statistically significant differences in femoral condylar cartilage thickness measured with ultrasound in the treated and in the untreated knees between MRT and placebo at baseline and 12 weeks after treatment. In the same study, there were no statistically significant differences in whole-organ MRI scores after surgery compared with baseline for MRT and placebo.<sup>2</sup>

In a case series of 14 patients, there were statistically significant improvements after the procedure in the mean cartilage thickness of the patella ( $1.93 \text{ mm} \pm 0.37 \text{ mm}$  compared with  $2.24 \text{ mm} \pm 0.39 \text{ mm}$ ,  $p < 0.001$ ), in the maximum cartilage thickness of the patella ( $4.14 \text{ mm} \pm 0.81 \text{ mm}$  compared with  $4.52 \text{ mm} \pm 0.88 \text{ mm}$ ,  $p < 0.05$ ), in the minimum cartilage thickness of the patella ( $0.02 \text{ mm} \pm 0.08 \text{ mm}$  compared with  $0.11 \text{ mm} \pm 0.16 \text{ mm}$ ,  $p < 0.05$ ), and in the volume of the cartilage of the patella ( $2,109.28 \text{ mm}^3 \pm 660.75 \text{ mm}^3$  compared with  $2,459.48 \text{ mm}^3 \pm 655.60 \text{ mm}^3$ ,  $p < 0.001$ ). However, there was no significant change in the surface of the cartilage of the patella ( $912.67 \text{ mm}^2 \pm 170.34 \text{ mm}^2$  compared with  $942.45 \text{ mm}^2 \pm 179.73 \text{ mm}^2$ , not significant). For the tibia, there were statistically significant improvements after the procedure in the mean thickness of the medial



cartilage ( $1.25 \text{ mm} \pm 0.30 \text{ mm}$  compared with  $1.37 \text{ mm} \pm 0.26 \text{ mm}$ ,  $p < 0.05$ ) and of the lateral cartilage ( $1.64 \text{ mm} \pm 0.49 \text{ mm}$  compared with  $1.67 \text{ mm} \pm 0.35 \text{ mm}$ ,  $p < 0.01$ ); in the maximum thickness of the medial cartilage ( $2.42 \text{ mm} \pm 0.60 \text{ mm}$  compared with  $2.63 \text{ mm} \pm 0.43 \text{ mm}$ ,  $p < 0.05$ ) and of the lateral cartilage ( $3.30 \text{ mm} \pm 0.98 \text{ mm}$  compared with  $3.38 \text{ mm} \pm 0.73 \text{ mm}$ ,  $p < 0.01$ ), and in the volume of the medial cartilage ( $1,343.36 \text{ mm}^3 \pm 446.61 \text{ mm}^3$  compared with  $1,511.67 \text{ mm}^3 \pm 342.49 \text{ mm}^3$ ,  $p < 0.05$ ) and of the lateral cartilage ( $1,706.83 \text{ mm}^3 \pm 630.84 \text{ mm}^3$  compared with  $1,739.23 \text{ mm}^3 \pm 453.24 \text{ mm}^3$ ,  $p < 0.05$ ). There were no significant changes after the procedure in the minimum medial cartilage thickness, and in the medial and lateral cartilage surfaces. The results were not clear for the minimal thickness of the lateral cartilage structure of the tibia. For the femur, none of the changes measured for the cartilage thickness were significant. <sup>3</sup>

## Safety summary

No adverse effects were reported during follow up in the RCT of 97 patients. <sup>2</sup>

## Anecdotal and theoretical adverse events

In addition to safety outcomes reported in the literature, professional experts are asked about anecdotal adverse events (events which they have heard about) and about theoretical adverse events (events which they think might possibly occur, even if they have never happened). For this procedure, we received no questionnaires.

## The evidence assessed

### Rapid review of literature

The medical literature was searched to identify studies and reviews relevant to magnetic resonance therapy for knee osteoarthritis. The following databases were searched, covering the period from their start to 12 April 2021: MEDLINE, PREMEDLINE, EMBASE, Cochrane Library and other databases. Trial registries and the Internet were also searched. No language restriction was applied to the searches (see the [literature search strategy](#)). Relevant published studies identified during consultation or resolution that are published after this date may also be considered for inclusion.

The [inclusion criteria shown in the following table](#) were applied to the abstracts identified by the literature search. Where selection criteria could not be determined from the abstracts the full paper was retrieved.

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### Inclusion criteria for identification of relevant studies

Characteristic	Criteria
Publication type	<p>Clinical studies were included. Emphasis was placed on identifying good quality studies.</p> <p>Abstracts were excluded where no clinical outcomes were reported, or where the paper was a review, editorial, or a laboratory or animal study.</p> <p>Conference abstracts were also excluded because of the difficulty of appraising study methodology, unless they reported specific adverse events that were not available in the published literature.</p>
Patient	Patients with knee osteoarthritis.
Intervention/test	Magnetic resonance therapy.
Outcome	Articles were retrieved if the abstract contained information relevant to the safety and/or efficacy.
Language	Non-English-language articles were excluded unless they were thought to add substantively to the English-language evidence base.

### List of studies included in the IP overview

This IP overview is based on 3,004 patients from 1 scoping review, 1 survey, 1 RCT, 1 case series and 1 cohort study.<sup>1-5</sup>

Other studies that were considered to be relevant to the procedure but were not included in the main [summary of the key evidence](#) are listed in the [appendix](#).

