Survey Report

Treatment options in osteoarthritis management

Version No.: 1.1

The study was conducted according to the approved protocol and in compliance with the protocol, Good Clinical Practice (GCP), and other applicable local regulatory requirements.

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1 INTRODUCTION

Osteoarthritis (OA) is a highly prevalent chronic joint disease. It is a progressively degenerating disease characterized by loss of articular cartilage, hypertrophy of bones at the margins, subchondral sclerosis, and biochemical and morphological changes of the synovium. The most frequently diagnosed type of arthritis is knee OA. Its incidence is continuously growing along with increasing life expectancy and obesity [1, 2]. Over 50% of people over the age of 65 years have radiological evidence of disease and approximately 10% of men and 18% of women have symptomatic OA [3].

Management of OA is complex and multifaceted, involving both pharmacological and non-pharmacological approaches aimed at reducing pain, improving function, and slowing disease progression. Non-pharmacological strategies, including patient education, exercise, weight management, and physical therapy, form the foundation of OA treatment [4]. Pharmacological options are typically introduced in a stepwise manner, beginning with simple analgesics like paracetamol for mild to moderate symptoms [5]. As symptoms progress, topical NSAIDs or capsaicin may be employed [6]. For moderate to severe persistent symptoms, oral NSAIDs are commonly prescribed after careful risk assessment, with considerations for gastroprotection in high-risk patients [7]. Viscosupplementation with hyaluronic acid products has shown efficacy for knee OA [8]. In cases of severe symptoms where surgery is contraindicated or delayed, opioid therapy may be considered, though with caution due to potential risks [9]. Intra-articular corticosteroid injections can provide short-term relief for acute symptom flares [10]. The role of supplements like glucosamine and chondroitin remains controversial, with limited evidence supporting their efficacy [11].

Recent research has focused on developing more selective NSAIDs and novel formulations to improve safety profiles while maintaining efficacy [12]. This includes unichiral NSAIDs and prolonged-release formulations, which aim to optimize therapeutic benefits while minimizing adverse effects [13]. The management of OA is further complicated by the frequent presence of comorbidities in affected patients. Conditions such as hypertension,

dyslipidemia, and diabetes are common among OA patients and can influence treatment decisions, particularly regarding the choice of NSAIDs [14].

Understanding the real-world practices and experiences of clinicians in managing OA, particularly their use of NSAIDs and newer formulations like S-Etodolac, is crucial for improving treatment strategies and patient outcomes. This survey-based study aims to contribute to this understanding by gathering insights from practicing physicians on their approach to OA management and their perceptions of various treatment options.

2 RATIONALE OF THE STUDY

Osteoarthritis (OA) is a highly prevalent and progressively degenerative joint disease, particularly affecting the knee. With an increasing incidence due to rising life expectancy and obesity, OA significantly impacts the quality of life for a large portion of the aging population. Despite established treatment guidelines emphasizing a combination of pharmacological and non-pharmacological strategies, there remains a gap between these guidelines and real-world clinical practices.

Traditional NSAIDs, a common pharmacological treatment for OA, are associated with concerns regarding their safety and efficacy, especially in patients with comorbidities such as hypertension, dyslipidemia, and diabetes. Newer formulations, including unichiral NSAIDs and prolonged-release options like S-Etodolac, have been developed to optimize therapeutic benefits while minimizing adverse effects. However, there is limited data on clinicians' perceptions and experiences with these newer NSAID formulations in routine practice.

This study aims to bridge this knowledge gap by assessing the current practices and perspectives of physicians managing OA, particularly focusing on their use of NSAIDs and newer formulations like S-Etodolac. The insights gained from this survey will inform clinical guidelines, improve patient care, and guide future research, ultimately contributing to optimized treatment strategies and enhanced outcomes for OA patients.

3 OBJECTIVES

The primary objective of this study is to evaluate current clinical practices and perceptions regarding the use of NSAIDs, particularly S-Etodolac, in the management of OA among practicing physicians in India.

