

What is the best treatment for Osgood-Schlatter's disease?

Evidence-Based Answer

Most patients with Osgood-Schlatter's disease (OSD) have symptomatic relief from conservative treatment (activity modification, rest, ice, nonsteroidal anti-inflammatory drugs [NSAIDs]) (SOR: **B**, prospective cohort and case series). Surgical treatment is rarely required, but may be beneficial in skeletally mature patients with symptoms despite conservative measures (SOR: **C**, case series).

A prospective Saudi Arabian cohort study reported on the effectiveness of conservative or surgical treatment in 261 patients with 1–2 years of OSD (97% males; average age of 16).¹ Conservative treatment consisted of activity modification, rest, and NSAIDs. Overall, 91% of patients responded well to conservative treatment. Twenty-four patients (9%) underwent surgery: 3 were bilateral surgeries and all returned to normal activity after 3–6 weeks without complications. A limitation of this study is that “responded well” was not explicitly defined.

A retrospective case series of 118 patients with clinical and radiographic documentation of OSD found that 88% of those treated nonoperatively with intermittent activity limitation or immobilization in a cylinder cast reported improved pain or healing at follow-up.² Approximately 12% of patients showed no improvement and underwent surgical excision of an ossicle, some combined with a tubercle-thinning procedure. The mean age at surgery was 14.3 years for female patients and 17 for male patients. All but 1 patient had complete relief of symptoms and returned to full activity at 6 weeks.

A retrospective analysis of 107 military recruits who had surgery for unresolved OSD sought to assess long-term outcomes.³ Surgery was recommended if the patient had radiographic and clinical evidence of OSD, a duration of symptoms long enough to demonstrate severity, if the patient could not continue military training because of failing conservative treatment, or if the patient was unable to kneel or squat without persistent pain during military service. Key outcomes included the Kujala scale (a 13-item knee-specific self-report questionnaire with a scale of 0–100; 95–100 points is considered excellent) and a 100-mm visual analog pain scale (VAS).

After a 10-year follow-up, 87% reported they could participate without restriction in daily work activities (median Kujala score 95 and median VAS score of 7 mm). Seventy-five percent of patients regained their preoperative sports activity level. Thirty-eight percent reported an ability to kneel without pain. Minor postoperative complications occurred with 6 patients, and 2 patients required reoperation.³

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What treatments are effective for chronic prostatitis?

Evidence-Based Answer

Alpha-blockers, antibiotics, or a combination of the 2 are effective treatment options for chronic prostatitis (SOR: **A**, systematic review of RCTs). Silodosin also reduces chronic prostatitis symptoms. Dutasteride improves prostatitis-related symptoms in older men who have an increased prostate-specific antigen level and negative biopsies (SOR: **B**, single RCTs).

A systematic review and meta-analysis in 2011 reviewed 23 RCTs (N=2,315) comparing chronic prostatitis symptom scores and treatment response among multiple therapies.¹ Mean ages of participants were from 29 to 56 years, with treatment duration from 4 to 52 weeks.

Compared with placebo, mean total National Institutes of Health Chronic Prostatitis Symptom Index (NIH-CPSI) scores (which range from 0 to 43) at follow-up were significantly lower for alpha-blockers (5 trials, N=568; weighted mean difference [WMD] –11.0; 95% CI, –14 to –8.1), antibiotics (3 trials, N=215; WMD –9.8; 95% CI, –15 to –4.6), alpha-blockers plus antibiotics (3 trials, N=382; WMD –14; 95% CI, –18 to –10), and finasteride (2 trials, N=105; WMD –4.6; 95% CI, –8.7 to –0.5). Alpha-blockers plus antibiotics were better than any other therapy and were significantly better than alpha-blockers alone (13 trials, N=1,541; WMD –2.9; 95% CI, –5.2 to –0.5).¹