Sustained Weight Loss Improves Symptoms of Knee Osteoarthritis

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VIENNA — Obese individuals with knee osteoarthritis who successfully lose 11% of their body weight and keep it off for a year can reasonably expect a 20% improvement in knee symptom scores, Robin Christensen reported at the annual European Congress of Rheumatology.

This is a moderate to large treatment effect. Clinically, it’s as good as or better than can be achieved with current drug therapy — and without the side effects, said Mr. Christensen of Frederiksberg Hospital, Copenhagen.

He presented a 1-year randomized trial in which 89 obese patients with knee osteoarthritis were assigned to an intensive dietary intervention featuring weekly counseling sessions, with an emphasis upon a low-energy diet, or to a control group that got standard dietary counseling on four occasions during the year. Patients averaged 63 years of age, with a mean baseline body mass index of 36 kg/m².

At year’s end, the intervention group had lost an average of 10.9 kg or 11% of baseline weight, while controls lost 3.3 kg, or 3%. Over all, 15% in the intervention arm and 9% of controls managed to sustain at least a 10% weight loss.

The key study finding: Patients in the intensive-diet arm experienced a mean 20% reduction in their total Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) scores from a baseline of 936, while there was no significant change in WOMAC scores in the control group.

Mr. Christensen and his coworkers calculated that for each 1% reduction in body weight maintained for a year, WOMAC scores improved by at least 15 points.

This yearlong study follows an earlier 8-week randomized trial by the same Danish investigators, in which they showed that more than one-fourth of obese patients with knee osteoarthritis were able to sustain at least a 10% weight loss.

The initial, unadjusted model showed that for women aged 75-84 years and those aged 85 and older, the odds ratios for reieving knee pain and muscle weakness, and those aged 85 and older, respectively. One “surprise” finding was that “the differences in exercise counseling across the age groups were more pronounced for men with less comorbidity than those with greater comorbidity,” Dr. Schonberg said for, example, the odds ratio for exercise counseling was 0.4 for women aged 85 or older with fewer than two comorbidities, compared with women aged 50-64 years with the same comorbidity, while it was 0.7 for women older than 85 with two or more comorbidities. This trend was consistent across all age groups.

These findings suggest that age is a conceptual barrier to clinicians discussing exercise, with patients, despite an awareness of the benefits of physical activity. “The greatest disparity is among older women.”