4 METHODS

This is a cross-sectional, questionnaire-based study aiming to evaluate the current clinical practices and perceptions regarding the use of NSAIDs, particularly S-Etodolac, in the management of OA among Indian physicians. The inclusion criteria were physicians currently practicing in India and those who manage patients with OA. The exclusion criteria were the physicians who are not currently involved in the management of OA and those who are not willing to provide informed consent. Physicians were identified and invited to participate through professional networks and medical associations. Invitations were sent via email and other electronic communication platforms, detailing the study's objectives and participation requirements. A structured questionnaire was developed, comprising 10 questions related to demographic information (age, gender, years of practice, specialty), clinical experience with OA management, prescribing practices of NSAIDs, perceptions of the safety and efficacy of traditional NSAIDs, experience and perceptions regarding newer NSAID formulations, specifically S-Etodolac.

The survey was administered electronically to ensure convenience and wide reach. A secure online platform was used for data collection, ensuring data integrity and confidentiality. Participants were provided with detailed information about the study and informed consent was obtained electronically before they proceed with the survey. Responses were collected and stored securely in a password-protected database. The target sample size was 100 Indian physicians. This number was chosen to ensure a diverse and representative sample, allowing for meaningful statistical analysis.

The study adhered to the ethical principles outlined in the Declaration of Helsinki. Ethical approval was obtained from an Independent Ethics Committee. Participants were assured for the right to withdraw from the study at any time

without any consequences. All the responses were anonymized to ensure participant's confidentiality. Data was analysed using descriptive Statistics to summarize demographic information and response frequencies. Inferential statistics was used such as chi-square tests or logistic regression to explore associations between physician characteristics and their perceptions and prescribing behaviors.

5 RESULTS

A total of 85 physicians participated in the survey.

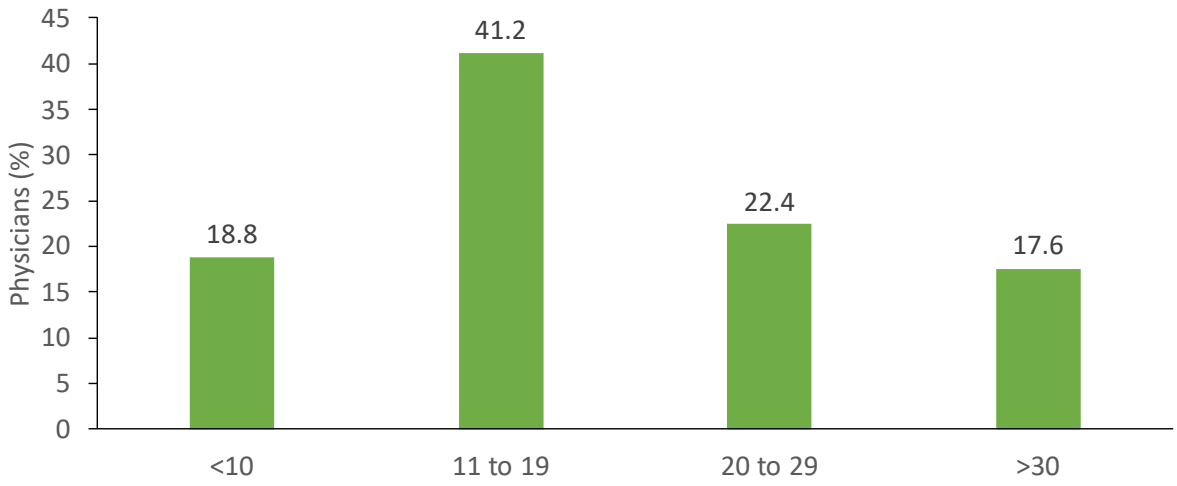
[1] In your clinical practice, how many patients of Osteoarthritis (OA) do you treat in a week?

A. <10

B. 11 to 19

C. 20 to 29

D. >30



- A total of 41.2% of physicians reported that they attend 11 to 19 patients of OA in a week.
- Similarly, 22.4% of them attend 20 to 29 patients in a week
- Around 19% of physicians mentioned the attend only less than 10 patients
- More than 30 patients are attended by around 18% of physicians

