**PRIMARY HEALTHCARE LEVEL ESSENTIAL MEDICINES LIST**

**CHAPTER 14: MUSCULOSKELETAL CONDITIONS**

**RECOMMENDATION FROM NEMLC MEETING: 2 NOVEMBER 2017**

**Medicine amendment recommendations, following initial review of the chapter, are listed below.**

**Kindly review the medicine amendments in the context of the musculoskeletal chapter.**

**AMENDMENTS:**

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| **SECTION** | **MEDICINE** | **ADDED/DELETED/AMENDED** |
| **14.2 Arthritis, rheumatoid** | NSAIDs, oral | Added |
| Prednisone, oral | Added |
| Proton pump inhibitor | Added |
| **14.4.1 Gout, acute** | Ibuprofen | Dose amended |
| Presdnisone, oral | Amended (indication updated) |
| **14.5 Osteoarthrosis (osteoarthritis)** | Ibuprofen, oral | Amended (prescriber level) |
| Proton pump inhibitor | Added |
| Amitriptylline, oral | Added |

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| **14.2 ARTHRITIS, RHEUMATOID**  |

NSAIDS, oral:*added*

Recommended for control of acute symptoms whilst awaiting referral (as doctor initiated) and for control of acute symptoms during disease flares and in severe extra-articular manifestations e.g. scleritis (as doctor prescribed), aligned with the Adult Hospital level STG and EML, 2015.

**Level of Evidence: III Guidelines**

Prednisone, oral:*added*

Where NSAIDs are contra-indicated, prednisone, oral, 7.5 mg daily recommended for 2 weeks in patients (with a confirmed diagnosis of RA) with acute symptoms during disease flares, prior to referral for further management by a specialist.

*An observational study*[[1]](#footnote-2) suggested that corticosteroids in RA are associated with a dose-dependent increase in mortality rates above the threshold of 8 mg per day.

*EULAR Guidelines* recommend that short-term corticosteroids should be considered when initiating or changing DMARDs, but should be tapered as rapidly as clinicallyfeasible.

*Rationale:* Aligned with EULAR 2016 Guidelines[[2]](#footnote-3) and evidence of safety recommending a daily threshold dose of corticosteroids as 8 mg.

**Level of Evidence: III Observational study, Guidelines**

Proton pump inhibitor, oral:*added*

For high-risk patients: > 65 years of age; history of peptic ulcer disease; on concomitant warfarin, aspirin, or corticosteroids, lansoprazole30 mg recommended as an example of the proton pump inhibitor class, for patients requiring NSAIDs. Aligned with the Adult Hospital STGs and EML, 2015 was added.

**Level of Evidence: III Guidelines**

**Referral**

Referral criteria were amended to ensure that appropriate management of rheumatoid arthritis takes place at the appropriate level of care:

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| **Urgent (to a specialist)**Severe extra-articular manifestations.**Non-urgent**1. Refer all patients early for confirmation of diagnosis and management.
2. Acute disease flares.
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| **14.4.1 GOUT, ACUTE** |

Ibuprofen, oral: *dose amended*

The oral ibuprofen dose was aligned with the Adult Hospital Level STGs (Rationale being that available evidence[[3]](#footnote-4) suggests that the ceiling dose for analgesia effect for ibuprofen, oral, is 400 mg 8 hourly).

Text amended as follows:

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| If no response and inflammation is present: **ADD*** ~~NSAIDs, e.g.:~~
* ~~Ibuprofen, oral, 800 mg 8 hourly with or after a meal for 24–48 hours.~~

~~Thereafter, if needed, reduce dose of NSAID, e.g.:~~* ~~Ibuprofen, oral, 400 mg 8 hourly with or after a meal until pain and inflammation has subsided.~~
* Ibuprofen, oral, 400 mg, 8 hourly with or after a meal for the duration of the attack.
 |

**Level of Evidence: III Guidelines**

Prednisone, oral: *amended (indication updated)*

Evidence[[4]](#footnote-5) suggests that NSAIDs are associated with a risk of heart failure. Thus, indication for prednisone (alternative to NSAIDs for management of acute gout) updated to include *"existing or high risk of heart failure".*

