OA — Practical Care

NSAID safety, injections & when to refer

CLINICAL PATHWAY

Match the NSAID to the patient's risk, not the other way round. Review cardiovascular, renal, GI and bleeding risk before every NSAID script. Steroid injections help short-term but are capped, and orthopaedic referral can be transformative once conservative care has genuinely failed.

ORAL NSAID RISK BY PATIENT GROUP

- **Low risk:** naproxen 250–500mg BD commonly preferred; avoid long courses; add PPI if age >65 or course >2 weeks
- **CV risk / IHD:** naproxen has the more favourable CV profile of the NSAIDs; avoid diclofenac and COX-2 selective agents; add PPI
- **GI risk** (prior ulcer, age >65): COX-2 selective agent + PPI commonly preferred; avoid long-term non-selective NSAID
- **Renal impairment** (eGFR <60): avoid all NSAIDs where possible — oral and topical both carry renal risk in this group
- **Anticoagulated:** topical NSAID only where possible; if oral is unavoidable, add a PPI and review closely

INTRA-ARTICULAR STEROID INJECTION

- Indications: knee OA with effusion or flare; shoulder, base-of-thumb or hip OA (image-guided)
- Typical agent: methylprednisolone acetate with local anaesthetic, or triamcinolone — confirm current product and dose at eTG
- Frequency: commonly capped at 3–4 injections per joint per year — more frequent dosing has been associated with accelerated cartilage loss
- Effect: symptomatic improvement over roughly 2–12 weeks — a bridge to other interventions, not a standalone fix
- Contraindications: active infection, septic joint, uncontrolled diabetes (transient glucose rise)

WHEN TO REFER ORTHOPAEDICS

- End-stage symptoms: severe pain, night pain or functional loss despite optimal conservative treatment
- Imaging-confirmed: severe radiographic OA (KL grade 3–4) with a matching clinical picture
- TKR/THR candidate: failed 3–6 months conservative treatment, age- and comorbidity-adjusted
- Red flags (urgent): locked knee, a mechanical block, or suspected septic arthritis

PATIENT RESOURCES & MBS PLANNING

MyJointPain (myjointpain.org.au) and the GLA:D Australia program (gladaustralia.com.au) for evidence-based exercise and education. Up to 5 Medicare-subsidised physiotherapy visits per calendar year are available under a GP Chronic Condition Management Plan (replacing the former EPC arrangements) — confirm current item numbers at mbsonline.gov.au. Image only if red flags or a surgical referral is being planned.

■ SAFETY

- Review CV, GI, renal and bleeding risk before every NSAID prescription — match the agent to the risk, not the reverse
- Cap intra-articular steroid at 3–4 injections per joint per year — more frequent dosing has been linked to accelerated cartilage loss
- Avoid all NSAIDs where possible if eGFR <60 — oral and topical both carry renal risk in this group

■ RED FLAGS / REFER

- Locked knee, a mechanical block, or suspected septic arthritis → urgent orthopaedic referral, same day
- Severe pain, night pain or functional loss despite optimal conservative treatment, or a TKR/THR candidate who has failed 3–6 months conservative care → orthopaedic referral
- Severe radiographic OA (KL grade 3–4) with a matching clinical picture and ongoing symptoms → orthopaedic referral