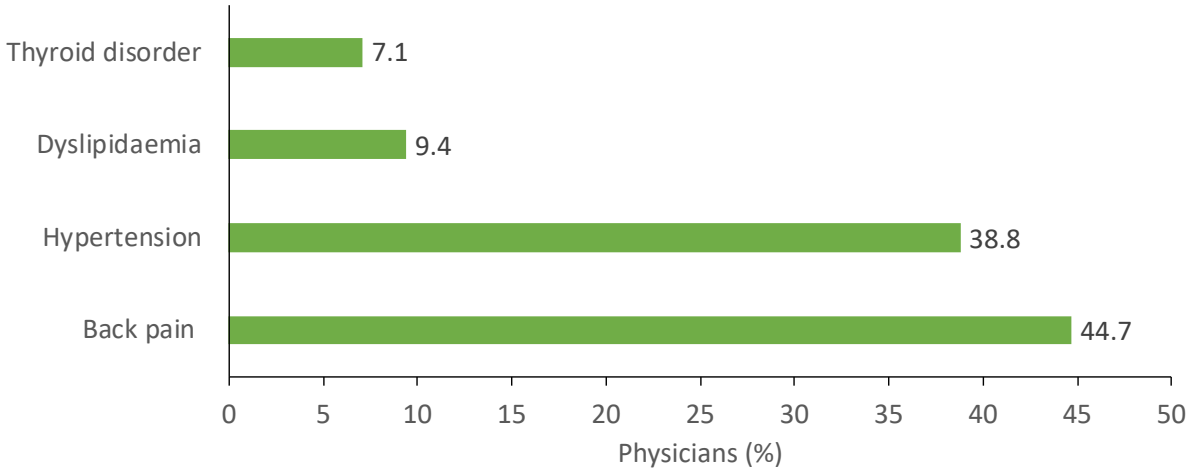
[2] Which co-morbidities are generally associated with osteoarthritis in your clinical practice?

A. Hypertension

B. Dyslipidaemia

C. Back pain

D. Thyroid disorder



- In clinical practice, majority of physicians reported back pain (44.7%) is associated with OA which is followed by hypertension (38.8%)
- However, some of the physicians (9.4%) believe dyslipidaemia is associated with OA
- Around 7% of physicians reported thyroid disorder is associated with OA

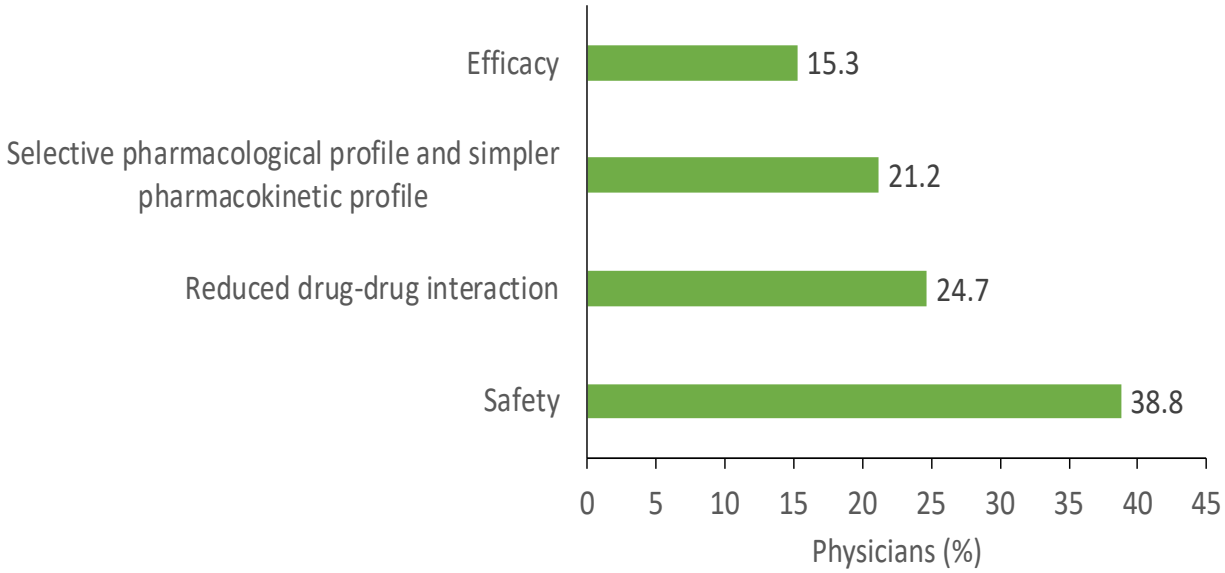
[3] What are the key attributes in selection of NSAIDs in patients with OA?

