NSAIDs plus a gastroprotective agent, or a selective cyclooxygenase-2 inhibitor, should be used.

- **Opioid analogs**, with or without acetaminophen, are useful alternatives in patients in whom NSAIDs (including celecoxib) are contraindicated, ineffective, and/or poorly tolerated.

- **Joint replacement** has to be considered in patients with radiographic evidence of hip OA who have refractory pain and disability.

- **Osteotomy** and joint preserving surgical procedures should be considered in young adults with symptomatic hip OA, especially in the presence of dysplasia or varus/varus deformity.

- **Diacerein and avocado soybean unsaponifiable** (ASU) were found to be effective in hip OA, especially in the presence of dysplasia or varus/varus deformity. However, their “effect sizes are small, suitable patients are not well defined, and structure-modifying effects are not well established,” according to the recommendations. In any case, such guidance has limited applicability in the United States, given the lack of availability of these two compounds, noted Dr. Hochberg, head of rheumatology and clinical immunology at the University of Maryland.

Three interventions—acetaminophen, glucocorticoid intra-articular injection—had no direct, high-specific evidence to support their use, and another three interventions—ASU, diacerein, and intraarticular steroid injection—had either evidence showing no symptomatic benefit or inconclusive evidence. Still, based on clinical experience, these treatments were deemed effective and have been recommended from cartilage OA.

“May be true treatment differences for OA according to the site affected,” wrote the task force members, “are more pronounced than in the hip. These differences are likely to be the result of the different mechanical stresses on the hip joint attributable to activity and the different anatomy of the hip joint.”

**Acetaminophen**—one of the three 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 C on an A-D scale), but a high rating of 44% based on clinical expertise. Opioids, on the other hand, received a high rating (A on an A-D scale) based on research evidence but a low rating (44%) based on clinical expertise. NSAIDs were rated highly with respect to both to research evidence of efficacy (A) and to clinical expertise (80%).

“It’s clear now that NSAIDs might have a controversial toxicity,” said Dr. Doughan, director of the TUI Research Center at the University of Michigan in Ann Arbor. Fibromyalgia patients and healthy individuals were found to have different thresholds of pain in areas not thought to be tender—the forearms and fingers, for example—as at the recognized tender points. In addition, the cutoff of 11 out of 18 tender points is arbitrary. “We know that tenderness varies a great deal from day to day and week to week, especially in women,” he said.

In clinical practice, many physicians are realizing an arbitrary nature of the diagnostic criteria. The diminished role of tenderness points represents a shift in the way that they view the disorder. In the past, the disorder was considered a discrete illness with pain and focal areas of tenderness. In more recent years, fibromyalgia has been appreciated as part of a larger continuum, with many somatic symptoms and diffuse tenderness all over the body—not just at tenderness points.

Tender points are “not even a good way to measure tenderness,” as study findings suggest that the number of tender points correlates with higher mental stress than with pain, Dr. Clauw pointed out.

—Kerrin Wachter