| Template for Osteoarthritis scope SH subgroup discussions<br>Date: Tuesday 2nd April 2019 Group 2 | | |
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| **Scope details** | **Questions for discussion** | **Stakeholder responses** |
| **<u>Population</u>**<br><br>**Groups that will be covered:**<br><br>• **Adults aged 18 years and over with osteoarthritis**<br><br>**No specific subgroups of people have been identified as needing specific consideration**<br><br>**Groups that will not be covered:**<br><br>• **People with predisposing and associated conditions including:**<br>• **crystal arthritis (gout or pseudo-gout)**<br>• **inflammatory arthritis (including rheumatoid arthritis, psoriatic arthritis and the seronegative arthritides)**<br>• **septic arthritis**<br>• **diseases of childhood that predispose to osteoarthritis**<br>• **medical conditions presenting with joint inflammation, such as haemochromatosis**<br>• **malignancy** | Is the population appropriate?<br><br>• Are there any specific subgroups that have not been mentioned?<br><br>• Are there any specific equality issues that need to be addressed that have not already been listed?<br><br>• Are there any groups that the guideline should not cover? | The group agreed that the population was reasonable but queried whether the age cut off for adults should be 16 or 18 and over. This will be checked to ensure consistency with other guidelines.<br><br>The group agreed that no subgroups were required.<br><br>The group argued that the title of the groups that will not be covered section should be changed to 'The primary management of the following conditions will not be covered' as the current wording is unclear as it seems to suggest people who develop OA as a result of one of these conditions will not be included (e.g. does this exclude a person with rheumatoid arthritis who then develops OA?). |

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| **Key areas that will be covered:**<br>**1. Information and support** | These are the key areas that we propose covering in the guideline.<br>Do you think these are appropriate, acknowledging we must prioritise areas for inclusion? | The group agreed that this area was important. They queried what this provision would look like and agreed that how it is delivered is important. |
| **2. Diagnosis** | | The group suggested this area be renamed 'radiological issues' and the focus should be imaging and the issues surrounding this area.<br><br>The group agreed that reducing inappropriate imaging is of high importance (there is a lot of overuse of imaging in primary care specifically) and this was an opportunity for the disinvestment of imaging in current practice.<br>There was discussion about when imaging might be appropriate such as before injections and concern that in some cases no imaging takes place before an intervention is initiated. |
| **3. Non-pharmacological management, such as**<br>• **Electrotherapy**<br>• **Thermotherapy**<br>• **Exercise therapy**<br>• **Weight loss**<br>• **Manual therapy**<br>• **Arthroscopic procedures e.g. joint washing**<br>• **Aids and devices e.g. orthotics** | Self management is something not directly included here;<br>• Ask whether this is important to look at. Has there been any new evidence on the effectiveness of self management programmes? | Electrotherapy:<br>The group said this was not in widespread use in the UK, but this area could possibly form a future research recommendation.<br><br>Thermotherapy:<br>The group suggested this could be removed as people generally do this for themselves and this is not a huge cost to the NHS.<br><br>Exercise therapy: |

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| • **Acupuncture** | | The group agreed this was an important inclusion. The combination of elements such as programmes including exercise and education was raised as well as programmes based on exercise and principles of cognitive behaviour.<br><br>Weight loss:<br>This should be separate to exercise. The group agreed this was a very important inclusion from a public health aspect, particularly for knees.There are separate issues of effect of weight loss on OA itself as well as weight loss prior to surgery. The group suggested that in current practice, people were still not being referred for surgery and CCGs restricted referral on this basis.,<br><br>Manual therapy:<br>The group agreed there was very little evidence in this area and therefore this could be removed from the list.<br><br>Arthroscopic procedures:<br>The group ageed that the example of joint washing should be taken out of this area as other reasons are given for arthroscopy such as cartilage trimming. There was a need to limit the arthroscopic procedures in the context of OA.<br><br>Aids and devices:<br>The group discussed this area and agreed it would be difficult to review. Should mobility aids be included here?<br><br>Acupuncture:<br>This area is included in the chronic pain guideline and is not specific to OA therefore should be removed from this list. |
| **4. Pharmacological management, such as:**<br>- **Oral medications**<br>- **Topical agents**<br>- **Intra-articular injections** | | Oral medications:<br>Yes this should be included.<br><br>Topical agents: |

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| | | The group agreed that these were used and prescribed a lot in current practice so should be included.<br><br>Intra-articular injections:<br>The group suggested that there has been a significant change in the evidence in this area since the last OA guideline and therefore should be included. |
| **5. Referral for joint surgery** | | The group agreed this should be included and was an important area. |
| **6. Follow-up and review** | | |
| **Key clinical issues that will not be covered:**<br><br>**1. Joint replacement surgery**<br>**2. Psychological interventions**<br>**3. Nutritional supplements (e.g. nutraceuticals)** | Are the excluded areas appropriate? | Psychological interventions:<br>The group discussed programmes based on CBT which should be included. Psychological interventions as stand alone intervention should not be included.<br><br>Nutritional supplements:<br>The group suggested that there was some evidence/ongoing studies in this area so this should be considered for inclusion. |

