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MYTHS AND MISCONCEPTION ABOUT KNEE OSTEOARTHRITIS

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Abstract

Osteoarthritis is a chronic disease of the synovial joints resulting in pain accompanied by varying degrees of functional limitation and reduced quality of life. Knee OA is extremely debilitating. Lot of myths and misconceptions exist among the general population about the identity, causes, consequences, timeline, and treatment of knee OA. The aim of this review is to bust such myths and thus encourage patients to opt for more conservative management strategies for the treatment of Osteoarthritis.

Key words: Osteoarthritis, myths and misconception, conservative management

Introduction

Arthritis and musculoskeletal conditions are a National health priority area and are more prevalent in our country than any other, including cancer, diabetes and obesity.[1] Osteoarthritis is a chronic disease of the synovial joints, resulting in pain accompanied by varying degrees of functional limitation and reduced quality of life. Knee OA is extremely debilitating. Pain is dominant, becoming persistent and are more limiting as OA progresses. Physical function becomes increasingly impaired, impacting substantially on quality of life and ability to participate in social, leisure and occupational activities. There is no cure for OA. Treatments to reduce symptoms and delay joint replacement are critical. Clinical guidelines emphasise non drug non surgical strategies focussing on self help and patient driven options rather than clinician delivered passive therapies. In particular advice and information for self management, exercise and weight control are core management, with drugs, injections and manual therapy considered adjunctive to core treatments.[2-4]

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People with knee OA typically present with some knowledge of their condition- and the knowledge may or may not be factually based

There are lot of myths and misunderstandings about OA among the general population which needs to be busted. So the aim of this review is to bust the general myths and misconception about OA

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Common Myths and misconception[5]

Knee OA is bone on bone

There is a common misunderstanding that Knee OA is a bone on bone disease which is not true. In reality osteoarthritis is an imbalance in cartilage breakdown and cartilage synthesis, yet ultimately, OA affects all structures within the knee joint. There is no single cause of OA, and the exact aetiology is unknown- there are a host of biological and mechanical factors that culminate in the development of OA.

Knee OA is caused by wear and tear

People tend to believe that knee OA is caused by wear and tear but the truth is that in OA there is thinning and fibrillation of the cartilage, with loss of joint space, osteophyte formation, subchondral bony sclerosis, subchondral cysts and deformity. Not just cartilage degradation, but also changes in subchondral bone, synovium, ligaments, tendons, muscle, meniscus and nerve tissues are seen

Exercise and loading the knee joint will cause further damage

Most of the people have a misconception that exercise and loading the knee joint will cause further damage but this is not true. In fact research suggests that peoplesuffering with OA should be told to exercise as a main mode of treatment, irrespective of age, pain severity, comorbidity or disability.

Paincaused due to knee OA will inevitably get worse over time

It is not necessary that pain caused due to knee OA should get worse over the period of time. The pain can be very well managed with exercises and analgesics. All the guidelines consistently recommend that education, advice and information, exercise and weight loss should be the first line of treatment for all patients. Pharmacological strategies, passive clinician delivered therapies, aids and devices for some patients

Physiotherapy, exercise and physical activity will increase knee pain

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Therapeutic exercises performed on land provides relief in knee pain and this improves the quality of life and improve physical function in people suffering with knee osteoarthritis.Any type of exercise programme that is performed regularly and is closely monitored can improve pain, physical function and quality of life related to knee OA in the short term. It is particularly noted that only a very small proportion of people sufferingwith knee OA meet the recommended physical activity guidelines. The current guidelines for adults and older adults suggest at least 150 min per week of moderate to vigorous physical activity. It is been observed that people having knee OA make upto only 50 min when measured in bouts of 10 mins or more.People with OA average 7753 daily steps- YET a popular health recommendation is for adults to achieve 10,000 daily steps.

Daily walking is important to prevent future functional decline in knee OA. It is seen that walking more than 6000 steps per day could gaurd against developing functional limitation in people suffering or at risk of developing knee OA.

Surgical treatments could replace lost cartilage and cure knee pain

People often believe that surgeries could replace the lost cartilage and cure knee pain. In fact we need to understand that there is no cure available to replace the degenerated cartilage.. Patients need to be made to understand that exercise is just as effective as common drugs but without the side effects of medications.

Knee joint replacement is inevitable

People often believe that knee joint replacement surgery is the only option to cure knee OA. But the truth is that you could always try other conservative management before you opt for surgery. Patients have overly optimistic expectations about surgery and don't realise that up to 25% of people after knee arthroplasty are dissatisfied with their outcomes. Surgery could be your last resort when everything else fails. The clinical guidelines also consistently recommend surgical intervention for a few patients only if an appropriate course of other non surgical strategies has been unsuccessful.

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Conclusion

Clinicians seeking to encourage engagement with nonsurgical interventions should explore and target these misconceptions that patients hold about the identity, causes, consequences, timeline, and treatment of knee OA.

Clinicians should ask patients about their understanding of knee OA, its causes and consequences, as well as their beliefs about treatment and recovery, to identify and target any misconceptions and encourage uptake of nonsurgical interventions

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