Vioxx withdrawal—an opportunity to review primary care management for osteoarthritis

To the Editor—The withdrawal of Vioxx means that a substantial number of patients with osteoarthritis (OA) in both primary and secondary care will require alternative analgesics. This offers an opportunity to review the medication and progress of those patients.

When reviewing medication, it is valuable to remember the role that simple analgesics can play. Paracetamol can be considered the cornerstone of analgesia in OA. European and American guidelines recommend initiating analgesic therapy with paracetamol and support its long-term use in OA.[1-3] This is because paracetamol at full therapeutic dose (4 g/d) provides adequate analgesia for many patients, in particular in the primary care setting, with less risk of side-effects or interactions compared with both conventional non-steroidal anti-inflammatory drugs (NSAIDs) and selective COX-2 inhibitors (coxibs). The recently published Hong Kong clinical guidelines for managing lower limb OA echo these recommendations and also emphasise the importance of non-pharmacological measures, such as exercise and weight loss.[4]

There is evidence that 4 g/d paracetamol is effective in the treatment of OA pain and that in many patients it is comparable with ibuprofen in the short term and almost as efficacious as naproxen,[1] but with fewer side-effects.[2] Patient preference studies indicate that around 40% to 45% of patients find paracetamol provides adequate relief for their OA pain.[5]

When using paracetamol and non-pharmacological treatment, additional treatment modalities (including NSAIDs/coxibs and opioids) can be added or substituted as necessary to control 'flare ups'. For patients who are unresponsive to paracetamol, treatment guidelines recommend NSAIDs. An alternative coxib or a conventional NSAID plus an effective gastroprotective agent may be appropriate for those at increased risk of gastrointestinal side-effects.[1-3]

A Lee, MD, FHKAM (Family Medicine)
(e-mail: alee@cuhk.edu.hk)
Family Medicine Unit
Department of Community and Family Medicine
The Chinese University of Hong Kong
Shatin, Hong Kong

References

1. Jordan KM, Arden NK, Doherty M, et al. EULAR Recommendations 2003: an evidence based approach to the management of knee osteoarthritis: Report of a Task Force of the Standing Committee for International Clinical Studies Including Therapeutic Trials (ESCISIT). Ann Rheum Dis 2003;62:1145-55.
2. Zhang W, Doherty M, Arden N, et al. EULAR evidence based recommendations for the management of hip osteoarthritis: report of a task force of the EULAR Standing Committee for International Clinical Studies Including Therapeutics (ESCISIT). Ann Rheum Dis 2004;Nov 4; [Epub ahead of print].
3. Recommendations for the medical management of osteoarthritis of the hip and knee: 2000 update. American College of Rheumatology Subcommittee on Osteoarthritis Guidelines. Arthritis Rheum 2000;43:1905-15.
4. Lee A, Tsang K, Wong WG, Wong SY. An evidence-based approach to manage osteoarthritis in the primary care setting. Hong Kong Pract 2004;26:457-8.
5. Pincus T, Swearingen C, Cummins P, Callahan LF. Preference for nonsteroidal antiinflammatory drugs versus acetaminophen and concomitant use of both types of drugs in patients with osteoarthritis. J Rheumatol 2000;27:1020-7.

Stapled haemorrhoidectomy in Chinese patients

To the Editor—I wish to bring readers' attention to the inappropriate use of statistics in the article by Lau et al[1] on stapled haemorrhoidectomy which had led to a misleading conclusion. The following are some of the these statistical tests and presentation of results in question:

(1) Table 1 (Symptoms): Would the Chi squared test not have been more appropriate than the Mann-Whitney *U* test used by the authors?

(2) Table 2 (Median operation time and median hospital stay): the interquartile range within the brackets should have been presented as a range (25th centile to 75th centile), and not as a

single figure. This same comment also applies to Table 3 (Postoperative pain scores).

