Appendix 2 - A stepwise approach to treating arthritis pain

Consider non-pharmacological therapies eg education, regular exercise and weight reduction

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Consider use of simple analgesics such as paracetamol and/or topical NSAIDs

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Consider oral NSAID where there is a clear indication for anti-inflammatory agent. If essential use the lowest effective dose for the minimum period of time.
Avoid if at all possible in patients with any of the following:
cardiovascular disease,
moderate heart failure,
cerebrovascular disease,
renal disease.
(Caution also advised if patient has diabetes mellitus, hypertension, is taking ACE inhibitor, angiotensin-II antagonist, or potentially nephrotoxic drug)

Consideration of CV risk

- In patients in whom CV risk is a significant concern, ibuprofen up to 1200 mg per day is advised
- COX-2s (celecoxib and etoricoxib are contraindicated in patients with established CVD).
- Diclofenac 150 mg / day appears to be associated with a similar excess risk of thrombotic events to COX-2s (approx 3 per 1000 pa)* and should be avoided in patients with established CVD unless patient benefits outweigh risks.

(* MeReC Extra 30 Nov 2007)

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Is the patient at high risk of developing serious GI adverse events?
If yes and NSAID use is unavoidable consider co-prescribing of PPI for gastroprotection
eg Omeprazole 20 mg

The following groups are at high GI risk:

- Those of 65 years of age and over
- Those with a previous clinical history of gastroduodenal ulcer, gastrointestinal bleeding or gastroduodenal perforations
- Those using concomitant medications known to increase the likelihood of upper GI events, especially steroids, anticoagulants and other NSAIDs (including aspirin)
- Those with serious co-morbidity such as cardiovascular disease, renal or hepatic impairment, diabetes and hypertension
- Those requiring prolonged use of maximum recommended dose NSAIDs
- Patients with osteoarthritis (NICE CG59)

In OA, NICE CG59 advises co-prescribing of a PPI with both standard NSAIDS and COX-2 inhibitors. The use of a PPI with any NSAID significantly reduces the risk of GI side effects. There is as yet no good evidence that adding a PPI to a COX-2 is more beneficial, equivalent or worse than adding a PPI to a traditional NSAID.

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First line NSAIDs
Ibuprofen 400 - 800 mg tds or
Naproxen 250 - 500 mg bd
(if longer action required)

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If ineffective consider other formulary NSAIDs

First line drugs [g]	Second line drugs [b]	Specialist initiated drugs [o]	Hospital only drugs [p]