**Level of Evidence: II Nested case control study**

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| **14.5 OSTEOARTHROSIS (OSTEOARTHRITIS)** |

**No response to paracetamol and inflammation is present:**

Ibuprofen, oral: *amended*

Amended to allow nurses to prescribe ibuprofen for 7 days, with the following text added to the STG, "*As many of these patients, particularly the elderly, have concomitant medical conditions such as cardiovascular, gastrointestinal disease or renal function impairment, NSAIDs must be used with caution. Patients on aspirin for cardiovascular risk reduction should take aspirin 30 minutes before the 1st dose of ibuprofen in the morning, as taking aspirin and ibuprofen at the same time may reduce aspirin’s efficacy",* aligned with the Adult Hospital Level STG and EML, 2015[[5]](#footnote-6).

**Level of Evidence: III Guidelines, Expert opinion**

Proton pump inhibitor, oral: *added*

For high-risk patients: > 65 years of age; history of peptic ulcer disease; on concomitant warfarin, aspirin, or corticosteroids, lansoprazole30 mg recommended as an example of the proton pump inhibitor class, for patients requiring NSAIDs. Aligned with the Adult Hospital STGs and EML, 2015 was added.

**Level of Evidence: III Guidelines**

Amitriptyline, oral: *added*

Considered for doctor prescribed step-up therapy for uncontrolled pain management in osteo-arthritis, aligned with the Adult Hospital STGs and EML,2015.

**Level of Evidence: III Guidelines**

1. del Rincón I, Battafarano DF, Restrepo JF, Erikson JM, Escalante A. Glucocorticoid dose thresholds associated with all-cause and cardiovascular mortality in rheumatoid arthritis. Arthritis Rheumatol. 2014 Feb;66(2):264-72. <https://www.ncbi.nlm.nih.gov/pubmed/24504798> [↑](#footnote-ref-2)
2. Smolen JS, Landewé R, Bijlsma J, Burmester G, Chatzidionysiou K, Dougados M, et al.. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. Ann Rheum Dis. 2017 Jun;76(6):960-977. <https://www.ncbi.nlm.nih.gov/pubmed/28264816> [↑](#footnote-ref-3)
3. Laska EM, Sunshine A, Marrero I, Olson N, Siegel C, McCormick N. The correlation between blood levels of ibuprofen and clinical analgesic response. ClinPharmacolTher. 1986 Jul;40(1):1-7..http://www.ncbi.nlm.nih.gov/pubmed/3522030 [↑](#footnote-ref-4)
4. Arfè A, Scotti L, Varas-Lorenzo C, Nicotra F, Zambon A, Kollhorst B, Schink T, Garbe E, Herings R, Straatman H, Schade R, Villa M, Lucchi S, Valkhoff V, Romio S, Thiessard F, Schuemie M, Pariente A, Sturkenboom M, Corrao G; Safety of Non-steroidal Anti-inflammatory Drugs (SOS) Project Consortium.. Non-steroidal anti-inflammatory drugs and risk of heart failure in four European countries: nested case-control study. BMJ. 2016 Sep 28;354:i4857.https://www.ncbi.nlm.nih.gov/pubmed/27682515 [↑](#footnote-ref-5)
5. Adult Hospital Level STG, 2015:

- Ibuprofen-aspirin interaction: Gladding PA, Webster MW, Farrell HB, Zeng IS, Park R, Ruijne N. The antiplatelet effect of six non-steroidal anti-inflammatory drugs and their pharmacodynamic interaction with aspirin in healthy volunteers. Am J Cardiol. 2008 Apr 1;101(7).http://www.ncbi.nlm.nih.gov/pubmed/18359332

- Ibuprofen-aspirin interaction: Meek IL, Vonkeman HE, Kasemier J, Movig KL, van de Laar MA. Interference of NSAIDs with the thrombocyte inhibitory effect of aspirin: a placebo-controlled, ex vivo, serial placebo-controlled serial crossover study. Eur J Clin Pharmacol. 2013 Mar;69(3):365-71. http://www.ncbi.nlm.nih.gov/pubmed/22890587 [↑](#footnote-ref-6)