(3) Table 4: it is not appropriate to use the Wilcoxon test for the percentage improvement in symptoms for the items presented in this table. I would suggest using the Chi squared test instead. The Wilcoxon test is the non-parametric equivalent of the paired *t* test which was used in Table 5 (correctly). The former would have been appropriate if the results in Table 4 had been presented as "before" and "after" figures as in Table 5, and not as "% improved", as published.

The importance of choosing and using the correct statistical test is that completely divergent results and conclusions are reached when data are subjected to different statistical analyses. When the data from Table 4 are re-analysed using the Chi squared test, the results shown in the Table below are obtained. The results suggest that the new stapled technique is superior in improving symptoms of *bleeding* and *pruritus*, but the conventional open technique is better in reducing the symptom of skin tag prolapse. In contrast, only the latter conclusion is suggested by the Wilcoxon test used by the authors.

It was surprising to encounter these errors in this Journal given the meticulous peer review and editorial process followed, with which I have had previous first-hand experience.

BB Lee, FHKCA, FHKAM (Anaesthesiology)
(e-mail: bblee@cuhk.edu.hk)
Department of Anaesthesia and Intensive Care
Prince of Wales Hospital
Shatin, Hong Kong

Reference

1. Lau PY, Meng WC, Yip AW. Stapled haemorrhoidectomy in Chinese patients: a prospective randomised control study. Hong Kong Med J 2004;10:373-7.

Table. Symptomatic improvement after operation

Characteristic	Patient group		P value	
	Open	Stapled	Wilcoxon test (as reported by Lau et al)	Chi squared (re-calculated)
Bleeding (% improved)	45	62	0.924	*0.023*
Prolapse (% improved)	100	62	0.003	<0.001
Pain (% improved)	45	31	0.366	0.058
Pruritus (% improved)	18	31	0.149	*0.048*
Williams incontinence score (% improved/ static)	100	100	0.277	1.00

Authors' reply

To the Editor—We would like to thank Dr BB Lee for his comments on the presentation of data and use of statistical tests in our article. We have revised Table 2 and Table 3 to show the interquartile ranges as he has suggested.

Table 4 presented data on the proportion of patients with symptom improvement only, while data on patients with static symptoms or symptom deterioration were not shown. The Wilcoxon test was used because the data were ordinal. Thus, the use of the Chi squared

Table 2. Operative results

Characteristic	Patient group		P value*
	Open	Stapled	
Median operation time (IQR†) [min]	30 (20-35)	35 (30.25-38)	0.26
Median hospital stay (IQR) [days]	2 (2-3)	1 (1-2)	0.014
Complications			-
Urinary retention	1	0	
Postoperative bleeding	0	0	

* Mann-Whitney *U* test
† IQR interquartile range

Table 3. Postoperative pain scores*

Characteristic	Patient group		P value‡
	Open Median (IQR†)	Stapled Median (IQR)	
Overall pain score for the first 2 days	3.1 (2.1-4.1)	4.0 (2.1-5.9)	0.931
Maximum pain score at rest for the first 2 days	4.7 (3.0-6.4)	5.1 (1.6-8.6)	0.622
Maximum pain score on defaecation	3.7 (1.1-6.3)	5.4 (3.7-7.1)	0.220
Dologesic tablets required	8.2 (0-17.3)	8.2 (0.6-16.1)	0.340
Pethidine, total (mg)	0 (0-15.0)	0 (0-67.5)	0.542

* Visual analog scale used for measurement
† IQR interquartile range
‡ Mann-Whitney *U* test

test would not have been appropriate in this instance and would have given erroneous results.

PYY Lau, FRCS (Edin), FHKAM (Surgery)
(e-mail: patrickyylau@yahoo.com)

W Meng, FRCS (Edin), FHKAM (Surgery)
A Yip, FRCS (Edin), FACS
Department of Surgery
Kwong Wah Hospital
Hong Kong

Notice to Trainees

From time to time, the *Hong Kong Medical Journal* receives sponsorship from the drug industry for trainees to receive free subscription to this Journal. If you are a trainee and would like to benefit from such offers, kindly write to the Editorial Office <hkmj@hkam.org.hk> with your full name and address, the date you started training, and the name of the College under which you are being trained.