A. Efficacy

B. Safety

C. Selective pharmacological profile and simpler pharmacokinetic profile

D. Reduced drug–drug interactions



- According to 38.8% of physicians, the most important attribute in selection of NSAIDs in patients with OA is safety
- Around 25% of physicians mentioned reduced drug-drug interaction should be important during selection of NSAIDs
- Selective pharmacological profile and simpler pharmacokinetic profile is important according to 21% of physicians
- Around 15% of physicians found efficacy as important factor in selection of NSAIDs

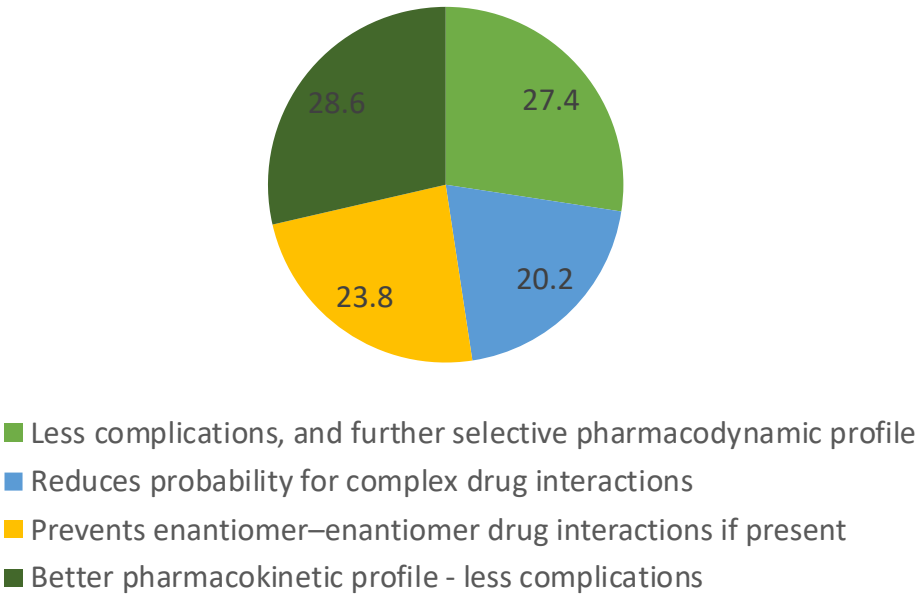
[4] According to you what are the advantages of unichiral NSAIDS?

A. Less complications, and further selective pharmacodynamic profile.

B. Reduces probability for complex drug interactions.

C. Prevents enantiomer–enantiomer drug interactions if present.

D. Better pharmacokinetic profile - less complications.



- According to 28.6% of physicians, the advantages of unichiral NSAIDs is its feature of better pharmacokinetic profile and less complications
- Similarly following this around 27% of them reported less complications, and further selective pharmacodynamic profile
- The advantage of unichiral NSAIDs is preventing enantiomer–enantiomer drug interactions if present as reported by 24% of physicians
- Around 20% of physicians reported the unichiral NSAIDS reduces probability for complex drug interactions

