Template for Osteoarthritis scope SH subgroup discussions Date: Tuesday 2nd April 2019		
Scope details	**Questions for discussion**	**Stakeholder responses**
<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** **Groups that will not be covered:** • **People with predisposing and associated conditions including:** • **crystal arthritis (gout or pseudo-gout)** • **inflammatory arthritis (including rheumatoid arthritis, psoriatic arthritis and the seronegative arthritides)** • **septic arthritis** • **diseases of childhood that predispose to osteoarthritis** • **medical conditions presenting with joint inflammation, such as haemochromatosis** • **malignancy**	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?	Osteoarthritis flares need to be considered in management

Key areas that will be covered: **1. Information and support**	These are the key areas that we propose covering in the guideline. Do you think these are appropriate, acknowledging we must prioritise areas for inclusion?	**Notes on each section are below in the specific questions section**
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**	Self management is something not directly included here; • Ask whether this is important to look at. Has there been any new evidence on the effectiveness of self management programmes?	
4. Pharmacological management, such as: - **Oral medications** - **Topical agents** - **Intra-articular injections**		
5. Referral for joint surgery		
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?	Psychological needs to be included in some way. Nutritional supplements – these are lower priority due to lower quality of evidence; are there safety concerns? This would be difficult to define and address all the possible supplements
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?	

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?	- HOW to manage is important – self management is important, - Importance of advice for BOTH patients and carers highlighted - Information for patients before NHS contact – so via community care, exercise specialists, pharmacists - Type or format – group settings can be important, brief discussion about developing technologies such as apps and social media for deliverying info and support - WHO delivers the information?
Diagnosis	If we include this area, what are the key questions?	Discussed current process of imaging, main xrays Consensus on xrays not useful and waste of resources – HOWEVER, acknowledgement of patient expectations regarding x-rays. Discussed other forms of diagnosistic imaging/prediction – Gait analysis technology Joint morphology discussed as good diagnosis tool Infrared analysis Thermology Morphology modelling Leeds MRI score

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 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?**	We will look at the effectiveness of each of these, would looking at combinations also be useful? Is there much RCT evidence on the effectiveness of combinations treatments?	

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 oral treatments. Is that useful and is there RCT data on that?	TENS discussed -This can be used independently via over the counter products, is it something we want to comment on if people will use without healthcare advice or input Discussed how weight loss is usually in combination with other interventions Thermotherapy is extremely useful, but is often used regardless of professional advice for self-help and not a cost to NHS Weight loss – significant to be able to state actual numerical targets for effectiveness for joint care if this is known Aids and devices – straps, braces, splints, “SWIFT”? Acupuncture –effective use as a placebo, making it worth including Electro acupuncture is an option

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?**	What are the specific issues around referring for joint surgery and how could that be phrased in a question? 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?	Obesity should be kept separate from other condtions Discussed indications for surgery briefly Need to get the right message across – surgery can be needed regardless of weight loss Concern around over referral – thresholds need to be clear Overlap with indicators for imaging as imaging before referral may be appropriate 4.1 – trial of conservative management needs to happen before, 4-6 months Criteria for direct referral to surgery discussed – knee locking, radiographic changes, failure of other methods
5. Follow up and review **5.1 What is the optimum frequency of followup and review for adults with osteoarthritis?**	OBS only?	Content of appointment? Psychological aspect Are we looking at inactive OA or flare-ups? Self referral? Options to have opt-in appointments discussed – allows flexibility of service, self care and other care in between appointments Reviews of medication if given Suggestion that this is just about frequency and very dependent on interventions.

Main outcomes - **Health-related quality of life** - **Physical function** - **Pain** - **Osteoarthritis flares** - **Psychological distress** - **Adverse events**	Are all outcomes appropriate?	Questioned psychological distress –anxiety / depression is better Carer burden is an issue Ability to return to work/activities is important
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?	Psychotherapist

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

A Leeds stem cell study was mentioned

Possibility of frailty as a subgroup discussed