Keeping younger OA patients active

By Maureen Leahy

Due to the breakdown of cartilage that can occur with aging, osteoarthritis (OA) is often associated with older patients. However, OA is becoming increasingly common in younger, active patients (aged 40 to 60 years), especially those who have sustained serious joint injuries, such as anterior cruciate ligament tears.

What challenges, if any, are associated with treating OA of the knee in this patient population? AAOS Now posed this question and others to Brian T. Feeley, MD, lead author of “Management of Osteoarthritis of the Knee in the Active Patient,” which appears in the July issue of the Journal of the AAOS (JAAOS).

AAOS Now: Why is treatment of OA of the knee more of a challenge in younger, active patients?

Dr. Feeley: Younger, more active patients are challenging to treat because their demands are much higher. Traditional treatment options in older patients usually include advising, “just back off your activities and you’ll feel better,” but that is not an option in younger patients. Our goal as sports medicine physicians is also to keep every patient as active as possible, even in the setting of arthritis.

AAOS Now: The AAOS Clinical Practice Guidelines on Treatment of OA Knee includes a recommendation that lateral heel wedges not be prescribed for patients with symptomatic medial compartmental OA knee, but your article points to studies that say there is a role for these devices. Which patients do you think would benefit from them?

Dr. Feeley: Treating patients with arthritis in the medial compartment of the knee is largely individualized to the patients’ goals, their limitations, and the best possible treatment options. It often requires trying multiple different modalities to best restore the patient to an active healthy state. Even though not a lot of evidence exists to say that the use of unloading bracing or heel wedge for isolated medial or lateral arthritis is beneficial, these modalities are often helpful as nonsurgical options. In addition, they can be predictive of who will do well with an osteotomy.

AAOS Now: Based on your research and clinical experience, do specific patients benefit from bracing? If so, what are the indications for its use?

Dr. Feeley: Patients who would do well with an osteotomy often will do well with a brace initially. My indications for using an unloading brace are patients with unicompartimental arthritis who do not wish to undergo a surgical procedure and wish to try a brace. I think that treatment for arthritis in this age group really must be individualized to focus on each patient’s problems and his or her desires.

AAOS Now: Have you observed a trend toward one type of treatment method over another for OA of the knee in younger, active patients?

Dr. Feeley: The trend in younger patients with OA of the knee is to maximize the nonsurgical and minimally invasive options prior to proceeding with a knee replacement. Many of these modalities can offer a relatively long-term improvement in symptoms prior to the need of joint replacement.

AAOS Now: Are nonsurgical treatment methods for OA of the knee merely short-term solutions in younger, active patients?

Dr. Feeley: In young patients with arthritis, nonsurgical treatment options are usually temporary solutions to a long-term problem. However, using a combination of modalities—such as physical therapy, some activity modification (ie, more biking and swimming, less running), injections, and bracing—often can give patients many years of continued athletic activities prior to a knee replacement.

Offloading procedures such as tibial and femoral osteotomies can also give many years of a pain-free knee with a high level of activity. Knee replacement is a tremendously successful procedure and should not be considered a failure of all other options. Although activity levels are not quite as high after knee replacement, patients can maintain a very athletic lifestyle after knee replacement.

AAOS Now: What are the indicators for potential success among the various surgical options?

Dr. Feeley: The best indicator for success of a surgical procedure is the proper indication for each surgery. For example, although arthroscopy is not indicated for generalized knee arthritis, it is a very successful procedure in patients with a background of arthritic pain and an acute onset of a meniscal tear. That acute pain will usually resolve following arthroscopic meniscal débridement. In addition, patients with isolated medial or lateral compartment arthritis are often good candidates for osteotomies.

AAOS Now: What about the use of complementary or alternative therapies? What do you tell patients who ask about the use of glucosamine and/or chondroitin sulfate?

Dr. Feeley: An individualized treatment plan that takes the patients’ desires into consideration is important. If patients wish to try alternative treatments such as acupuncture, then I think it is worth a try. However, I do caution patients that there is not good evidence to support the use of these treatments. I do not typically recommend the use of glucosamine/chondroitin sulfate because not much good evidence supports their use, and I have not had experience with these supplements improving pain or activity levels in patients with arthritis. However, if patients have had success taking these supplements, then I encourage them to continue their use.

Disclosure information: Dr. Feeley reports no conflicts related to the subject of the JAAOS article.

A link to the JAAOS article is available in the online version of this article, at www.aaosnow.org

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Fig. 1 Treatment algorithm for knee arthritis in the young, active person. NSAIDS = nonsteroidal anti-inflammatory drugs, OA = osteoarthritis