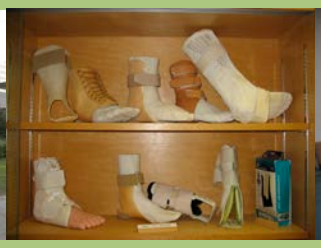
Arthritis Clinical Link Newsletter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A newsletter for health professionals working with people with arthritis **July 2012**

Editor's Message

After completing an issue, I always think that I have written about every single existing arthritis resource and therefore I won't have anything to discuss in future issues. Fortunately, or unfortunately, it never seems to work out this way, and the file of news clippings and emails I get from colleagues always provides a bountiful supply of material upon which to report. For example, I am amazed by the growing number of online tools to help clients track and manage their health, a phenomenon I describe in a piece on electronic patient health records. There are also many tools that we can use as health care providers to support client self-management. These are discussed below and arose from a presentation on the 5 A's Approach at our recent MPAP Education Day. And back to computer technology, there is an interesting article on how computers may change the future way we work with clients. Other articles in the newsletter address new ACE education and resources, the dangers of opioids for the elderly, new or recently updated treatment guidelines, new Rheuminfo resources, author and researcher kudos to MPAP staff, clinical pearls, a review of highlights from the recent CRA/AHPA Annual Meeting, and finally a study that may be of interest to those of you who treat hip and knee osteoarthritis. Please help me deal with my anxiety that I won't have anything to report in future issues by emailing me if you have questions or informing me of resources to include in an upcoming newsletter.

Paul Adam, Rheumatology Liaison & Outreach Services Coordinator Paul.Adam@vch.ca

MPAP Education Day

Approximately 140 Mary Pack Arthritis Program staff and ACE members attended the day's events at the Paetzold Auditorium at Vancouver Hospital. Many other ACE members viewed the sessions by videoconference at one of 15 remote sites that ranged from Whitehorse to Burnaby, and from Victoria to Revelstoke. Presentations were wide-ranging and included the 5 A's Approach to supporting client self-management; Arthritis and the Athlete: A youth perspective; an Update on Osteoporosis; a poster fair highlighting various arthritis programs and initiatives; and Oral Health and Arthritis. Unfortunately, technical difficulties with the videoconferencing system meant that we were unable to proceed with Dr. Hewlett's talk from the United Kingdom on Fatigue and Arthritis. However, Dr. Hewlett has offered to do this presentation by teleconference the date for which will be circulated by email in the next few weeks.

One of the more popular sessions, Dr. McGowan's presentation on the 5 A's Approach, combined a nice balance of theoretical information and practical tools for supporting client self-management. Subsequently, PT's and OT's from Mary Pack participated in a 3-hour session to discuss and prioritize tools for

each of the 5 A's for use on either a 1-to-1 or group education basis. The following tools were thought to have the most clinical benefit:

Assess - Assessing beliefs, behaviours, and knowledge
- Patient Activation Measure for assessing client readiness
- Internet tools, such as an iPad for use with clients in the waiting room

Advise - Providing specific information about health risks and the benefits of change
- Ask-Tell-Ask and Teach Back as tools to foster more effective communication
- Decision aids, such as those that are available to help clients decide about taking a medication or having joint replacement surgery

Agree - Collaboratively set goals based on patient's interest and confidence in their ability to change behaviour
- Decisional balance as a tool for quickly understanding client barriers and for encouraging clients to look at the pros and cons of not changing
- Action plans were thought to be useful, as a way to record client-determined goals and to provide a focus when doing follow-up

Assist - Identify personal barriers, strategies, problem-solving techniques and socioenvironmental support
- A large number of community-based self-management support programs were discussed, many of which were thought to be useful. These included CDSMP and the online CDSMP, ASMP, Bounce Back, Chronic Pain Self-management, Active Choices, the Intercultural Online Health Network, and the Patient Voices Network. I will be doing a summary of key facts for each program, i.e., program description, target population, how to access, etc., that I will make available in the next few weeks.