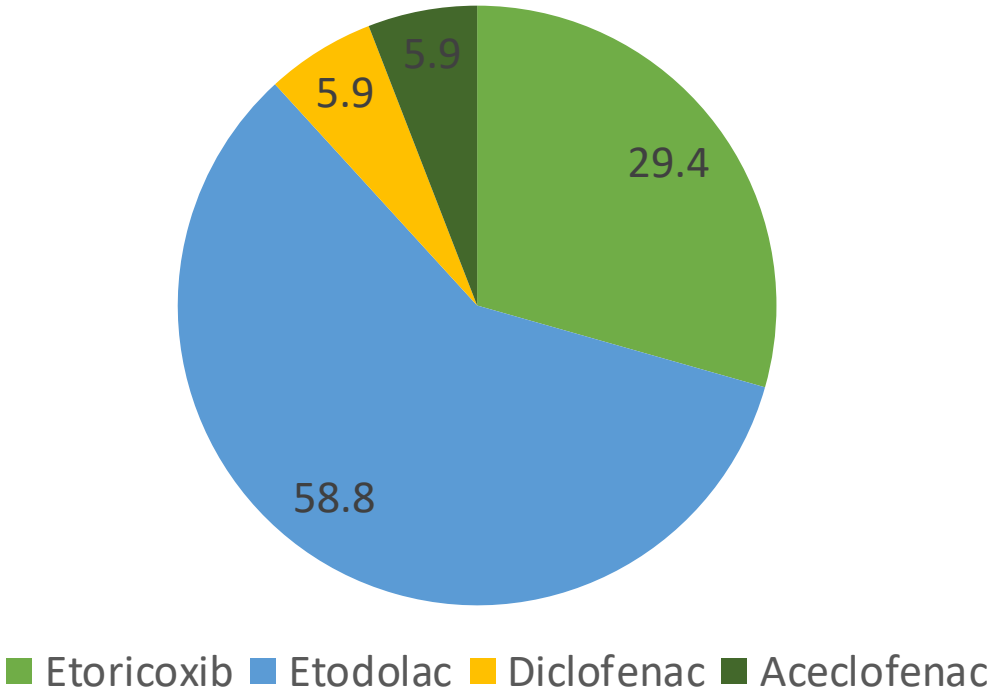
[5] Which NSAID is not preferred in OA patients at high CV risk in your routine clinical practice?

A. Etoricoxib

B. Etodolac

C. Diclofenac

D. Aceclofenac



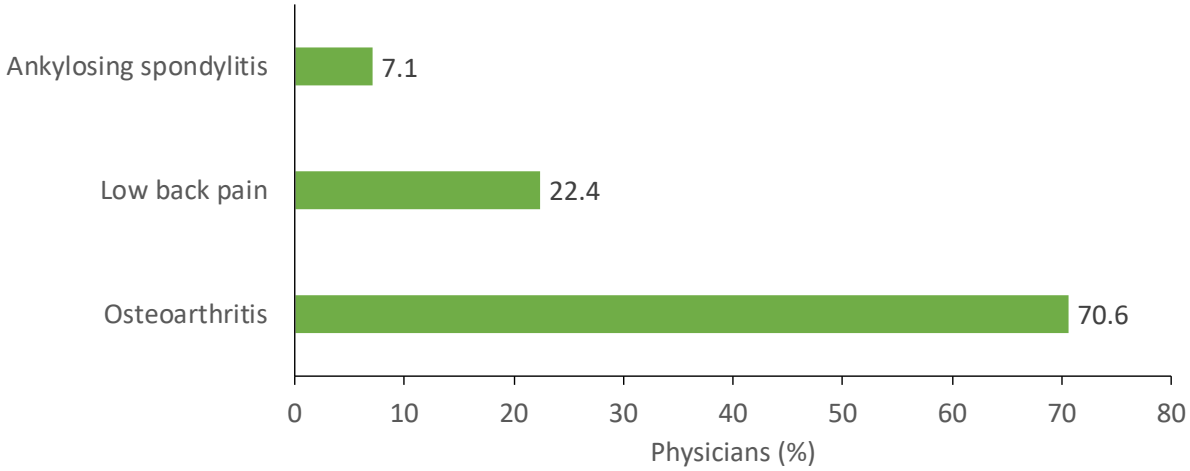
- Majority of physicians (58.8%) reported that in clinical practice etodolac is not preferred in OA patients at high CV risk
- However, some of the physicians (29.4%) reported etoricoxib is not preferred in OA patients at high CV risk
- While, 5.9% each of physicians reported diclofenac and aceclofenac is not preferred at high CV risk

[6] In which indications do you prefer for Prolonged Release formulation?