## Summary of key evidence on magnetic resonance therapy for knee osteoarthritis

### Study 1 Kullich W (2013)

#### Study details

<b>Study type</b>	Survey
<b>Country</b>	Germany and Austria (61 centres)
<b>Recruitment period</b>	2000 to 2010
<b>Study population and number</b>	n=4,518 patients including <b>2,770 patients with osteoarthritis of the knee</b> , 673 patients with osteoarthritis of the hip, 420 patients with osteoarthritis of the ankle joint and 655 patients with low back pain.
<b>Age and sex</b>	OA of the knee: mean 62 years; 58% (1,609/2,770) female OA of the hip: mean 65 years; 51% (343/673) female OA of the ankle joint: mean 59 years; not reported Low back pain: mean 63 years; 62% (408/655) female
<b>Patient selection criteria</b>	The diagnoses of OA of the knee, OA of the hip, OA of the ankle, and low back pain were verified by radiological diagnostics. Included patients had given their informed consent for data collection and had been treated with nuclear magnetic resonance in accordance with the indications mentioned above.
<b>Technique</b>	Therapeutic nuclear magnetic resonance with devices belonging to the company Wetzlar, Germany. The nuclear field consists of 3 matched fields: (a) main magnetic field, (b) variable, modulating sweep-field, (c) alternating magnetic field at the Larmor frequency vertically to (a) and (b). It is generated in a Helmholtz coil with a permanent basic field up to 40 mT and a dynamic field strength of radiofrequency up to 2.3 mT. The nuclear magnetic resonance frequency is about 17 to 85 kHz. The applicators of the therapy systems respond to a central control unit according to a chipcard which is programmed for the special parameters adapted for tissue and indication. The duration of the treatment totalled up to 9 therapy units for 1 hour each on consecutive days.
<b>Follow-up</b>	1 year
<b>Conflict of interest/source of funding</b>	Not reported

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## Analysis

Follow-up issues: Patients were followed up immediately after treatment, 6 to 8 weeks, 6 months, and 1 year after treatment.

Study design issues: Evaluation criteria were pain at rest, pain on load, and peak pain, measured with a visual analogue scale (VAS). Further evaluation of clinical success was done using validated function indices covering disability, function deficit and restrictions of everyday functions. The collected data were entered centrally (IEB – Institute for Development of New Therapy Methods, Wetzlar, Germany).

Study population issues: For the knee OA indication, there were 46 % of patients who were overweight and 22% who were obese. the mean BMI of obese patients was  $33.9 \pm 4.0$ .

Other issues: The numbers from the figures representing the improvements in knee flexion and in pain symptoms were not reported.

## Key efficacy findings

Number of patients analysed: 2,770

### Lequesne OA index (mean $\pm$ SD [median])

Lequesne OA index	Before NMR	After NMR	3 months	6 months	12 months
Global score	7.77 $\pm$ 4.33 (7.50)	6.62 $\pm$ 3.92 (6.50)	5.70 $\pm$ 3.87 (5.50)	4.97 $\pm$ 3.86 (4.50)	4.69 $\pm$ 3.94 (4.00)
Pain/complaints (1st component)	3.05 $\pm$ 1.86 (3.00)	2.52 $\pm$ 1.75 (2.00)	2.03 $\pm$ 1.62 (2.00)	1.74 $\pm$ 1.63 (1.00)	1.58 $\pm$ 1.64 (1.00)
Walking distance (2nd component)	1.80 $\pm$ 1.66 (1.00)	1.63 $\pm$ 1.50 (1.00)	1.49 $\pm$ 1.47 (1.00)	1.29 $\pm$ 1.34 (1.00)	1.21 $\pm$ 1.24 (1.00)
Function (3rd component)	2.92 $\pm$ 1.82 (3.00)	2.47 $\pm$ 1.64 (2.00)	2.18 $\pm$ 1.63 (2.00)	1.94 $\pm$ 1.63 (2.00)	1.89 $\pm$ 1.74 (2.00)

There was a statistically significant improvement in Lequesne index after the procedure and during follow up ( $p < 0.000001$ ).

The global score ranges from 0 (no pain, no disability) to 24 (maximum pain, stiffness, and disability). For each of the 3 sections, the score ranges from 0 to 8.

## Pain

- Peak pain, pain on load and pain at rest scores measured on a visual analogue scale decreased statistically significantly after the 9 NMR treatment sessions, with further reductions after 3, 6, and 12 months ( $p < 0.00001$ ).
- The pain frequency also decreased with all 3 types of pain, especially 6 and 12 months after NMR therapy. Pain on load diminished on a 10-part scale from 6 (daily) to 4 (once a week), the frequency of peak pain

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reduced to “very little/only twice a month” (= 3), and pain at rest decreased to “rare” to “very rare” (as written in the article).

- The number of patients with osteoarthritis of the knee who had no complaints during the night increased from 39% at baseline to 72% 12 months after NMR therapy.
- Regarding walking, the pain-free group increased from 23.5% to 48.2%.
- One year after treatment, 31.9% of patients with osteoarthritis of the knee could kneel or crouch down without any difficulty, at baseline this was possible for only 14.9% of patients.

### **Range of motion**

- Three months after NMR therapy, statistically significant improvements in the active range of motion were recorded ( $p < 0.000001$ ), with a further enhancement of flexion and extension after 6 and 12 months.

### **Key safety findings**

Not reported.