Arrange - Arrange specific plans for follow-up (e.g., visits, phone calls, mailed reminders)
- Automated health behaviour reminders
- Use of email to touch base with clients
- Educating clients about when it is appropriate and reasonable to seek follow-up
- Charting system that cues therapists as to when follow-up actions or contacts should be made
- Scheduling of booster sessions to foster long-term adherence and address issues arising since and related to the prior treatment

I would be interested in hearing about your experiences in using specific tools or approaches for facilitating client self-management at any level of the 5 A's. In the meantime, a small multidisciplinary team including nursing, occupational therapy, physical therapy, and social work will be looking at the easiest and most effective way to incorporate these or other tools into our Patient Education Program at the Mary Pack Arthritis Program in Vancouver. I will report on this in the next newsletter.

Electronic Patient Health Records

On a related topic, last November's ACE Clinical Exchange had as its subject, Implementing Practical Interventions to Support Chronic Illness Self-Management. During the discussion, Dawn Powell, an occupational therapist from Kootenay Lake Hospital in Nelson, noted the role that Smart Cards may play in supporting client self-management. She then emailed me some information from the Smart Card Alliance - http://www.smartcardalliance.org

Smart cards have many applications, one of which is to act as a portable patient health record card with information that can be accessed by a contact or contactless card reader. This is similar to how the embedded chip in a credit card works. Some smart cards allow the individual who owns the card to check and update their own health data.

Systems have also been set up to allow individuals to access their health records through a computer or mobile app. In many cases, this allows the patient to manage and monitor the signs and symptoms of their

condition(s); manage the impact of their condition on their physical, social, and emotional life; and actively share in decision-making with their health care providers.

In general, Electronic Health Records (EHRs) are private and secure applications through which an individual can access, manage, and share his or her health information. There is considerable variety in how EHRs work; some only allow patient-entered data, whereas others also allow for the input of health data from external sources, such as labs, pharmacies, and health care providers. In the same way, access to the EHR data varies from systems in which only the patient has the sole ability to view data, to systems in which the individual can allow select health care providers to view their EHR data.

In the United States, the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program provides funding to providers that meet set criteria, including the following: providing clinic summaries to patients at each visit, sending patient reminders for preventative / follow-up care, providing timely access to medical records when requested, and providing timely access to online personal health data, although information of a sensitive nature may be kept hidden in order to be discussed in person at the next office visit. One of the goals with this initiative is to foster the meaningful use of health data by patients through patient-centered health information technology. Effective patient engagement through the delivery of the right health information at the right time is seen as being essential to motivate patient adherence and foster lifestyle modifications.

In British Columbia there is no standard approach to electronic patient health records. To fill this void some alternatives are slowly starting to spring up. While consumers cannot yet purchase direct access to TELUS health space, it is available through some government, private, and non-profit organizations - http://telushealthspace.com/default.aspx Health space is a secure, online personal health record that allows individuals to collect, store, and analyze their health information anytime and anywhere. It also allows the user to share this information with members of one's family or health care team. Finally, the user can also access various chronic disease management and personal wellness. tools. Another online resource that is in development is Connect for Care. This is being designed to offer an online personal network with video chat, mobile collaboration tools, and a secure vault for storing personal and health information.

Snapshot of Highlights from BCATPR

I attended the annual British Columbia Alliance on Telehealth Policy and Research (BCATPR) workshop on June 21st and learned the following:

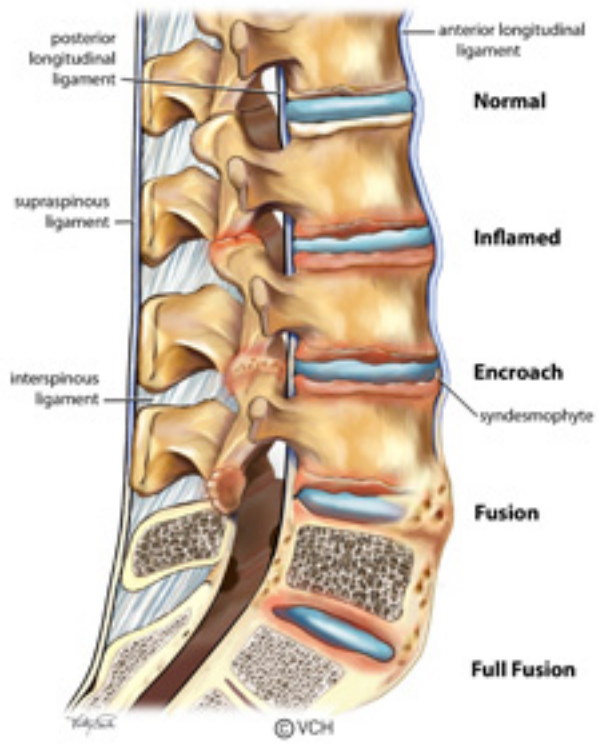
- In a previous newsletter, I have praised the work that Drs. Dan Bilsker and Randy Paterson have done in developing a set of skills workbooks, and then making these freely available online. One of these has now been turned into an online tool. Antidepressant Skills Online is a free interactive web site that allows individuals experiencing low mood or depression to learn information & skills to cope with their mood problems - https://antidepression.ca/
- InspireLIFE BC is a program to make integrative cancer care accessible to people living in rural parts of the province. The program begins with a two-day educational and experiential workshop for cancer patients and their loved ones. Attendees can then access online health information resources - http://www.inspirehealth.ca/ Both the telephone and Internet are used by the physicians to develop and implement a personal integrative health plan.
- My Care Web is in development by Dr. Tammie Dewan, a pediatrician at BC Children's Hospital. This online site will target the families of children who have complex, multi-system chronic disease. Planned features include the opportunity to ask questions by email, symptom tracking and home monitoring tools, a personal health record, electronic library, and an opportunity for the sharing of information among communities of practice.
- Tyze Personal Networks is an online site that al-

lows individuals who pay an annual fee to build a network of support, and within this network to schedule appointments, ask for help with tasks, share information and resources, plan events or outings, etc. - http://www.tyze.com/tyze-networks/

BCATPR holds a yearly spring workshop in Vancouver that anyone can attend for minimal cost. This year's $30 fee to attend the half-day event included lunch. If you are interested in keeping on top of eHealth initiatives in BC, check out their website at www.bcatpr.ca

New ACE Education and Resources

The Mary Pack Arthritis Program has had 12 medical images produced that we now use for patient and professional education. If there is sufficient interest from the ACE membership, we will sell these at cost as a set of 6 double-sided, laminated pages. I have included a sample image below



Other images include 3 side-by-side images of AS Posture: Early, Moderate, Advanced; Normal Joint; Osteoarthritis: Early; Osteoarthritis: Advanced; Rheumatoid Arthritis: Early; Rheumatoid Arthritis: Moderate; Rheumatoid Arthritis: Advanced; Boutonniere Deformity; Swan Neck Deformity; Ulnar Drift Deformity; 3 side-by-side images of Osteoporosis: Normal bone, Mild Osteporotic Bone, Advanced Ostoporotic Bone. If you are interested in purchasing a set of 12 images at a cost of $25, please contact Paul.Adam@vch.ca

Two plenary presentations from our past Introduction to the Assessment and Management of Rheumatic Disease course are now available for viewing on the Centre of Excellence for Simulation, Education, and Innovation (CESEI) website. Dr. Raheem Kherani is speaking on **Rheumatic Diseases: Classification and Immunology**, and Dr. Diane Lacaille is presenting on the **Medical Management of Rheumatic Diseases**. The web site is set up to simulaneously show the speaker and the slides presentation.

The following are the instructions on how to view these presentations:

1. Go to www. cesei.org
2. Login with username pt and password pt2012
3. Click on "Curriculum Delivery"
4. Click on "PT-100 Rheumatic Diseases"
5. Under Module Resources, click on "Lecture on Demand"
6. Click on either of the two lectures to play

Opioids: Dangers for the Elderly

The April 2011 issue of The Rheumatologist published an article with the conclusion that opioiods are more dangerous for the elderly than other analgesics. The data supporting this conclusion comes from two studies recently published in the Archives of Internal Medicine (see citations list on page 10) that showed that elderly patients taking narcotics are at higher risk of cardiovascular disease, fractures, and death in comparison to individuals taking NSAIDs and coxibs. Five opioids were studied, including hydrocodone, codeine, oxycodone, propoxyphene, and tramadol. Of these, propoxyphene and codeine ex-

hibited the highest levels of cardiovascular risk. And tramadol users were shown to have a reduced risk of fracture as compared with hydrocodone users.

