Template for Osteoarthritis scope SH subgroup discussions Date: Tuesday 2nd April 2019		
Scope details	**Questions for discussion**	**Stakeholder responses group 3**
<u>Population</u> **Groups that will be covered:** **Adults aged 18 years and over with osteoarthritis** **No specific subgroups of people have been identified as needing specific consideration**	Is the population appropriate? • Are there any specific subgroups that have not been mentioned? • Are there any specific equality issues that need to be addressed that have not already been listed? Are there any groups that the guideline should not cover?	The group discussed whether it would be useful to differentiate for example between OA in weight-bearing and non-weight-bearing joints, or in different parts of the body. One stakeholder queried whether the frail elderly needed special consideration, as management can be difficult (for example engagement with treatments, surgery) and opioids tend to be used in this group rather than NSAIDs. It was decided that neither area needed mentioning in the scope, but it was pointed out that they could be considered by the committee when drafting the protocols.
Key clinical issues that will be covered: **1. Information and support**	These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion?	

2. Diagnosis		
3. Non-pharmacological management, such as - **Electrotherapy** - **Thermotherapy** - **Exercise therapy** - **Weight loss** - **Manual therapy** - **Arthroscopic procedures e.g. joint washing** - **Aids and devices e.g. orthotics** - **Acupuncture**		One stakeholder described a treatment not currently available on the NHS, for which RCT evidence is available. They confirmed that as it was a form of MRI, it would be covered by 'electrotherapy', and they will give further details when commenting on the draft scope. Should self-management be included, either here or under information and support? Aids and devices – add braces and taping as well as orthotics. Move arthroscopic procedures down to the referral for joint surgery section, and delete the example. Stakeholders queried whether physiotherapy would fall within exercise or manual therapy, as it contains elements of both.

4. Pharmacological management, such as: - **Oral medications** - **Topical agents** - **Intra-articular injections**		One stakeholder noted that intra-articular injections can be both ultrasound- and landmark-guided – should these methods be compared? One stakeholder asked whether cannabinoids would be covered under oral medication.
5. Referral for joint surgery		Joint washing: The group's view was that there is no new evidence in this area, but current guidance not to use it is not being followed, so it's an important area. It should be covered in the scope , or the guideline should cross-refer to relevant guidance from other organisations.
6. Follow-up and review		
Key clinical issues that will not be covered: **1. Joint replacement surgery** **2. Psychological interventions** **3. Nutritional supplements (e.g. nutraceuticals)**	Are the excluded areas appropriate?	The group agreed issues 1 and 3 should be excluded. With regard to 2: The group raised the issue of the important connection between chronic conditions like OA and mental health, but were reminded that relevant NICE guidance already covered this, including the guideline on depression in people with a chronic physical health problem.

Economic aspects 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? Are there any new practices that might save the NHS money compared to existing practice? Which areas of the scope have the most variation in practice?	Joint replacement is the definitive treatment and is very cost effective, so it's important to make sure that referral is appropriate. The group did not think there were any areas with a large amount of potential changes with regard to either clinical or cost effectiveness.
Key issues and questions: **1. Information and support** **1.1 What are the information and support needs of adults with osteoarthritis, their family and carers after diagnosis?**	Are these the correct questions?	Should self-management be covered here?

Diagnosis	If we include what are the key questions	Stakeholders thought it was very important to include this in the guideline as it's the gateway to treatment – it would be strange not to cover it and might imply that the current guidance is no longer valid. The evidence for the current recs hasn't changed -the same questions could be used. OA is usually a safe clinical diagnosis based on the history. Important areas to include would be red flags for alternative diagnoses, and the role of imaging – want to avoid people having MRI, which isn't useful for OA. Where should imaging be included, here or under referral for surgery?
2. Non-pharmacological management **2.1 What is the clinical and cost effectiveness of electrotherapy for the management of osteoarthritis?** **2.2 What is the clinical and cost effectiveness of thermotherapy (heat and cold) for the management of osteoarthritis?** **2.3 What is the clinical and cost effectiveness of exercise therapy for the management of osteoarthritis?** **2.4 What is the clinical and cost effectiveness of manual therapy (manipulation and stretching) for the management of osteoarthritis?** **2.5 What is the clinical and cost effectiveness of arthroscopic procedures (e.g. joint washing) for the management of**	We are thinking of comparing combinations of treatments	Stakeholders did not think there was much evidence available on combinations of treatments. Expert opinion would be needed. 2.6 – stakeholders mentioned two recent trials.

osteoarthritis? **2.6 What is the clinical and cost effectiveness of aids and devices (e.g. orthotics) for the management of osteoarthritis?** **2.7 What is the clinical and cost effectiveness of acupuncture for the management of osteoarthritis?**		
3. Pharmacological management **3.1 What is the clinical and cost-effectiveness of oral pharmacological interventions for the management of osteoarthritis?** **3.2 What is the clinical and cost-effectiveness of topical agents for the management of osteoarthritis?** **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 treatments	Stakeholders did not think there would be much evidence available on combinations of treatments, because trials tend to be funded by pharmaceutical companies focusing on their product. It will be important to look at opioids, because they are being inappropriately prescribed for some people. One stakeholder said that 3.2 should include lidocaine.

4. Referral for joint surgery **4.1 What factors indicate the need for referral to consider joint replacement surgery in adults with osteoarthritis?** **4.2 What is the clinical and cost-effectiveness of weight loss and/or exercise before surgery in adults with osteoarthritis?** **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?**		Stakeholders reported that CCGs are using BMI/obesity as an inappropriate way of rationing surgery for OA – there is no evidence that obesity makes the surgery less effective for OA so considering place of weight loss advice or weight loss requirement before surgery is important. Obesity is a risk factor for arthritis 4.2 could be deleted as there is no evidence – focus on 4.3 4.3 Should also target other inappropriate factors used for rationing, such as smoking and diabetes. Stakeholders warned that BMI alone is not a good indicator, because rapid weight loss (e.g. through bariatric sugery) can lead to a drop in BMI that is not matched by an equivalent improvement in metabolic function – can be dangerous.
5. Follow up and review **5.1 What is the optimum frequency of follow up and review for adults with osteoarthritis?**		

Main outcomes - **Health-related quality of life** - **Physical function** - **Pain** - **Osteoarthritis flares** - **Psychological distress** - **Adverse events**	Are all outcomes appropriate?	
GC composition - **General practitioner** - **Consultant rheumatologist** - **Physiotherapist** - **First contact practitioner (physiotherapist)** - **Orthopaedic surgeon** - **Geriatrician** - **Clinical pharmacist** - **Pain specialist** - **Musculoskeletal service commissioner** - **Nurse practitioner (primary care** - **Lay members x2** - **Co-opted members** • **Occupational therapist** • **Podiatrist** • **Osteopath** • **Acupuncturist** • **Dietician**	Do you have any comments on the proposed membership of the committee?	Stakeholders felt the following could be excluded: • Pain specialist – they only deal with extremes, not 98% of patients • Geriatrician – they don't deal with OA, unless someone with a special interest in OA could be recruited • Nurse practitioner – they don't receive specialist OA teaching It would be good to include a co-opted radiologist.

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