

Negrín, Centro de Salud Dr. Guigou (Tenerife), Antonio Pérez Márquez, Centro de Salud La Orden (Huelva), Vicente Reyes Adrian, Centro de Salud La Vileta (Palma de Mallorca), Emilio Aberasturi CS. Abechuchu Vitoria Gasteiz

References

1. Peat G, McCarney R, Croft P. Knee pain and osteoarthritis in older adults: a review of community burden and current use of primary health care. *Ann Rheum Dis.* 2001;60:91-7.
2. WHO. Monthly Bulletin. 2003. Available on: <http://www.who.int/bulletin/volumes/81/9/ITMB.pdf>.
3. Jordan KM, Arden NK, Doherty M, Bannwarth B, Bijlsma JW, Dieppe P, et al. EULAR Recommendations 2003: an evidence based approach to the management of knee osteoarthritis: Report of a Task Force of the Standing Committee for International Clinical Studies Including Therapeutic Trials (ESCISIT). *Ann Rheum Dis.* 2003;62:1145-55.
4. Zhang W, Doherty M, Arden N, Bannwarth B, Bijlsma J, Gunther KP, et al. EULAR evidence based recommendations for the management of hip osteoarthritis: report of a task force of the EULAR Standing Committee for International Clinical Studies Including Therapeutics (ESCISIT). *Ann Rheum Dis.* 2005;64:669-81.
5. Phillips LS, Branch WT, Cook CB, Doyle JP, El-Kebbi IM, Gallina DL. Clinical inertia. *Ann Intern Med.* 2001;135:825-34.
6. Hansson L, Zanchetti A, Carruthers SG, Dahlof B, Elmfeldt D, Julius S, et al. Effects of intensive blood-pressure lowering and low-dose aspirin in patients with hypertension: principal results of the Hypertension Optimal Treatment (HOT) randomised trial. HOT Study Group. *Lancet.* 1998;351:1755-62.
7. UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). *Lancet.* 1998;352:854-65.
8. Cook CB, Ziemer DC, El-Kebbi IM, Gallina DL, Dunbar VG, Ernst KL, et al. Diabetes in urban African-Americans. XVI. Overcoming clinical inertia improves glycemic control in patients with type 2 diabetes. *Diabetes Care.* 1999;22:1494-500.
9. Altman RD. Classification of disease: osteoarthritis. *Semin Arthritis Rheum.* 1991;20:40-7.
10. Huskisson EC. Measurement of pain. *Lancet.* 1974;2:1127-31.
11. Escobar A, Quintana JM, Bilbao A, Azkarate J, Guenaga JI. Validation of the Spanish version of the WOMAC questionnaire for patients with hip or knee osteoarthritis. Western Ontario and McMaster Universities Osteoarthritis Index. *Clin Rheumatol.* 2002;21:466-71.
12. Vilagut G, Valderas JM, Ferrer M, Garin O, Lopez-Garcia E, Alonso J. [Interpretation of SF-36 and SF-12 questionnaires in Spain: physical and mental components]. *Med Clin (Barc).* 2008;130:726-35.
13. Ware JE, Kosinski M, Keller SD. *How to score the SF-12 physical and mental health summary scales.* 2nd edn Boston: The Health Institute; 1995.
14. Utah Health Status Survey. Interpreting the SF-12. 2001. Available on: <http://health.utah.gov/oph/publications/2001hss/sf12/SF12-Interpreting.pdf>.
15. McCarney R, Warner J, Iliffe S, van Haselen R, Griffin M, Fisher P. The Hawthorne effect: a randomised, controlled trial. *BMC Med Res Methodol.* 2007;7:30.
16. O'Connor P, Sperl-Hillen J, Johnson P, Rush W, Biltz G. Clinical inertia and outpatient medical errors. In: Henriksen K, Battles JB, Marks ES, editors. *Advances in Patient Safety: From Research to Implementation.* L DI, vol. 2. Rockville: Agency for Healthcare Research and Quality; 2005.
17. Borgermans L, Goderis G, Broeke CV, Mathieu C, Aertgeerts B, Verbeke G, et al. A cluster randomized trial to improve adherence to evidence-based guidelines on diabetes and reduce clinical inertia in primary care physicians in Belgium: study protocol [NTR 1369]. *Implement Sci.* 2008;3:42.
18. Feldman RD, Zou GY, Vandervoort MK, Wong CJ, Nelson SA, Feagan BG. A simplified approach to the treatment of uncomplicated hypertension: a cluster randomized, controlled trial. *Hypertension.* 2009;53:646-53.
19. Conaghan PG, Dickson J, Grant RL. Care and management of osteoarthritis in adults; Summary of Nice guidance. *BMJ.* 2008;336:502-3.