Updated Contact Information

In the last newsletter I reviewed a wonderful and free CD-Rom from the Public Health Agency of Canada called, "Resources relating to chronic disease prevention and control". Rather than use the contact information I previously provided, a better way of accessing this resource is to contact:
Christine Gray, Project Officer
Chronic Disease Intervention Division
(613) 957-1072
Christine.Gray@phac-aspc.gc.ca

Update of Patient Care Guidelines: Protocol for Management of Nitritoid Reactions

The protocol for managing nitritoid reactions (NR) was recently updated and a copy uploaded to the Arthritis Resource Guide for BC website. This protocol addressess recommended actions for assessing, preventing, and treating NR. Although NR are ordinarily mild, myocardial infarction, stroke, and death have been reported. Case reports have suggested a relationship between NR and use of angiotensin-converting enzyme (ACE) inhibitor medication. Please see the updated guidelines for further details.
http://www.argbc.ca/practitioner/guidelines-protocols

Other Guidelines / Diagnostic Criteria

Management of hip, knee and hand Osteoarthritis
Highlights of these new ACR guidelines include:
- Topical rather than oral nonsteroidal anitinflammatory drugs (NSAIDs) should be used whenever possible for people over age 75 years
- For hand OA, provision of assistive devices, use of thermal modalities and trapeziometacarpal joint splints, and use of oral and topical NSAIDs, tramadol, and topical capsaicin are conditionally recommended
- Also for management of hand OA, it is conditionally recommended that intraarticular therapies and opioids not be used
- Acetaminophen, recommended previously as initial therapy for knee and hip OA, is now only conditionally recommended among other pharmacologic agents, such as oral and topical NSAIDs, which can be used as initial therapy in patients with hip or knee OA
- Aerobic, aquatic, resistance exercises, and weight loss are strongly recommended for knee and hip OA
- For both knee and hip OA, nutraceuticals such as chondroitin sulfate, glucosamine, and topical capsaicin are conditionally recommended not to be used
- Tai chi is conditionally recommended for knee OA, as is acupuncture in certain situations; no recommendation is given for tai chi for hip OA
- Management is addressed for those patients who would normally be referred to orthopedic surgeons but who choose not to have a joint replacement or are not medically suitable for surgery

These guidelines were developed using a case-based approach and had the involvement of primary care physicians, an orthopedic surgeon, podiatrists, arthritis-related health professionals, and rheumatologists. All members of the technical expert panel submitted patient scenarios based on the patients they typically see. These scenarios were amalgamated and then reviewed by the ACR Board of Directors to ensure that nothing was missed. As a result, the recommendations should be clinically relevant and cover the vast majority of OA patients.

Marie Westby will be chairing the **ARHP Clinical Focus Course** in Washington, DC in November on the topic of Osteoarthritis, which will feature a presentation by Dr. Marc Hochberg, the lead author.

The OA guidelines can be viewed here:
http://www.rheumatology.org/practice/clinical/guidelines/PDFs/ACR_OA_Guidelines_FINAL.pdf

New Diagnostic Criteria for Axial Spondylarthritis

Axial spondylarthritis (SpA) is now the preferred name for a set of diseases, including ankylosing spondylitis (AS), as a result of new criteria released by the Assessment of Spondyloarthritis International Society (ASAS). One of the reasons for the new criteria is to promote early diagnosis in the absence of x-ray changes. This is especially important given that therapies, like TNF antagonists, are more effective if used in the early stages of the disorder. With the new criteria, diagnosis can be made by putting a stronger emphasis on either imaging (one clinical parameter, plus sacroiliitis on either x-ray or MRI) or clinical parameters (positive HLA-B27 test and the presence of two other clinical parameters). The list of clinical parameters includes inflammatory back pain, arthritis, enthesitis, uveitis, psoriasis, Crohn's disease / ulcerative colitis, good response to NSAIDs, family history of SpA, elevated c-reactive protein, and presence of HLA-B27.

