Guidance on the use of cyclo-oxygenase (Cox) II selective inhibitors, celecoxib, rofecoxib, meloxicam and etodolac for osteoarthritis and rheumatoid arthritis

National Institute for Clinical Excellence

Record Status
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Citation

Authors' objectives
To provide guidance on the use of cyclo-oxygenase (Cox) II selective inhibitors, celecoxib, rofecoxib, meloxicam and etodolac for osteoarthritis and rheumatoid arthritis.

Authors' conclusions
Guidance 1.1 Cox II selective inhibitors and other non-steroidal anti-inflammatory drugs (NSAIDs) are indicated for pain and stiffness in inflammatory rheumatoid arthritis and for the short-term management of pain in osteoarthritis. All NSAIDs are associated with adverse events and should only be prescribed when there is a demonstrable clinical need and in accordance with their summary of product characteristics. Long-term use should be avoided without appropriate monitoring and re-evaluation of the clinical need.

1.2 Of particular concern is the propensity of NSAIDs, including the Cox II selective agents, to cause gastro-intestinal adverse events, which can include life threatening gastro-intestinal perforations, ulcers or bleeds. These agents should therefore only be prescribed after careful consideration of their risks and benefits, especially in patients who may be at increased risk of such adverse events.

1.3 Cox II selective inhibitors are not recommended for routine use in patients with rheumatoid arthritis (RA) or osteoarthritis (OA). They should be used, in preference to standard NSAIDs, when clearly indicated as part of the management of RA or OA only in patients who may be at high risk of developing serious gastrointestinal adverse effects.

1.4 Patients at high risk of developing serious gastrointestinal adverse events include those of 65 years of age and over, those using concomitant medications known to increase the likelihood of upper gastrointestinal adverse events, those with serious co-morbidity or those requiring the prolonged use of maximum recommended doses of standard NSAIDs. The risk of NSAID-induced complications is particularly increased in patients with a previous clinical history of gastroduodenal ulcer, gastrointestinal bleeding or gastroduodenal perforation. The use of even a Cox II selective agent should therefore be considered especially carefully in this situation.

1.5 In all patients with cardiovascular disease, there remains uncertainty over the use of Cox II selective inhibitors and they should not therefore be prescribed routinely in preference to standard NSAIDs where these are indicated in this group of patients. Furthermore, many patients with cardiovascular disease receive low dose aspirin and this carries an increased risk of gastro-intestinal events. In patients who are taking low dose aspirin, the benefit of using Cox II selective agents (to decrease gastrointestinal toxicity) is reduced. Prescribing Cox II selective agents preferentially over standard NSAIDs in this situation is therefore not justified on current evidence.

1.6 There is no evidence to justify the simultaneous prescription of gastroprotective agents with Cox II selective inhibitors as a means of further reducing potential gastrointestinal adverse events.
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