

## NSAIDs Quiz - feedback

The NSAID quiz is a little different from our usual case studies. We had 50% more responses than we usually get from the case studies. The panel thought that participants probably get more educational value out of the case studies but this is balanced by the increased number of participants in the quiz.

The answers showed that participants had a good level of knowledge of NSAID use. Some questions that left people in doubt produced debate among panellists over the correct answer. In question five most participants erred on the side of caution.

### Q1. Do NSAIDs modify the disease process of rheumatoid arthritis?

No ✓	97.1%
Yes	2.9%

Most people knew that NSAIDs are not disease modifying agents and do not alter the course of rheumatoid arthritis (RA). NSAIDs do of course have a major role in controlling the pain and inflammation associated with RA.

### Q2. Which of the following is the most appropriate first line medication for most people with osteoarthritis?

Cox-2	0.0%
Non-Specific NSAID	0.8%
Paracetamol + Codeine	0.3%
Regular Paracetamol ✓	99.2%

The panel was not sure how the results of this question translate into actual practice. Just about everyone knows that regular paracetamol is the most appropriate first line medication for most people with osteoarthritis. However, regular paracetamol may mean a TDS or QID regime. The panel suspects that this is a barrier to both prescribers and patients, and NSAIDs are selected for the convenience of a once or twice daily regime. Most people with osteoarthritis do get safe and effective pain relief if they take regular paracetamol, and it is worthwhile for prescribers to stress this and work with patients to achieve adherence to this regime.

### Q3. Should NSAIDs be used instead of aspirin for cardioprotection?

No ✓	99.8%
Yes	0.2%

The benefits of regular low-dose aspirin in the reduction of cardiovascular risk outweigh the risk of adverse GI events when the cardiovascular risk is greater than 15%. Knowing that the risk of adverse GI events of aspirin and other NSAIDs is additive may tempt prescribers to stop aspirin and hope the NSAID does the trick. This is not the case. If alternatives to the NSAID cannot be found, a cautious approach using low-dose aspirin, low dose diclofenac and omeprazole is appropriate.

### Q4. Which NSAID has been linked with possibly negating the protective effect of aspirin?

Diclofenac	6.1%
Ibuprofen ✓	81.9%
Indomethacin	9.3%
Naproxen	4.8%

The review panel did not like this question. As one member put it "anything is possible" so the wording of the question was poor. In addition the possible negating effect has not been shown to have clinical significance. The question was included because we wanted to remind prescribers of the powerful, complex and wide ranging actions of NSAIDs. Knowledge in this area is still evolving and prescribers have the difficult job of keeping up to date with evidence which may be tainted by economic, corporate or political influence.

Q5. What effect do NSAIDs usually have on blood pressure?

Increase by 5mmHg	95.0%
Lower by 5mmHg	0.6%
None ✓	4.4%

All NSAID users experience some degree of salt and water retention; hypertension occurs in less than 10% of users. Hypertension is most likely in people already on anti-hypertensive medication. The responses reflected a cautious approach by prescribers.

Q6. Which of the following is the most appropriate strategy for decreasing risk of NSAID related GI adverse events in at-risk people?

Co-prescribe Omeprazole ✓	96.7%
Co-prescribe Ranitidine	1.4%
Use Enteric-coated formulation	1.9%

Most people knew that omeprazole is the most appropriate of the options available in decreasing the risk of NSAID related adverse GI events. Misoprostol may be even more effective but has a higher incidence of side effects and is less available in New Zealand.

Q7. When is the peak time for adverse events during NSAID use?

After one month	5.8%
After one year	1.1%
First two weeks	4.5%
Throughout use ✓	87.4%

Often when we warn our long-term NSAID users of adverse effects they reply that they have had no problems so far and therefore think that the NSAID is safe for them. This is not the case, as the risk of adverse GI events is fairly constant

throughout use. In addition their cardiovascular risk may be changing, for example with increasing age. The panel agreed with bpac<sup>NZ</sup>'s recommendation that the need to continue with NSAIDs should be reconsidered before every repeat prescription.

Q8. Is there evidence that NSAIDs aid tissue repair / healing in soft tissue injuries?

No ✓	96.6%
Yes	3.4%

Given the answers to this question it is surprising how often NSAIDs are taken for soft tissue injuries. On current evidence paracetamol is a better alternative on most occasions.

Q9. Which NSAID appears to have the lowest risk of causing GI bleeding?

Diclofenac	1.3%
Ibuprofen ✓	97.6%
Indomethacin	0.8%
Naproxen	0.5%

Ibuprofen appears to have the lowest risk of causing GI bleeding. However, there is an opinion that this is because ibuprofen is usually recommended in low doses. This may be the case but we must be guided in our prescribing

by current evidence, and that is that low-dose ibuprofen is effective for pain relief and is the safest NSAID for that indication.

Q10. Elderly people are at increased risk of which of the following adverse events of NSAID use?

Cardiac	0.3%
Gastrointestinal	2.1%
Renal	0.6%
All of these ✓	97.0%

Elderly people are at higher risk of adverse events not only because of their age but also because they often have co-morbidities which increase the risk of GI, renal and cardiovascular adverse events.