Tapping Computer Power to Promote Physical Therapy

The May 2012 issue of The Rheumatologist featured a Tech Talk column that looked at innovative uses of computer technology to foster exercise in people with arthritis. One project discussed in this article used a hands-free mouse that allowed people with severe arthritis to move the cursor around the screen and to participate in playing a video game. In this project led by Dr. Maura Iverson, participants are connected to the computer with a cyberglove with sensors. The computer system also knows where the individual is looking by using infrared light bounced from the computer to the eye, and back again. In the game, which is still in the development phase, participants find themselves on a tropical island. By flexing their fingers, they can walk forward. By moving their eyes, they can change the view of the island that appears on the screen. Throughout the island are tropical "games" to play, such as picking up coconuts with a gentle pinch of the fingers and throwing them at targets, or taking a boulder to a hill and rolling it down. The game can be modified to require greater flexing in order to do the movements so that the game can adapt to the increasing capability of the participant using it. In another project called RPLAY, patients do physical therapy at home while a computer system monitors their joint motions, motor performance, and other physiological indicators. This information helps the therapist to know how well their patient's therapy is coming along. The system also includes interactive games and social media activities to make the system more engaging and fun to use. This project is led by Fillia Makedon, chair of University of Texas at Arlington's computer science and engineering department.

Just Dial 211 for Community Service Information in Vancouver, Fraser Valley, and Squamish-Lillooet Regional Districts

Operated in collaboration with the United Way, BC211 has launched a new telephone number for the public who want to learn more about community services in their area. Starting in December of 2011, residents of Vancouver, the Fraser Valley, and the Squamish-Lillooet Regional Districts have been able to dial 211 to make contact with an information specialist who can provide information and referral to social, community, and government services. This is a free, confidential, and mulilingual service that is available 24 hours/day and 7 days/week. The BC211 website has more information about this telephone service. It also provides a way for members of the public to email stories, questions or comments. Finally, the site has a search tool to allow individuals to search for community services on the Red Book Online, a listing of over 5,600 community, social, and government services in the Lower Mainland. The site can be accessed at http://www.bc211.ca

What is the Single Best Thing We Can Do for Our Health?

Marie Westby alerted me to a new video that has been posted on YouTube. It's by Dr. Mike Evans, a physician from St. Michael's Hospital in Toronto, and its called, "**23 and 1/2 hours: What is the single best thing we can do for our health?**" Clocking in at 9 minutes and 19 seconds, this video describes the many health benefits of exercise. The video uses the increasingly popular "animate" technique in which an experienced illustrator draws images related to the content of a speaker's presentation. This style is thought to be a more effective way of translating knowledge, as it both engages the visual learner while simplifying the message. In addition to being a physician, Dr. Evans is also the founder of the Health Design Lab at the Li Ka Shing Knowledge Institute, and is an Associate Professor of Family Medicine and Public Health at the University of Toronto. As Marie says, "I encourage you to watch this and share it widely among your colleagues and patients". The video can be found at: http://www.youtube.com/user/DocMikeEvans/videos

What's New on Rheuminfo

Exemplifying the popularity of these new animated videos, Rheuminfo has a great video on chronic pain called, "**Understanding pain: What to do about it in less than five minutes**". This video from Australia has been recommended as a great educational tool for people with Fibromyalgia. The fibromyalgia page on the Rheuminfo site also has a pamphlet to download and print, and both the 1990 and 2010 fibromyalgia classification criteria. The site also has pages for ankylosing spondylitis, dermatomyositis, giant cell arteritis, gout, osteoarthritis, polymyalgia rheumatica, polymyositis, psoriatic arthritis, rheumatoid arthritis, sjogren's syndrome, systemic lupus erythematosus, and wegener's granulomatosis. Pages are also available on a variety of lifestyle issues and understanding common tests. Another section of rheuminfo has videos and pamphlets on a full range of medications, including 10 of the biologics, two chronic pain medications, two corticosteroids, 10 DMARD agents, 3 gout medications, 2 NSAIDs, 6 medications for osteoporosis, and 1 for intravenous immune globulin (IVIG).