COMMENTARY

Clinical Inertia in Osteoarthritis

Inercia clínica en la artrosis

Antoni Sisó Almirall

Transverse Group for Research in Primary Care, Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS) and University of Barcelona, Centre d'Atenció Primària - Les Corts, GESCLINIC, Barcelona, Spain

Osteoarthritis (OA), or degenerative joint disease, refers to a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life

(QoL). Moreover OA is one of the leading causes of pain and disability worldwide. Any synovial joint can develop osteoarthritis but hips, knees, ankles and small hand joints are the peripheral sites most commonly affected. Risk factors include age older than 50, injury to a joint, obesity, competitive contact sports, and heredity. The number of

people with osteoarthritis or low back pain is increasing as the population ages, and as the prevalence of risk factors such as obesity and poor levels of physical activity also continues to rise.¹

The concept - *clinical inertia* - appeared indexed for first time in 2001 by Philips et al.,² and defined as “failure of healthcare providers to initiate or intensify therapy when indicated” and “recognition of the problem, but failure to act”. Although - *therapeutic inertia* - may be used in the literature to mean failure to use pharmacological treatments, the term clinical inertia is used more broadly and can be synonymous.

Observational and qualitative studies found that pain, disability and depressed mood were important factors affecting the QoL of patients with OA, but these patients also have fatigue, stiffness, anxiety, sleep disturbances and depression. There are a wide range of clinical patterns: patients that believe OA is not a serious disease and view its symptoms as an inevitable part of getting old, disabled patients with affected mood, patients that know how to manage an acute episode, or patients who consult their family doctor too often. Probably for this reason, and due to the fact that pain threshold is different for each patient, the family doctors may underestimate or overestimate the care they give.

Clinical inertia has been studied in many diseases such as hypertension, diabetes, cardiovascular diseases, osteoporosis, etc.^{3,4} Most of them have clear clinical outcomes (goals), a treatment efficacy that can be measured, and numerical variables available that may improve disease control. Sometimes in OA is difficult to collect these features. In the case of OA there is evidence to show that patients’ perception of how patient centered a consultation is strongly predicts positive health outcomes and health resource efficiency (that is, fewer referrals), as Tejedor et al. demonstrated in their study.⁵ Recently, Lineker et al.⁶ review studies evaluating the influence of educational programs to implement clinical practice guidelines for OA and rheumatoid arthritis in primary care, and their conclusion is similar to Tejedor again. Literature on educational programs for the implementation of OA clinical guidelines in primary care is sparse, and it’s difficult to change health professional behaviors because only the structural and organizational behavior changes might improve the educational interventions. Nevertheless, Lineker et al. demonstrated that educational intervention led by trained physicians may improve physician prescribing, and workshops with nurse case-management support decrease referrals to orthopedics (grade A evidence). Self-management can be part of the solution. Patients who are able to believe in their ability to control pain can become more active participants in making decisions regarding their disease (such as exercise or weight loss).

In accordance with the recommendation of Royal College of Physicians,¹ there are three *core interventions* which should be considered for OA: a) Education, advice and information access, b) strengthening exercise aerobic fitness

training, and c) weight loss if overweight or obese. General Practitioners and nurses should be trained to promote self-care in the core interventions, and every follow-up visit should include a patient-centered assessment of progress, a review of pharmacological treatment and adverse effects, considerations related to general health promotions and disease prevention, and a review of functional abilities. If patient requires pharmacological treatment we should to consider patient’s needs, preferences and comorbid conditions.

Tejedor et al found that patients did not seem to obtain a clinical benefit from the intervention, but there are still many unanswered questions that can be studied in the future: we have a very little data about use of non-pharmacological therapy in very elderly, we don’t know the long-term benefits that can offer a patient-centred approach for pain management, or long-term benefits by self-management programmes. We still have much to do.

Key points

In the case of OA there is evidence to show that patients’ perception of how patient centered a consultation is strongly predicts positive health outcomes and efficiency (that is, fewer referrals).

It’s difficult to change health professional behaviors because only the structural and organizational behavior changes might improve the educational interventions.

Self-management can be part of the solution. Patients who are able to believe in their ability to control pain can become more active participants in making decisions regarding OA.

References

1. National Collaborating Centre for Chronic Conditions. Osteoarthritis: National Clinical Guideline for care and management in adults. London: Royal College of Physicians; 2008. ISBN 978-1-86016-329-6.
2. Phillips LS, Branch WT, Cook CB, Doyle JP, El-Kebbi IM, Gallina DL. Clinical inertia. *Ann Intern Med.* 2001;135:825–34.
3. Gil-Guillén V, Orozco-Beltrán D, Pérez RP, Alfonso JL, Redón J, Pertusa-Martínez S, et al. Clinical inertia in diagnosis and treatment of hypertension in primary care: quantification and associated factors. *Blood Press.* 2010;19:3–10.
4. Harris SB, Kapor J, Lank CN, Willan AR, Houston T. Clinical inertia in patients with T2DM requiring insulin in family practice. *Can Fam Physician.* 2010;56:e418–24.
5. Tejedor Varillas A, León Vázquez F, Lora Pablos D, Pérez Martín A, Vargas Negrín F, Gómez de la Cámara A. Can an intervention on clinical inertia have an impact on the perception of pain, functionality and quality of life in patients with hip and/or knee osteoarthritis? Results from a cluster randomised trial. *Aten Primaria.* 2012;44:65–72.
6. Lineker SC, Husted JA. Educational interventions for implementation of arthritis clinical practice guidelines in primary care: effects on health professional behavior. *J Rheumatol.* 2010;37:1562–9.