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| **Economic aspects**<br><br>We will take economic aspects into account when making recommendations. We will develop an economic plan that states for each review question (or key area in the scope) whether economic considerations are relevant, and if so whether this is an area that should be prioritised for economic modelling and analysis. We will review the economic evidence and carry out economic analyses, using an NHS and personal social services (PSS) perspective, as appropriate. | Which practices will have the biggest cost implications for the NHS?<br><br>Are there any new practices that might save the NHS money compared to existing practice?<br><br>Which areas of the scope have the most variation in practice? | |
| **Key issues and questions:**<br><br>**1. Information and support**<br><br>**1.1 What are the information and support needs of adults with osteoarthritis, their family and carers after diagnosis?** | Are these the correct questions? | • Good models of delivery of support<br>• Particular programmes of information delivery that are used a lot?<br>• Needs to be local context to the information delivered- what activity is in my local area?<br>• More about what is needed to be commissioned re local resources/pathways. |

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| **Diagnosis** | If we include this area, what are the key questions? | |
| **2. Non-pharmacological management**<br><br>**2.1 What is the clinical and cost effectiveness of electrotherapy for the management of osteoarthritis?**<br>**2.2 What is the clinical and cost effectiveness of thermotherapy (heat and cold) for the management of osteoarthritis?**<br>**2.3 What is the clinical and cost effectiveness of exercise therapy for the management of osteoarthritis?**<br>**2.4 What is the clinical and cost effectiveness of manual therapy (manipulation and stretching) for the management of osteoarthritis?**<br>**2.5 What is the clinical and cost effectiveness of arthroscopic procedures** | We will look at the effectiveness of each of these, would looking at combinations also be useful?<br>Is there much RCT evidence on the effectiveness of combinations treatments? | The group agreed that the following questions should be removed based on their earlier discussions: 2.2, 2.4.<br><br>2.3 Exercise therapy:<br>Exercise and education should be included and there may be some psychological input here.<br><br>2.5 Arthroscopic procedures:<br>Joint washing should be removed. This question should be asked in the context of OA.<br><br>2.6 Aids and devices:<br>Add mobility aids? |

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| **(e.g. joint washing) for the management of osteoarthritis?**<br>**2.6 What is the clinical and cost effectiveness of aids and devices (e.g. orthotics) for the management of osteoarthritis?**<br>**2.7 What is the clinical and cost effectiveness of acupuncture for the management of osteoarthritis?** | | |
| **3. Pharmacological management**<br><br>**3.1 What is the clinical and cost-effectiveness of oral pharmacological interventions for the management of osteoarthritis?**<br>**3.2 What is the clinical and cost-effectiveness of topical agents for the management of osteoarthritis?**<br>**3.3 What is the clinical and cost-effectiveness of intra-articular injections with corticosteroids or hyaluronic acid for the management of osteoarthritis?** | We are thinking of comparing combinations of oral treatments. Is that useful and is there RCT data on that? | |

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| **4. Referral for joint surgery**<br><br>**4.1 What factors indicate the need for referral to consider joint replacement surgery in adults with osteoarthritis?**<br>**4.2 What is the clinical and cost-effectiveness of weight loss and/or exercise before surgery in adults with osteoarthritis?**<br>**4.3 What are the benefits and harms of delaying surgery due to specific factors (e.g. obesity/BMI) in people for whom it is indicated?** | What are the specific issues around referring for joint surgery and how could that be phrased in a question?<br><br>BMI thresholds are being used to ration surgery that are not evidence based – do you agree it is important to look at this, and how shall we do that? | • Should focus on management pre-referral<br>• Facilitating patient choice<br>• Managing obesity in terms of managing the disease of OA<br>• When is the most effective time to engage in weight loss?<br>• What is the benefit of weight loss for people with OA? |
| **4. Follow up and review**<br><br>**5.1 What is the optimum frequency of followup and review for adults with osteoarthritis?** | | • Who should be following up? |

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| **Main outcomes**<br><br>- **Health-related quality of life**<br>- **Physical function**<br>- **Pain**<br>- **Osteoarthritis flares**<br>- **Psychological distress**<br>- **Adverse events** | Are all outcomes appropriate? | Osteoarthritis flares:<br>What does this mean as an outcome measure?<br>Very unlikely to find any studies that describe OA flares but may find ones that discuss variation in symptoms.<br><br>The group also added patient reported outcomes, specifically remaining at work and participation in sport. |
| **GC composition**<br><br>- **General practitioner**<br>- **Consultant rheumatologist**<br>- **Physiotherapist**<br>- **First contact practitioner (physiotherapist)**<br>- **Orthopaedic surgeon**<br>- **Geriatrician**<br>- **Clinical pharmacist**<br>- **Pain specialist**<br>- **Musculoskeletal service commissioner**<br>- **Nurse practitioner (primary care**<br>- **Lay members x2**<br><br>- **Co-opted members**<br><br>• **Occupational therapist**<br>• **Podiatrist**<br>• **Osteopath**<br>• **Acupuncturist**<br>• **Dietician** | Do you have any comments on the proposed membership of the committee? | • Important to have both a physiotherapist and first contact practitioner<br>• Orthopaedic surgeon is very important inclusion<br>• Geriatrician doesn't need to be an ortho geriatrician<br>• Can pain specialist position be covered by geriatrician and GP?<br>• Commissioner should be from a local CCG<br>• Osteopath may not be required if manual therapies are not included. Can physio cover the co-opted osteopath?<br>• Rheumatologist with an interest in OA<br>• Radiologist would be useful co-opted member |

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1. Any other issues raised during subgroup discussion for noting:

Related NICE guidance – add lower back pain