Rheuminfo is a Canadian website that is the creation of Dr. Andy Thompson, a practicing rheumatologist at Western University in London, Ontario, and Marlene Thompson, a licensed physiotherapist at St. Joseph's Hospital, who has also completed her Advanced Physiotherapy Practitioner in Arthritis Care (ACPAC) training. Rheuminfo can be found at http://rheuminfo.com/

Research Study Looking for Clinicians who Treat Hip or Knee OA

Study Title: Towards consensus of functional performance-based measures for osteoarthritis: your opinion matters

Who can participate? Anyone whose research or clinical practice involve people with hip or knee OA.

What is the purpose of the study? This Osteoarthritis Research Society International (OARSI) initiative aims to identify and recommend a core set of the most feasible performance-based tests of physical function for people with hip and knee OA.

What will you have to do? 1) Complete an online decision survey (approximately 20 minutes): you will be asked to make a series of choices between two performance-based measures of physical function that you think are more feasible to conduct in the research or clincal setting, and 2) Complete a short demographic survey (less than 5 minutes). *All data will not be individually identified and you can remain anonymous, if you choose.*

About the researchers: This project is led by Professor Kim Bennell, Associate Professor Rana Hinman and Dr. Fiona Dobson from the Centre of Health, Exercise and Sports Medicine at the University of Melbourne and Professor Ewa Roos from the University of Southern Denmark. It is informed by an international Working Party including Aileen Davis, Paul Stratford, Haxby Abbott, Rachelle

Buchbinder, Lynn Synder-Mackler, Yves Henrotin and Julian Thumboo.
Sign Up: For more information and/or to self-enroll in this survey, please click here:
Online survey: Performance-based measures of physical function in OA

Please feel free to forward this invitation to anyone that you think may be suitable.

This survey will be open online until July 31, 2012

Any queries can be emailed to:
fdobson@unimelb.edu.au

Author and Researcher Kudos

Congratulations to Barbara Porter, OT, and Asuko Brittain, PT, from the Mary Pack Arthritis Program for their recent article on splinting and hand exercises for three common hand deformities in RA that was published in Current Opinion in Rheumatology (see the full reference in the list of citations further on in the newsletter).

Your newsletter editor was also fortunate to have been part of a team that received a recent CIORA grant.

$59850 for "***Development and Pilot Testing of a Patient Passport for Rheumatoid Arthritis***" (Co-investigators: Dr. Diane Lacaille, Dr. Linda Li, Dr. Anne Townsend, Dr. Charles Goldsmith, Bev Mitchell, Gwen Ellert, Nadia Prestley.

This team has forged a partnership with Telus and Microsoft to develop and test an online passport for people with rheumatoid arthritis to assist in monitoring disease activity and fostering collaborative decision-making between patients and rheumatologists.

Clinical Pearls

Jackie Harris discovered a new product called "Shearban" at a recent Pedorthic Conference in Whistler. It is a material that can be used to reduce friction. Typical places to use Shearban would be on the top of foot orthotics or on the inside of shoes, wherever there is a problem with friction. The Canadian supplier for this material is OrtoPed. The price is $165 for 5, 8" X 12" sheets. For more information - www.OrtoPed.ca

Update from the 2012 CRA/AHPA Annual Meeting

I am pleased to share information gleaned from the 67th Annual Meeting of the Canadian Rheumatology Association and Arthritis Health Professions Association, which was held in March 2012.

First, I would like to say I had never been to the CRA/AHPA annual meeting. I found it to be well organized, and I liked the scale of the conference (sometimes these types of meetings can get overwhelming in size). There was interesting information pertinent to rheumatologists and allied health professionals alike. I would recommend that allied health be sure and attend the AHPA preconference. I found out about that day too late, and I was sorry I missed that part of the conference. I heard it was very good.

One talk that stood out for me was Dr. Paul Peter Tak, who described the idea of pre-clinical RA and the possibility of prevention. It was interesting to learn that in preclinical RA or early undifferentiated arthritis, there is no change in the synovium and there is no difference in pain modulators, yet people have arthralgias. They do present with increased CRP, however.

Dr. Tak questioned whether there is a "preventative window of opportunity" for these patients. If there is RA in the family, and a +CRP, doctors and health care professionals may put more emphasis on education of the importance of avoiding known triggers to RA like smoking, smoking and alcohol, or smoking and increased BMI . I certainly know that I meet

clients and their families, and can use this info when speaking about risks to family members.

