SUMMARY OF DEBATE

Management of Side-effects from Anti-rheumatic Drugs

K.D. RAINSFORD
Division of Biomedical Sciences, Sheffield Hallam University, Sheffield, UK

Panel:

Professor W Watson Buchanan (McMaster University & Osler Health Institute, Hamilton, Ontario, Canada), Professor George E Ehrlich (Philadelphia, PA, USA), Dr Brian L Hazleman (Addenbrooke’s Hospital, Cambridge, UK), Professor Richard H Hunt (McMaster University, Hamilton, Ontario, Canada), Professor Walter F Kean (McMaster University, Hamilton, Canada), Professor George Nuki, University of Edinburgh, Edinburgh, UK), Professor Laurie F Prescott (University of Edinburgh, Edinburgh, UK), Dr Michael L Snaith (University of Sheffield, Sheffield, UK), and Professor Kim D Rainsford, Chairman (Sheffield Hallam University, Sheffield, UK).

The objectives of the debate were (a) to identify the major issues concerning the problems of managing the patient with the drugs used to treat rheumatic patients with the objective of trying to reduce the occurrence of serious side-effects from these drugs, (b) where possible arrive at a consensus for recommending preventative procedures or treatments to reduce the side-effects from anti-rheumatic and analgesic agents, and (c) to make recommendations for future studies.

The panel were asked, individually, to make a statement concerning a major issue they considered important for consideration. The other members of the panel were then asked to either challenge the point(s) made by this individual or if they agreed to state the basis for their agreement. Finally, the issue was addressed to the audience participating in the meeting for comment(s).

The major issues identified were:

1. The occurrence of acute gastro-intestinal (GI) bleeding and ulceration from NSAIDs and whether paracetamol (acetaminophen) should be more widely prescribed in place of NSAIDs especially for the elderly patients at risk of potential for such serious GI side-effects;

2. The real risk for the patient, especially in the elderly, of hepatotoxicity from paracetamol;

3. Many patients with mild painful conditions (e.g. shoulder or back pain) should not be given NSAIDs (or indeed any drugs) but that they should be given alternative treatments (e.g. physical therapy);
(4) Should patients with osteoarthritis (OA) be treated with paracetamol rather than NSAIDs to control the pain?

(5) Should colchicine or chloroquine (or hydroxychloroquine) be given for osteoarthritis?

(6) Many patients want to know from the doctor 'what will happen if you treat me' as well as 'what will happen if you don't treat me'. It follows that (a) the doctor usually addresses the former and prescribes drug(s), and (b) little attempt is made to address the natural history of the disease in the individual;

(7) Are patients being over-medicated?

(8) Most adverse events occur in the first few weeks after treatment. What are the consequences of this?

(9) Should the role of the doctor be to act as an advisor rather than an advocate?

(10) Major inroads will be made in controlling NSAID-associated gastrointestinal (GI) ulceration and bleeding by altering prescribing patterns.

(11) What are the risk factors for GI ulceration and bleeding?

The main outcomes from the discussion of these points were:

1. Paracetamol for osteoarthritis and mild-moderate Pain

Paracetamol has been preferentially advocated for pain in osteoarthritis (OA) in the belief that it relieves pain as effectively as most NSAIDs, will not cause acceleration of joint damage and will be less risky in causing upper GI ulceration and bleeding compared with NSAIDs. Some members of the panel and the audience were of the view that very high doses of paracetamol could be taken quite safely. There was, however, scepticism about the risks of hepatotoxicity especially in the elderly and those who consume substantial quantities of alcohol. Also, it was considered that NSAIDs might be beneficial in controlling the early stage of joint inflammatory reactions and pyrophosphate crystal arthropathy leading to early stage erosion whereas in later stage OA where the joint has become severely eroded and there is no evident local inflammation there is a case for using paracetamol. This is especially so since potent NSAIDs taken at this stage may, indeed, accelerate joint destruction.

Alternative drugs for OA

There was debate about using colchicine for pyrophosphate crystal arthropathy and early stage OA but the case for using this drug is, as yet, unproven. It is useful in pseudogout due to chondrocalcinosis. However, there are risks of bone marrow changes with this drug.

The possibility of using chloroquine or hydroxychloroquine, both of which inhibit