## Study 2 Goksen N (2016)

### Study details

<b>Study type</b>	Randomised double-blind placebo-controlled trial
<b>Country</b>	Turkey (single centre)
<b>Recruitment period</b>	2012 to 2013
<b>Study population and number</b>	n=97 (49 MRT versus 48 placebo) Patients with mild to moderate knee OA.
<b>Age and sex</b>	Mean 54 years; 81% (79/97) female
<b>Patient selection criteria</b>	<p><u>Inclusion criteria:</u> consecutive patients who met the American College of Rheumatology classification criteria for knee OA, age between 35 [30 written in the abstract] and 75 years, symptomatic OA of a single knee, radiological stage of 2 or 3 according to Kellgren and Lawrence scale.</p> <p><u>Exclusion criteria:</u> cardiac arrhythmias or failure and symptomatic pulmonary diseases, uncontrolled hypertension, history of knee surgery or any inflammatory rheumatic disease, malignancy or trauma of the knee joints, pregnancy, active infection of the knee or adjacent soft tissues, treatment with viscosupplementation within the last year, or contraindications for magnetic resonance and magnetic fields like use of cardiac pacemakers.</p>
<b>Technique</b>	<p>Patients using NSAIDs or supplementary therapies were asked to stop their medication at least 2 weeks before having MRT and were only allowed to take paracetamol tablets.</p> <p>Device used: NuclearMagneticReseonance Therapy, MBST® Open System 350, Medtec Medizitechnik GmbH, Wetzlar, Germany. The nuclear MR frequency was about 17 to 85 kHz.</p> <p>During the placebo treatment, only the led were active but there were no pulses.</p> <p>The patients were treated for 1 hour daily on all weekdays for 2 weeks. Patients were checked for compliance every week for 2 weeks of treatment.</p>
<b>Follow-up</b>	12 weeks
<b>Conflict of interest/source of funding</b>	This study was supported with a grant from the Research Fund of the Erciyes University. The authors certified that there is no conflict of interest.

### Analysis

Follow-up issues:

- All patients had clinical examinations at baseline, 2 weeks and 12 weeks after the procedure. Imaging included blindly assessed ultrasonography and MR of the knee.

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- From 152 patients assessed for eligibility, 100 had been randomised to MRT or placebo. In the MRT group, 1 patient did not have the procedure because of a lack of time. In the placebo group, 2 patients did not have the placebo procedure because of a lack of time and a change in address.
- MR scans of 44 patients who had MRT and of 43 patients who had the placebo were taken at baseline and follow up.
- Two patients who had MRT and 3 patients who had the placebo were 1 day off the treatment.

#### Study design issues:

- The physiotherapist applying MRT or placebo, the assessors and the radiologist scoring the MR scans were all blinded to the group assignment. For randomisation, the manufacturer of the MRT device provided coded individual chips to operate the machine and a sealed envelope with serial numbers and randomly assigned corresponding groups. Fifty chips were signal negative and 50 chips were signal positive.
- The main outcome measures were: pain (assessed with a visual analogue scale), quality of life (assessed with the SF-36) and physical functions (assessed with the WOMAC Likert scale).
- The X-rays were scored using the Kellgren-Lawrence scoring system. The cartilage thickness was measured using ultrasonography. Whole organ MRI score (WORMS) was used to evaluate cartilage signal and morphology. Marrow abnormalities, bone cysts, bone attrition, osteophytes, lesion of menisci, ligaments and synovitis were also evaluated.

## Key efficacy findings

- Number of patients analysed: 97 (49 MRT versus 48 placebo)

### Pain - VAS (from 0 to 10, lower scores indicate better outcomes)

Changes in VAS-pain from baseline to after the procedure	MRT			Placebo		
	Mean (SD)	95% CI	p value	Mean (SD)	95% CI	p value
Baseline	6.36 (2.24)	5.72 to 7.01		5.48 (1.99)	4.91 to 6.06	
2 weeks	3.76 (3.16)	2.85 to 4.67	<0.001	3.85 (3.20)	2.90 to 4.80	<0.001
12 weeks	3.75 (3.14)	2.85 to 4.65	<0.001	3.63 (2.65)	2.86 to 4.40	<0.001

Reductions in VAS-pain scores from baseline to 2-week or 12-week follow up were statistically significant for both MRT and placebo.

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Differences in VAS-pain compared between groups	MRT		Placebo		p value
	Mean (SD)	95% CI	Mean (SD)	95% CI	
Difference between baseline and week 2* *corrected by analyst	-2.6 (3.35)	-3.56 to -1.63	-1.63 (3.35)	-2.61 to -0.66	0.160
Difference between baseline and week 12	-2.61 (3.19)	-3.53 to -1.69	-1.85 (3.42)	-2.84 to -0.86	0.263

There were no statistically significant differences between groups for the improvements in VAS-pain scores at 2 and 12 weeks.

### Physical function - WOMAC (higher scores indicate worse outcomes)

Changes in WOMAC from baseline to after the procedure	MRT			Placebo		
	Mean (SD)	95% CI	p value	Mean (SD)	95% CI	p value
<b>WOMAC-pain</b>						
Baseline	4.25 (2.08)	3.65 to 4.85		4.08 (2.09)	3.47 to 3.69	
2 weeks	2.16 (2.09)	1.56 to 2.76	<b>&lt;0.001</b>	2.16 (2.36)	1.47 to 2.85	<b>&lt;0.001</b>
12 weeks	2.26 (2.11)	1.65 to 2.87	<b>&lt;0.001</b>	2.50 (2.09)	1.89 to 3.10	<b>&lt;0.001</b>
<b>WOMAC-stiffness</b>						
Baseline	3.46 (2.16)	2.84 to 4.09		2.96 (2.38)	2.27 to 3.66	
2 weeks	1.65 (1.84)	1.12 to 2.18	<b>&lt;0.001</b>	1.69 (2.02)	1.11 to 2.28	<b>&lt;0.001</b>
12 weeks	1.54 (1.60)	1.08 to 2.00	<b>&lt;0.001</b>	1.84 (1.94)	1.28 to 2.41	<b>&lt;0.001</b>
<b>WOMAC-physical function</b>						
Baseline	4.27 (2.02)	3.69 to 4.85		3.88 (2.36)	3.19 to 4.57	
2 weeks	2.31 (1.90)	1.76 to 2.86	<b>&lt;0.001</b>	2.34 (2.28)	1.68 to 3.00	<b>&lt;0.001</b>
12 weeks	2.48 (2.09)	1.87 to 3.08	<b>&lt;0.001</b>	2.25 (1.77)	1.73 to 2.77	<b>&lt;0.001</b>

Reductions in WOMAC scores from baseline to 2-week or 12-week follow up were statistically significant for both MRT and placebo.