Another memorable presentation was Dr. Gabalawy's reflections on his experience and challenges caring for an isolated group of First Nations people with RA. There was no evidence of RA in Europe before the new world was discovered, so there may be a viral or environmental component to RA. Phenotypes of RA tend to be different with First Nations groups. More large joints affected, more strongly sero+, higher HAQ scores, and more pronounced familial or genetic risk. Two thirds of First Nations people have alleles to predispose them to chillinated antigens (as opposed to 1/3 Caucasians). All this helps explain why we see such severe disease in such a large proportion of this population.

Risk factors, like smoking, are also more pronounced. Years of smoking puts Caucasians at risk for RA: for First Nation groups it is months of smoking. Periodontitis is also a risk factor and 80% of Dr. Gabalawy's patient population had gum disease. Could better diet and oral care reduce the incidence of RA in this population? Finally less than 1 year post partum increased the risk of First Nations people getting RA, if there is RA in family. It is a good reminder to counsel and monitor families of patients with known RA, and help them reduce risk factors they can control – smoking and gum disease in particular.

Update provided by Linda Frodyma, OT at the Victoria Arthritis Centre.

Essential Evidence PLUS

Essential Evidence is a powerful, one-stop, state-of-the-art reference that includes best-evidence answers to your most important clinical questions concerning symptoms, diseases, and treatment. Its concise, highly structured content is tightly integrated and hyperlinked to thousands of calculators, articles, and evidence summaries within Essential Evidence Plus make searching for answers quick and seamless.

Each topic has a "strength of evidence" rating for every recommendation, a "Bottom-line" summary that introduces each section, and a broad array of helpful algorithms. An individual subscription to this Wiley-Blackwell service is $85 USD/year. A smattering of the recent topics and bottom-line summaries include:

How should the diagnosis of knee OA be made?
European guidelines suggest that a combination of risk factors and typical symptoms can allow for a diagnosis of OA without radiographic changes.

Is acupuncture effective in decreasing pain in patients with chronic shoulder pain?
Fifteen acupuncture sessions resulted in significantly greater pain relief than sham acupuncture or conventional treatments when shoulder pain was not due to OA or RA. This effect lasted for at least 3-months post-treatment.

Is glucosamine effective in the treatment of chronic low back pain from degenerative lumbar OA in adults?
No. Glucosamine is no more effective than placebo treatment in reducing pain and improving quality of life in adults with this condition.

Can the use of a "Personal Pain Tracker" increase patient satisfaction with their care?
A 2-page form, called the Personal Pain Tracker, did indeed increase patient satisfaction with their visits to their family physician.

Does asking about suicidal ideation increase a patient's feelings that life is not worth living?
Asking about suicide, or in the case of the study reviewed, asking six questions about suicide, does not increase the number of thoughts that depressed patients have that life is not worth living.

Are corticosteroid injections more effective than usual care in treating patients with trochanteric bursitis?
Patients receiving corticosteroid injections for trochanteric bursitis experienced better short-term recovery rates than patients receiving usual care, but there were no differences in outcomes one year later.

As is evident, questions are very clinically-focused and in addition to the bottom-line message, each

question also has a summary of the study data or evidence reviewed to reach the answers given, as well as a concise outline of the study details, and a reference to where more detailed findings can be found.

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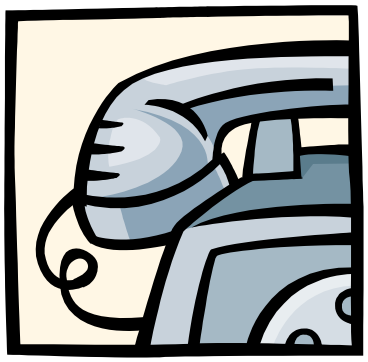
Clinical Consultation available through your ACE membership



As an ACE member, you have access to physical therapists, occupational therapists and nurses with many years of rheumatology experience. If you have a clinical question or complex or challenging client and would like to consult with one of our experienced clinicians, please contact one of the people listed below. We will return your call or e-mail as quickly as possible.

You can also contact senior clinicians in our regional centres
(Cranbrook, Penticton & Victoria). They are a valuable local resource.

An ACE member who used this service in the past states: “Great resource. Please continue!”

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