A. Osteoarthritis

B. Ankylosing spondylitis

C. Low back pain



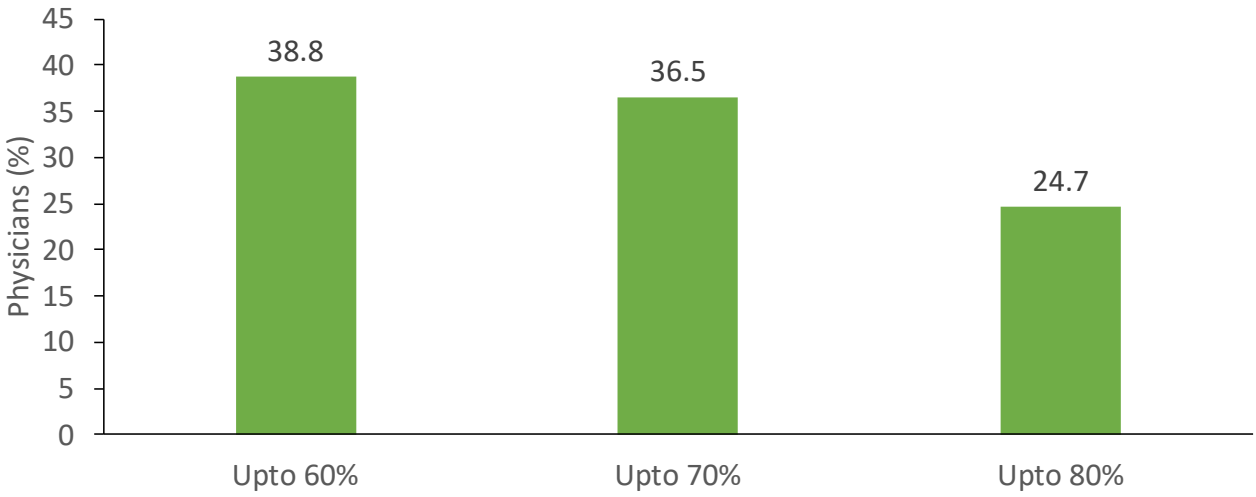
- A total of 70.6% of physicians reported in OA prolonged Release formulation is indicated
- However, 22.4% of physicians reported in low back pain prolonged release formulation is preferred
- While in ankylosing spondylitis, 7.1% of physicians preferred prolonged release formulation

[7] How you will rate the reduction in pain intensity with S-Etodolac prolonged release tablets (300 mg) in your clinical practice in OA?

A. Up to 60%

B. Up to 70%

C. Up to 80%



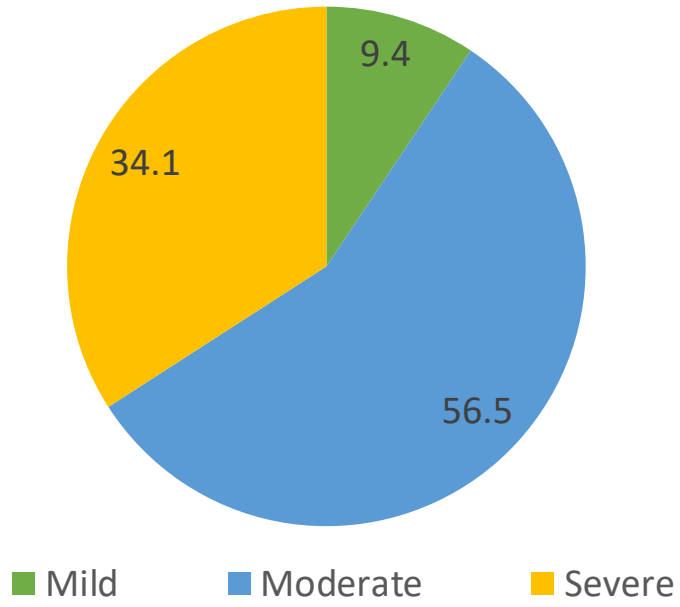
- The majority of physicians (38.8%) observed up to 60% reduction in pain intensity when using S-Etodolac prolonged release tablets (300 mg) for OA, indicating that a significant portion of patients experienced notable pain relief.
- A considerable percentage of physicians (36.5%) observed a higher level of pain reduction (70%) on using S-Etodolac prolonged release tablets (300 mg), suggesting that a substantial number of patients had even better outcomes.
- A smaller but still notable group of physicians (24.7%) observed up to an 80% reduction in pain, indicating that a quarter of the patients achieved substantial pain relief.

[8] In which severity of OA would you recommend/prescribe S-Etodolac in your routine clinical practice?