Differences in WOMAC compared between groups	MRT		Placebo		p value
	Mean (SD)	95% CI	Mean (SD)	95% CI	
<b>WOMAC-pain</b>					
Difference between baseline and week 2* *corrected by analyst	-2.09 (2.15)	-2.71 to -1.47	-1.91 (2.49)	-2.64 to -1.19	0.712
Difference between baseline and week 12	-1.98 (2.13)	-2.60 to -1.37	-1.58 (2.13)	-2.20 to -0.96	0.351
<b>WOMAC-stiffness</b>					
Difference between baseline and week 2* *corrected by analyst	-1.81 (2.12)	-2.42 to -1.20	-1.27 (2.12)	-1.88 to -0.65	0.213
Difference between baseline and week 12	-1.92 (2.20)	-2.55 to -1.28	-1.1 (2.03)	-1.71 to -0.52	0.660
<b>WOMAC-physical function</b>					
Difference between baseline and week 2* *corrected by analyst	-1.96 (1.87)	-2.49 to -1.42	-1.54 (2.56)	-2.28 to -0.79	0.361
Difference between baseline and week 12	-1.79 (1.81)	-2.31 to -1.27	-1.63 (2.32)	-2.30 to -0.95	0.700

There were no statistically significant differences between groups for the improvements in WOMAC index scores at 2 and 12 weeks.

### Quality of life – SF-36 (higher scores indicate more favourable health states)

Changes in SF-36 score from baseline to after the procedure	MRT			Placebo		
	Mean (SD)	95% CI	p value	Mean (SD)	95% CI	p value
<b>SF-36 (PCS)</b>						
Baseline	29.79 (8.53)	27.34 to 32.24		33.09 (9.40)	30.35 to 35.85	
2 weeks	39.14 (10.82)	36.03 to 42.25	<b>&lt;0.001</b>	39.47 (12.40)	35.85 to 43.10	<b>&lt;0.001</b>
12 weeks	39.06 (12.47)	35.47 to 42.64	<b>&lt;0.001</b>	41.40 (12.90)	37.89 to 44.91	<b>&lt;0.001</b>
<b>SF-36 (MCS)</b>						
Baseline	49.80 (12.38)	46.24 to 53.36		45.87 (12.50)	42.23 to 49.51	
2 weeks	52.45 (11.91)	49.03 to 55.87	0.146	52.20 (11.98)	48.72 to 55.68	<b>0.002</b>
12 weeks	54.50 (10.16)	51.57 to 57.42	<b>0.006</b>	47.98 (13.12)	44.17 to 51.79	0.18

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Differences in SF-26 scores compared between groups	MRT		Placebo		p value
	Mean (SD)	95% CI	Mean (SD)	95% CI	
<b>SF-36 (PCS)</b>					
Difference between baseline and week 2 [corrected by analyst]	9.35 (8.70)	6.85 to 11.85	6.37 (11.59)	3.01 to 9.74	0.158
Difference between baseline and week 12	9.2 (9.94)	6.41 to 12.12	8.3 (12.30)	4.72 to 11.88	0.673
<b>SF-36 (MCS)</b>					
Difference between baseline and week 2 [corrected by analyst]	2.64 (12.55)	-0.95 to 6.25	6.32 (13.09)	2.52 to 10.12	0.161
Difference between baseline and week 12	4.69 (11.3)	1.44 to 7.94	2.1 (10.93)	-1.06 to 5.28	0.255

There was no statistically significant difference between groups.

#### Femoral condylar cartilage thickness (ultrasonographic measurement, unit not specified)

Changes in FCT from baseline to 12 weeks after the procedure	MRT		Placebo		p value
	Mean (SD)	95% CI	Mean (SD)	95% CI	
<b>Treated knee</b>					
LFC at baseline	1.90 (0.29)	1.82 to 1.99	1.92 (0.33)	1.81 to 2.00	0.840
LFC at 12 weeks	1.92 (0.26)	1.84 to 1.99	1.92 (0.34)	1.82 to 2.03	0.918
FICA at baseline	2.07 (0.38)	2.07 to 1.96	2.19 (0.42)	2.06 to 2.30	0.158
FICA at 12 weeks	2.01 (0.32)	1.92 to 2.11	2.09 (0.41)	1.97 to 2.21	0.299
MFC at baseline	1.95 (0.35)	1.84 to 2.05	1.94 (0.37)	1.83 to 2.05	0.969
MFC at 12 weeks	1.92 (0.30)	1.83 to 2.00	1.88 (0.36)	1.77 to 1.99	0.568
<b>Untreated knee</b>					
LFC at baseline	1.87 (0.3)	1.78 to 1.95	1.90 (0.3)	1.80 to 1.98	0.628

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LFC at 12 weeks	1.90 (0.25)	1.83 to 1.98	1.88 (0.30)	1.78 to 1.96	0.644
FICA at baseline	2.08 (0.36)	1.97 to 2.18	2.20 (0.35)	2.09 to 2.31	0.930
FICA at 12 weeks	2.05 (0.36)	1.95 to 2.16	2.07 (0.33)	1.97 to 2.17	0.851
MFC at baseline	1.89 (0.3)	1.80 to 1.97	1.96 (0.35)	1.84 to 2.05	0.301
MFC at 12 weeks	1.94 (0.28)	1.86 to 2.02	1.88 (0.34)	1.78 to 1.98	0.362

There were no statistically significant differences in femoral condylar cartilage thickness between MRT and placebo at baseline and 12 weeks after treatment.

