

Osteoarthritis *in older adults*

Osteoarthritis is the most common chronic disease affecting older persons—half of all individuals age 65 years and older report having “arthritis.”¹ X-ray evidence of osteoarthritis is seen in 27 percent of people aged 65–69 years, increasing to 51 percent for those aged 85 or older.² Osteoarthritis is associated with pain, functional disability,^{3,4} and being homebound,⁵ and accounts for half of all disability among older persons.^{5,6} Identified risk factors include aging, gender, trauma, obesity, genetic factors, and increased bone density.⁷

Because there is no cure for osteoarthritis, the primary goals of therapy are to minimize pain and disability, maintain or improve joint mobility, and educate patients and their families about the disease and its therapy. Pharmacologic, non-pharmacologic, and surgical treatments are available for patients with osteoarthritis. The recent literature includes some important findings about the treatment of this disease:

According to a review of multiple clinical trials, moderate exercise programs may reduce pain and improve the functional status of patients with osteoarthritis of the knee and hip.⁸

People age 75 and older who use non-selective COX-inhibitor types of non-steroidal anti-inflammatory drugs (NSAIDs) to treat osteoarthritis are two and a half times more likely to develop peptic ulcer disease than individuals who are not treated with these agents.⁹

A randomized clinical trial has shown that acetaminophen, in adequate doses, is as effective as ibuprofen for treating osteoarthritis of the knee and is less toxic.¹⁰

One clinical trial has reported equivalent efficacy between a COX-2 inhibitor and a traditional NSAID for the treatment of osteoarthritis. Two other clinical trials reported that COX-2 inhibitors are associated with a modest reduction in GI intolerance relative to traditional NSAIDs.^{11–13}

Clinical trial data show that most patients who undergo total joint replacement for severe osteoarthritis of the knee or hip have substantial improvements in function and quality of life.^{14–19}

As the literature shows, effective therapies exist to treat osteoarthritis; however, some of these therapies are associated with substantial risks. Therapeutic regimes should maximize patient outcomes while simultaneously helping to reduce the risks of therapy. Several studies have demonstrated that the use of pharmacologic, non-pharmacologic, and surgical treatments differs by region and subspecialty.^{20–22} Indirect evidence suggests these differences lead to variations in outcomes and quality of care.

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