A. Mild

B. Moderate

C. Severe



- A majority (56.5%) of physicians recommend S-Etodolac for moderate cases of OA in routine clinical practice. This suggests that the drug is considered particularly effective and suitable for patients experiencing moderate pain and symptoms.
- A significant portion (34.1%) of physicians recommend S-Etodolac for severe cases of OA. This indicates that many healthcare providers also find the medication effective for more advanced stages of the condition, where patients experience more intense pain and disability.
- A smaller group (9.4%) of physicians recommend S-Etodolac for mild cases of OA. This suggests that while the drug is effective, it is less commonly prescribed for patients with mild symptoms, possibly because alternative treatments may be sufficient for managing less severe pain and symptoms

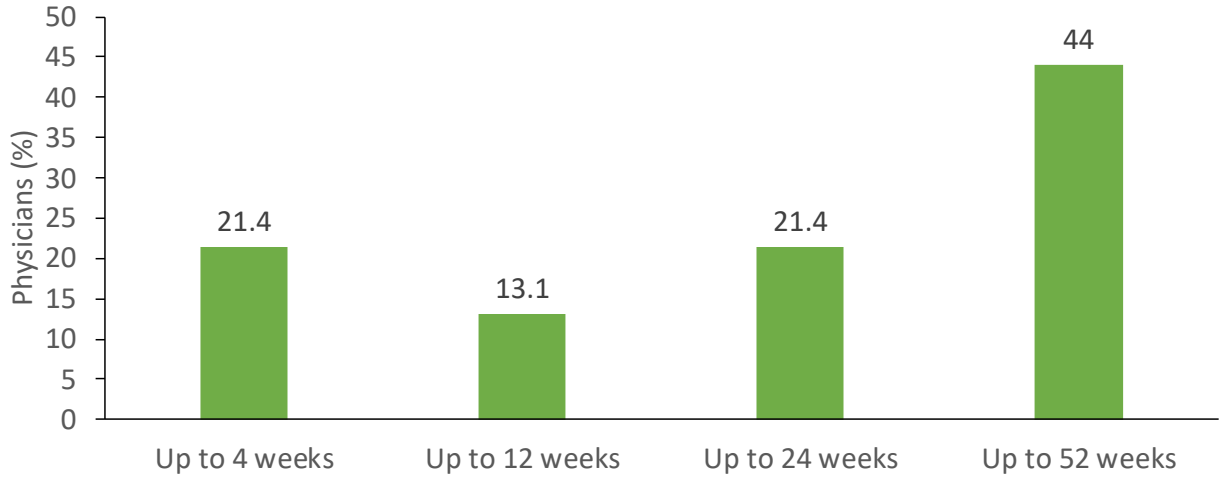
[9] What is the longest duration you have used S-Etodolac in your practice?