### Whole-organ MRI score (WORMS, higher scores indicate worse outcomes)

	Before surgery		12 weeks after surgery		$\Delta$	P value
	Mean (SD)	95% CI	Mean (SD)	95% CI		
MRT (n=44)	33.60±32.38	23.75 to 43.44	33.89±32.94	23.87 to 43.90	-0.28	0.577
Placebo (n=43)	20.91±21.73	14.22 to 27.59	21.19±22.40	14.29 to 28.08	-0.28	0.634

There were no statistically significant differences in WORMS scores after surgery compared with baseline for MRT and placebo.

### Analgesic consumption during the study

	MRT (% of patients)	Placebo (% of patients)
<b>No paracetamol consumption</b>	57.1%	60.4%
<b>1 to 5 paracetamol tablets</b>	18.4%	20.8%
<b>4 to 10 paracetamol tablets</b>	14.3 %	6.2%
<b>10 to 15 paracetamol tablets</b>	4.1%	0%
<b>More than 15 paracetamol tablets</b>	6.1%	12.5%

There was no significant difference in the paracetamol consumption between MRT and placebo groups.

### Key safety findings

The journal article states that 'no adverse effects on patients were reported during the follow-up period'.

## Study 3 Froböse I (2000)

### Study details

<b>Study type</b>	Case series
<b>Country</b>	Germany
<b>Recruitment period</b>	Not reported
<b>Study population and number</b>	n=14 Patients with knee OA (stages 2 and 3)
<b>Age and sex</b>	Mean 54 years; 100% (14/14) female
<b>Patient selection criteria</b>	Patients with stages 2 and 3 knee OA who reported discomfort in the knee joint for more than 10 years and who had symptoms such as pain and mobility reduction. <u>Exclusion criteria</u> : pregnancy, presence of any electronic implant, presence of metal in the area of treatment, and heart disorder.
<b>Technique</b>	MultiBioSignal Therapy with the MBST 1-CELLREMAKE device from the company MedTec Medizintechnik.  The therapy consisted of 9 treatments sessions of 1 hour each. They were carried out on consecutive days with a break at the weekend. For the treatment, the knee joint was rested in a specially designed treatment coil which was controlled by a control unit. Through the control unit, the treatment coil received the commands to generate the complex therapy fields that are typical for the MBS therapy. The control unit did also guarantee a predefined standard of therapy.
<b>Follow-up</b>	'After therapy'
<b>Conflict of interest/source of funding</b>	Not reported

### Analysis

Study design issues:

- The main outcomes were the volume of the cartilage and its thickness before and after the therapy. The cartilage thickness was calculated using a 3D algorithm. The statistical evaluation was carried out with a T-Test for dependent random samples, using SPSS.
- The authors wrote that there were problems related to the measurement technology for the femur cartilage thickness evaluation that could partially explain that the changes in cartilage thickness for the femur did not show statistical significance.

### Key efficacy findings

- Number of patients analysed: 14

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**Cartilage thickness of the patella (mean ± SD)**

Clinical outcome	Before therapy	After therapy	p value
Mean thickness (mm)	1.93 ± 0.37	2.24 ± 0.39	<0.001
Maximum thickness (mm)	4.14 ± 0.81	4.52 ± 0.88	<0.05
Minimum thickness (mm)	0.02 ± 0.08	0.11 ± 0.16	<0.05
Volume (mm <sup>3</sup> ) interpolated	2109.28 ± 660.75	2459.48 ± 655.60	<0.001
Area (mm <sup>2</sup> ) Cartilage-Bone boundary	912.67 ± 170.34	942.45 ± 179.73	NS

**Cartilage thickness of the tibia (mean ± SD)**

Clinical outcome	Before therapy	After therapy	p value
<b>Medial cartilage structure of the tibia</b>			
Mean thickness (mm)	1.25 ± 0.30	1.37 ± 0.26	<0.05
Maximum thickness (mm)	2.42 ± 0.60	2.63 ± 0.43	<0.05
Minimum thickness (mm)	0.29 ± 0.08	0.31 ± 0.00	NS
Volume (mm <sup>3</sup> ) interpolated	1343.36 ± 446.61	1511.67 ± 342.49	<0.05
Area (mm <sup>2</sup> ) Cartilage-Bone boundary	930.03 ± 255.85	906.54 ± 105.55	NS
<b>Lateral cartilage structure of the tibia</b>			
Mean thickness (mm)	1.64 ± 0.49	1.67 ± 0.35	<0.01
Maximum thickness (mm)	3.30 ± 0.98	3.38 ± 0.73	<0.01
Minimum thickness (mm)	0.31 ± 0.00	0.31 ± 0.00	<0.01 [as written in journal article]
Volume (mm <sup>3</sup> ) interpolated	1706.83 ± 630.84	1739.23 ± 453.24	<0.05
Area (mm <sup>2</sup> ) Cartilage-Bone boundary	896.69 ± 232.44	897.29 ± 165.35	NS

**Cartilage thickness of the femur (mean ± SD)**

Clinical outcome	Before therapy	After therapy	p value
Mean thickness (mm)	1.62 ± 0.25	1.54 ± 0.21	NS
Maximum thickness (mm)	3.61 ± 0.38	3.50 ± 0.58	NS
Minimum thickness (mm)	0.27 ± 0.11	0.22 ± 0.15	NS
Volume (mm <sup>3</sup> ) interpolated	9214.30 ± 1862.46	8349.79 ± 1555.34	NS

**Key safety findings**

Not reported.

