**EULAR Straddles the Data-Opinion Gap on Hip OA**

BY CHRISTINE KILGORE Contributing Writer

ew recommendations from the European League Against Rheumatism on the management of hip osteoarthritis come from two camps—the best available research evidence, and expert opinion/current practice—and these camps are not always in agreement.

Discordances between expert opinion and the literature demonstrate the need for more clinical trial data specifically on hip osteoarthritis (OA) and make EULAR’s 10 treatment recommendations truly an “open recommendation set” that should provide a frame of reference for physicians, said Maxime Dougados, M.D., who led the multidisciplinary task force that wrote the recommendations.

“We provide 10 take-home messages, but without providing any strict guidelines or a treatment algorithm,” said Dr. Dougados, chief of rheumatology at the Hospital Cochin in Paris.

Total hip replacement is not supported by strong research evidence, for instance, but “nevertheless, all the experts consider it of clinical benefit,” he said.

In their report, he and his colleagues note that “more clinical trial data specific to hip OA are needed, especially because some interventions appear to show different efficacy according to the joint site” (Ann. Rheum. Dis. 2005;64:669-81).

Despite shortcomings in research, the recommendations are useful and “eminently reasonable,” said Marc C. Hochberg, M.D., who helped develop the American College of Rheumatology’s recommendations for managing osteoarthritis of the hip and knee. ACR’s recommendations were published in 2000.

The recommendations, each of which includes an analysis of cost-effectiveness, indicate that optimal management of hip OA should be individually tailored; that it requires a combination of nonpharmacologic and pharmacologic treatment modalities; and that nonpharmacologic treatment should include education, exercise, devices such as insoles, and weight reduction if necessary.

The experts were asked to assess separately the strength of each intervention based on research evidence and clinical experience. Of the interventions reviewed in the new recommendations, 15 were positively supported by evidence of many grades. However, only 15% of these interventions with no direct efficacy data—received a relatively high mean “strength of recommendation” rating (79%) based on clinical expertise, for instance.

Total hip replacement was similar: It received a low “strength of recommendation” rating based on research evidence (A on an A-D scale), but a high rating (86%) based on clinical expertise.

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The high-resolution delineation of cartilage defects and abnormalities that MRI provides can help guide patient selection and preoperative planning. Postoperatively, MRI can be used to monitor the integrity and durability of the repair, said Dr. Hochberg, head of rheumatology and clinical immunology at the University of Maryland.

Three interventions—acetaminophen, glucocorticoids, and opioids—had no direct, hip-specific evidence to support their use, and another three interventions—ASU, diacerein, and intraarticular steroid injection—had either evidence showing no significant benefit or inconclusive evidence. Still, based on clinical experience, these treatments were deemed effective and have been recommended for use in OA.

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