1. Do not perform arthroscopy with lavage and/or debridement or partial meniscectomy for patients with symptomatic osteoarthritis of the knee and/or degenerate meniscal tear.

There is consistent evidence to indicate that arthroscopic lavage and/or debridement to treat people for symptomatic knee osteoarthritis, and/or partial meniscectomy for patients with a degenerate meniscal tear (with or without underlying osteoarthritis), is no more effective than placebo surgery or non-operative alternatives. There appears to be a high rate of conversion from knee arthroscopy to total knee arthroplasty, which rises with increased age, further suggesting arthroscopic surgery should be avoided in people over the age of 50 years. Additionally, arthroscopy is associated with peri- and post-operative risks and considerable cost.

2. Do not order antinuclear antibody (ANA) testing without symptoms and/or signs suggestive of a systemic rheumatic disease.

Antinuclear antibodies (ANAs) are present in healthy individuals and ANA testing is only useful in patients with symptoms and/or signs of a rheumatic disease where it can aid in the confirmation or exclusion of systemic connective tissue diseases. ANA testing has a very high negative predictive value for excluding connective tissue diseases as a cause for patients’ symptoms. However, a positive ANA result does not have a high positive predictive value for diagnosing these conditions in isolation, and further sub-serology testing is needed to accurately diagnose and classify these conditions.

3. Do not undertake imaging for low back pain in patients without indications of a serious underlying condition.

Most episodes of low back pain (~90%) do not require imaging. Imaging may identify irrelevant incidental findings and increase the risk of exposure to unnecessary, and sometimes invasive treatment, in addition to increasing costs. For patients with low back pain and no suggestion of serious underlying conditions there are no significant differences in pain or disability outcomes between immediate imaging as compared with usual care without imaging.
Do not use ultrasound guidance to perform injections into the subacromial space as it provides no additional benefit in comparison to landmark-guided injection. Currently there is no high-quality evidence to support the superiority of ultrasound-guided subacromial injections compared with injections guided by landmarks alone. Based upon moderate quality evidence from five trials, a Cochrane review was unable to find any advantage (in terms of pain, function, range of motion or adverse events) of ultrasound-guided injection over either landmark-guided or intramuscular injection. These results are consistent with a more recent trial. In view of the currently available data and the significant added cost, there is little clinical justification in using ultrasound to guide injections for shoulder pain.

Do not order anti-double stranded (ds) DNA antibodies in ANA negative patients unless clinical suspicion of systemic lupus erythematosus (SLE) remains high. International recommendations advise testing for anti-dsDNA antibodies only after detecting a positive ANA in patients with symptoms consistent with systemic lupus erythematosus. In patients who are ANA negative, anti-dsDNA should only be ordered in clinical situations where the pre-test probability of SLE is very high. Where positive, repeating anti-dsDNA antibodies titre is a useful test for monitoring disease activity, especially in lupus nephritis.
SUPPORTING EVIDENCE


HOW THIS LIST WAS MADE

An ARA Evolve working group comprising 19 rheumatologists and 3 advanced rheumatology trainees was established after a call for interest. The group agreed that items should be included if they were either primarily a rheumatologist issue or an issue that rheumatologists should advocate for on behalf of their patients. A preliminary list of low-value clinical practices was created based upon the working group’s clinical experiences, as well as consideration of potentially relevant items identified from a review of other lists generated. This list was refined into 12 items and small teams for each topic were formed to review the evidence pertaining to these items and their relevance to Australian healthcare. Brief summaries of the evidence were written based on NHMRC evidence review standards. An anonymous online survey was created based on these summaries and all ordinary (356 rheumatologists) and associate (72 rheumatology trainees) ARA members were invited to participate. Survey participants were asked to select the five recommendations for which they considered the evidence to be the strongest. The survey attracted a 50% response rate and based on its results, the ARA top five recommendations were formulated.

Last reviewed: February 2018