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## Study 4 Levers A (2011)

### Study details

<b>Study type</b>	Cohort study (survey)
<b>Country</b>	Germany
<b>Recruitment period</b>	Not reported
<b>Study population and number</b>	n=39 patients with gonarthrosis of the knee who had MBST 4 years previously.
<b>Age and gender</b>	Age range 20 to 80 years (54% [22/39] above 60 years; 46% [18/39] under 60 years). 57% (22/39) male
<b>Patient selection criteria</b>	Not reported
<b>Technique</b>	MBST® nuclear magnetic resonance therapy was done in 9 sessions of 60 minutes on subsequent working days (device and frequency not specified)
<b>Follow-up</b>	Time since MBST: <1 year (n=9), 1 to 2 years (n=9), 2 to 3 years (n=8), 3 to 4 years (n=13)
<b>Conflict of interest/source of funding</b>	Not reported

### Analysis

Follow-up issues: long term follow-up was only in 13 patients.

Study design issues: patient reported outcomes (intensity, duration and frequency of pain and everyday activity restrictions) were assessed using an anonymised subjective patient questionnaire. Pain level (peak, medium under strain and resting) was recorded on a numerical analogue scale of 0 (no pain) to 10 (strong/continuous pain). Everyday activities restrictions were recorded on Lequesne index for knee diseases via a multiple choice questionnaire with total 24 points (where 0 to 2 represents no problem and higher values indicate a worse joint function).

Study population issues: only 8% patients were aged under 50; 90% of patients took part in endurance activities and 10% took part in sports that caused a strain on the joints.

### Key efficacy findings

- Number of patients analysed: 39

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**Patient reported outcomes: comparison of the percentage of patients with increase and decrease in pain level and Lequesne index** (time point number of patients in each category not specified)

	Pain intensity			Pain frequency			Lequesne index
	Peak level pain	Medium level pain under strain	Resting pain	Peak level pain	Medium level pain under strain	Resting pain	
Increase %	35	22	11	16	8	11	39
Decrease %	54	68	62	68	76	49	61

**Pain level and Lequesne index (according to age, gender and physical activity)** (time point and number of patients in each category not specified)

	Pain intensity			Pain frequency			Lequesne index
	Peak level pain	Medium level pain under strain	Resting pain	Peak level pain	Medium level pain under strain	Resting pain	
<b>Age</b>							
< 60 years, before/after (difference %)	3.9/2.8 (-28)	3.7/2.3 (-38)	1.6/0.6 (-63)	4.9/3.4 (-31)	5.4/3.3 (-39)	2.6-0.9 (-65)	6.4/5.3 (-17)
>60 years before/after (difference %)	3.8/2.1 (-45)	4.0/1.8 (-55)	1.8/0.4 (-78)	5.2/1.9 (-63)	6.1/2.2 (-64)	2.8/0.5 (-82)	6.9/5.1 (-26)
<b>Gender</b>							
Male, before/after (difference %)	4.0/2.6 (-35)	3.9/2.5 (-36)	1.7/0.5 (-71)	5.9/2.6 (-56)	6.4/3.0 (-53)	3.1/0.6 (-81)	7.0/5.8 (-17)
Female, before/after (difference %)	3.7/2.2 (-41)	3.8/1.5 (-61)	1.6/0.5 (-69)	4.1/2.4 (-41)	4.9/2.3 (-53)	2.2/0.8 (-64)	6.2/4.4 (-29)
<b>Physical activity</b>							
Active, before/after (difference %)	4.1/2.6 (-37)	4.1/2.3 (-44)	1.8/0.7 (-61)	5.6/2.6 (-54)	6.1/2.7 (-56)	2.6/0.9 (-65)	7.1/5.6 (-21)
Not active, before/after (difference %)	3.4/2.2 (-35)	3.4/1.8 (-47)	1.6/0.2 (-88)	4.1/2.4 (-41)	5.2/2.6 (-50)	2.9/0.2 (-93)	6.0/4.5 (-23)

## Study 5 Schmidt JK (2021)

### Study details

<b>Study type</b>	Scoping review
<b>Country</b>	Denmark
<b>Study period</b>	Search period: 1999 to 2019. databases searched: PubMed, CINAHL, AMED, Cochrane and Embase. Additional studies were identified by screening of references of included studies.
<b>Study population and number</b>	n=7 studies (6 studies on MRT on the knee, 1 study on MRT for finger, ankle and hip) (2 were RCTs and 5 were descriptive cohort studies) sample sizes ranged from 14 to 4,500 patients
<b>Age and gender</b>	mean age of patients ranged between 30 and 75 years.
<b>Study selection criteria</b>	<u>Inclusion criteria:</u> Systematic reviews, qualitative, quantitative, and mixed methods studies of any design or methodology in English, German, Swedish Norwegian and Danish languages; studies on adult patients diagnosed with osteoarthritis, examining different MRT devices and treatment programmes conducted in clinics or hospital settings, reporting all types of outcomes. <u>Exclusion criteria:</u> duplicate studies, and studies in languages not specified above.
<b>Technique</b>	MBST magnetic resonance therapy (with devices of different models from MedTec Company). Applied kHz frequency differed between 17kHz and 100 kHz. <u>Treatment duration:</u> 1 hour daily treatment (in 4 studies for 9 days, in 2 studies for 5 days and in 1 study on weekdays for 2 weeks).
<b>Follow-up</b>	Follow-up times varied between studies.
<b>Conflict of interest/source of funding</b>	None

### Analysis

Follow-up issues: follow-up times varied between studies.

Study design issues: the review was done according to the methodology of scoping reviews developed by the Joanna Briggs Institute. Comprehensive searches were done, studies were selected by 2 independent reviewers and any disagreements were resolved through consensus. Quality assessment of the studies was not performed. Review included few cohort studies with small sample size (ranging between 14 and 97 patients), and results were at high risk of bias; subjective outcome measurements such as pain, quality of life and joint function, were measured using different self-reported questionnaires in 6 studies. Structural joint changes were evaluated by a radiologist using ultrasonography with MRI in 1 study. Objective measurement of cartilage thickness through a minimal distance algorithm was done in 1 study. Evidence was synthesised narratively.

All studies used similar treatment programs. Several of the studies were in German.

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Other issues: Studies 1 to 4 in table 2 are already included in this scoping report.

## Key efficacy findings

- Number of studies analysed: 7 studies (n=4700 patients)

The review showed that there seems to be a beneficial effect of MRT in the treatment of patients with osteoarthritis in relation to improvement in pain, joint function, and quality of life and regeneration of cartilage.

### Study details and outcomes

Study details	Technique and treatment	Follow-up	Outcomes	Results
Frobose 2000 Cohort study N=14 with knee OA	MBST system 1 Cellermake Frequency-not specified, 1 hour session, 9 days	10 weeks	Objective-cartilage thickness (minimal distance algorithm)	There is distinct growth in cartilage structures
Auerbach 2003 Cohort study N=59 with cartilage knee defects	MBST system Frequency-not specified, 1 hour session, 5 days	6 months	Subjective-VAS, WOMAC, Lequesne index, lysholm	Significant improvement in pain, knee function and quality of life
Fagerer 2007 Cohort study N=25 with knee OA	MBST system KSRT 300 Frequency-100kHz, 1 hour session, 5 days	6 months	Subjective-VAS, Lequesne index,	Clear improvement in pain, knee function and quality of life
Kulich 2008 RCT N=58 with finger joint OA (34 intervention versus 28 control)	MBST system MBST 300 Frequency-100 kHz, 1 hour session, 9 days	6 months	Subjective-VAS, QUABA	Significant improvement in pain, hand function in intervention group.
Levers 2011 Cohort study N=39	MBST system Frequency-not specified, 1 hour session, 9 days	6 months -4 years	Subjective-VAS, Lequesne index,	Significant improvement in pain, knee function
Kulich 2013 Cohort study N=4500 (knee 2770)	MBST system Frequency-17-85 kHz, 1 hour session, 9 days	1 year	Subjective-VAS, Lequesne index, MAZUR	Significant improvement in pain, knee function
Gocksen 2016	MBST open system 300	12 weeks	Subjective -MRI, ultrasound	No significant differences between groups in cartilage thickness on MRI/US scores.

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RCT, N=97 (49 intervention versus 48 control)	Frequency-17-85 kHz, 1 hour session, 10 days		WOMAC, VAS, SF-36 scores.	Significant improvement in pain, knee function, quality of life but the differences were not significant between the groups.
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## Validity and generalisability of the studies

- Only 5 studies in the English language were found suitable for inclusion in the overview.
- There may be more relevant studies available in German.
- The Froböse (2000) study was published in German but we used an English translation of this study to extract the main outcomes.
- One RCT is included in the overview.
- The longest follow-up was 1 year.
- No studies on pulsed electromagnetic fields (PEMFs) were included as it was considered out of remit.
- Two of the studies<sup>2,3</sup> used the same device and the third one<sup>1</sup> used a different device.

## Existing assessments of this procedure

The Osteoarthritis Research Society International (OARSI) guidelines for the non-surgical management of knee, hip, and polyarticular osteoarthritis were published in 2019. They recommended against the use of electromagnetic therapies interventions for knee OA. <sup>4</sup>

## Related NICE guidance

Below is a list of NICE guidance related to this procedure.

### Interventional procedures

- Platelet-rich plasma injections for knee osteoarthritis. NICE interventional procedures guidance 637 (2019). Available from <http://www.nice.org.uk/guidance/IPG637>

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- Mosaicplasty for symptomatic articular cartilage defects of the knee. NICE interventional procedures guidance 607 (2018). Available from <http://www.nice.org.uk/guidance/IPG607>
- Joint distraction for knee osteoarthritis without alignment correction. NICE interventional procedures guidance 529 (2015). Available from <http://www.nice.org.uk/guidance/IPG529>
- Implantation of a shock or load absorber for mild to moderate symptomatic medial knee osteoarthritis. NICE interventional procedures guidance 512 (2015). Available from <http://www.nice.org.uk/guidance/IPG512>
- Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. NICE interventional procedures guidance 230 (2007). Available from <http://www.nice.org.uk/guidance/IPG230>

### **Technology appraisals**

- Autologous chondrocyte implantation using chondrosphere for treating symptomatic articular cartilage defects of the knee. NICE technology appraisal 508 (2018). Available from <http://www.nice.org.uk/guidance/TA508>
- Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee. NICE technology appraisal 477 (2017). Available from <http://www.nice.org.uk/guidance/TA477>

### **NICE guidelines**

- Osteoarthritis: care and management. NICE clinical guideline 177 (2014). Available from <http://www.nice.org.uk/guidance/CG177>

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## **Additional information considered by IPAC**

### **Professional experts' opinions**

Expert advice was sought from consultants who have been nominated or ratified by their professional Society or Royal College. The advice received is their individual opinion and is not intended to represent the view of the society. The advice provided by professional experts, in the form of the completed questionnaires, is normally published in full on the NICE website during public consultation, except in circumstances but not limited to, where comments are considered voluminous, or publication would be unlawful or inappropriate. No professional expert questionnaires for magnetic resonance therapy for knee osteoarthritis were submitted.

### **Patient commentators' opinions**

NICE's Public Involvement Programme was unable to gather patient commentary for this procedure.

### **Company engagement**

A structured information request was sent to 1 company who manufacture a potentially relevant device for use in this procedure. NICE received 1 completed submission. This was considered by the IP team and any relevant points have been taken into consideration when preparing this overview.

### **Issues for consideration by IPAC**

The remit of this IPG is restricted to MRT only. NICE considered pulsed electromagnetic fields (PEMFs) out of remit for this guidance.

## References

1. Kullich W, Overbeck K and Spiegel H U (2013) One-year-survey with multicenter data of more than 4,500 patients with degenerative rheumatic diseases treated with therapeutic nuclear magnetic resonance. *Journal of back and musculoskeletal rehabilitation* 26(1): 93-104
2. Goksen N, Calis M, Dogan S et al. (2016) Magnetic resonance therapy for knee osteoarthritis: a randomized, double blind placebo-controlled trial. *European journal of physical and rehabilitation medicine* 52(4): 431-9
3. Froböse I, Eckey U, Reiser M et al. (2000) Evaluation of the effectiveness of three-dimensional pulsating electromagnetic fields of MultiBioSignalTherapy (MBST ®) on the regeneration of cartilage structures [Evaluation der Effektivität dreidimensionaler pulsierender elektromagnetischer Felder der MultiBioSignalTherapie (MBST®) auf die Regeneration von Knorpelstrukturen]; *Orthopaedische Praxis* 8/2000, 510–515
4. Levers A, Staat M, van Laack W et al. (2011) Analysis of the long term effect of the MBST nuclear magnetic resonance therapy on gonarthrosis. *Orthopedic Practice* 11, p. 521-528.
5. Schmid JK, Debess JE, Moller L (2011) Magnetic resonance therapy in the treatment of osteoarthritis: A scoping review. *Radiography* (article in press) <https://doi.org/10.1016/j.radi.2021.02.011>
6. Bannuru RR, Osani MC, Vaysbrot EE, et al. (2019) OARSI guidelines for the non-surgical management of knee, hip, and polyarticular osteoarthritis. *Osteoarthritis Cartilage*. 27(11):1578-1589. doi:10.1016/j.joca.2019.06.011

## Literature search strategy

Databases	Date searched	Version/files
Cochrane Database of Systematic Reviews – CDSR (Cochrane Library)	12/04/2021	Issue 4 of 12, April 2021
Cochrane Central Database of Controlled Trials – CENTRAL (Cochrane Library)	12/04/2021	Issue 4 of 12, April 2021
International HTA database (INAHTA)	12/04/2021	-
MEDLINE (Ovid)	12/04/2021	1946 to April 09, 2021
MEDLINE In-Process (Ovid)	12/04/2021	1946 to April 09, 2021
MEDLINE Epubs ahead of print (Ovid)	12/04/2021	1946 to April 09, 2021
EMBASE (Ovid)	12/04/2021	1974 to 2021 April 09

The following search strategy was used to identify papers in MEDLINE. A similar strategy was used to identify papers in other databases.

### Literature search strategy

- 1 Osteoarthritis, Knee/ (20044)
- 2 exp Knee Joint/ (60472)
- 3 OA.tw. (29335)
- 4 ((knee\* or patella\* or meniscal\* or articular\* or patellofem\*) adj4 (OA or osteoarthritis\* or arthrosis\* or cartilage\* or degenerat\* or diseases\* or deteriorat\* or injur\* or defect\*)).tw. (51640)
- 5 ((cartilage\* or joint\* or cap\*) adj4 (degenerat\* or diseases\* or deteriorat\* or injur\* or defect\*)).tw. (45374)
- 6 Gonarthrosis\*.tw. (974)
- 7 (degenerat\* adj4 arthriti\*).tw. (1676)
- 8 or/1-7 (151298)
- 9 nuclear magnetic resonance, biomolecular/ (29086)
- 10 Magnetic Field Therapy/ (1150)
- 11 ((magnet\* or electromagnet\* or "electro-magnet\*" or "electro magnet\*") adj4 (resonan\* or field\* or stimulat\*) adj4 (therap\* or treatment\*)).tw. (4660)
- 12 (magnet\* adj4 resonan\* adj4 stimulat\*).tw. (550)
- 13 (MBST or MRT or NMRT or TMR or TNMR).tw. (5953)
- 14 ((magnet\* or electromagnet\* or "electro-magnet\*" or "electro magnet\*") adj4 (cartilage or bone\* or cell\*) adj4 (regenerat\* or repair\* or regrow\* or re-grow\* or heal\* or rehab\* or reconstruct\*)).tw. (292)
- 15 ("NMR Therap\*" or NMR-Therap\*).tw. (2)
- 16 (biophysic\* adj4 stimulat\*).tw. (262)
- 17 or/9-16 (41643)

IP overview: magnetic resonance therapy for knee osteoarthritis

18 8 and 17 (392)  
19 ARTHRO SPIN FLEX.tw. (0)  
20 ARTHRO SPIN LIFT.tw. (0)  
21 OPEN SYSTEM 700.tw. (0)  
22 OPEN SYSTEM 350.tw. (0)  
23 MBST PRO MOBILE.tw. (0)  
24 or/19-23 (0)  
25 18 or 24 (392)  
26 animals/ not humans/ (4692605)  
27 25 not 26 (331)  
28 limit 27 to ed=20210430



## Appendix

There were no additional papers identified.