A. Up to 4 weeks

B. Up to 12 weeks

C. Up to 24 weeks

D. Up to 52 weeks

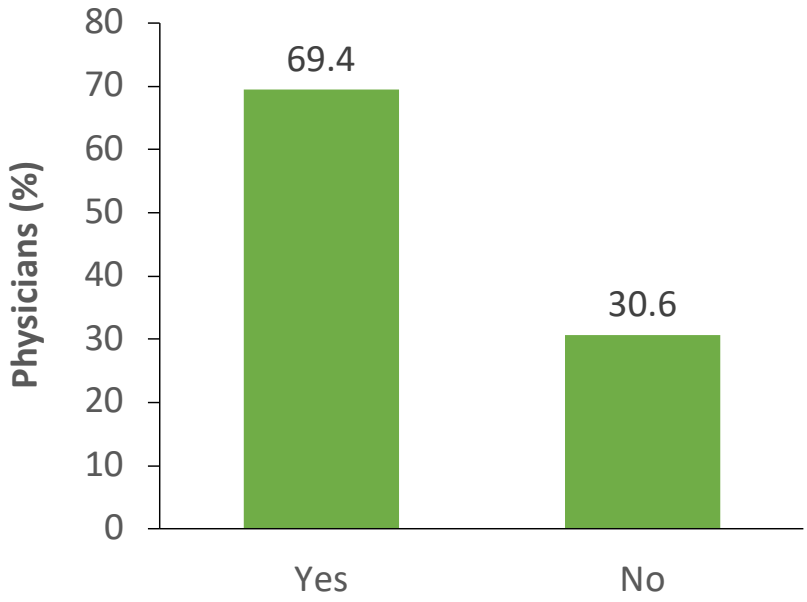


- A substantial portion (44%) of physicians reported that the longest duration of S-Etodolac use in clinical practice is up to 52 weeks. This indicates that the medication is often prescribed for long-term use, suggesting its sustained effectiveness and tolerability for chronic management of conditions like OA
- 21.4% each of physicians reported prescribing S-Etodolac for durations of up to 4 weeks and up to 24 weeks. This shows variability in prescribing patterns, with some physicians opting for shorter or intermediate-term use depending on the patient's condition and response to treatment.
- 13% of physicians have prescribed S-Etodolac for up to 12 weeks. This further highlights the diversity in treatment durations, with some patients receiving the medication for a moderate-term period.

[10] In your routine clinical practice, does chronic usage of S-Etodolac therapy adversely affect renal function in patients with arthritis?

A. Yes

B. No



- A majority (69.4%) of physicians believe that chronic usage of S-Etodolac therapy can adversely affect renal function in patients with OA. This indicates a significant concern among healthcare providers regarding the potential renal side effects of long-term S-Etodolac use.
- A smaller proportion (30.6%) of physicians responded that chronic usage of S-Etodolac does not adversely affect renal function. This suggests that there is a notable minority who either do not observe this adverse effect in their practice or believe that the benefits of S-Etodolac outweigh the risks.

6 SUMMARY

The survey revealed various insights into physician practices and perceptions regarding OA and NSAID use. A total of 41.2% of physicians reported attending 11 to 19 OA patients per week, while 22.4% attend 20 to 29 OA patients weekly. Approximately 19% of physicians see less than 10 OA patients per week, and around 18% attend more than 30 OA patients weekly.

In terms of associated conditions, 44.7% of physicians identified back pain as being associated with OA, followed by hypertension at 38.8%. A smaller percentage, 9.4%, believe dyslipidemia is associated with OA, and 7% reported an association with thyroid disorders. When selecting NSAIDs for OA patients, 38.8% of physicians prioritize safety, 25% emphasize reduced drug-drug interactions, and 21% consider a selective pharmacological profile and simpler pharmacokinetic profile important. Only 15% of physicians value efficacy as the most critical factor in NSAID selection.

Regarding the advantages of unichiral NSAIDs, 28.6% of physicians highlighted a better pharmacokinetic profile and fewer complications, while 27% focused on fewer complications and a selective pharmacodynamic profile. Additionally, 24% mentioned the prevention of enantiomer-enantiomer drug interactions, and 20% reported a reduced probability of complex drug interactions. In clinical practice, 58.8% of physicians avoid prescribing etodolac for OA patients with high cardiovascular (CV) risk. In comparison, 29.4% avoid etoricoxib, and 5.9% each avoid diclofenac and aceclofenac for patients at high CV risk.

Regarding the use of prolonged release formulations, 70.6% of physicians indicated their use in OA, 22.4% preferred them for low back pain, and 7.1% favored them for ankylosing spondylitis. Physicians reported varying levels of pain reduction with S-Etodolac prolonged release tablets (300 mg). Specifically, 38.8% observed up to 60% pain reduction, 36.5% saw a 70% pain reduction, and 24.7% reported up to an 80% reduction in pain intensity. In terms of recommendations, 56.5% of physicians recommend S-Etodolac for moderate OA cases, 34.1% for severe OA, and 9.4% for mild OA. The duration of S-Etodolac use also varied, with 44% reporting usage for up to 52

weeks, 21.4% each for up to 4 weeks and 24 weeks, and 13% for up to 12 weeks.

Lastly, there are concerns about the potential adverse effects of chronic S-Etodolac therapy on renal function. A majority of 69.4% of physicians believe that prolonged use can adversely affect renal function, while 30.6% do not observe significant renal side effects or believe the benefits outweigh the risks.

7 DISCUSSION

The current survey provides valuable insights into physician practices and perceptions regarding the management of OA with NSAIDs. The management of OA often involves the use of nonsteroidal anti-inflammatory drugs (NSAIDs) to alleviate pain and improve function, though the selection of an appropriate NSAID remains a critical decision influenced by several factors (Sen & Hurley, 2022). A substantial proportion of physicians attend to a significant number of OA patients weekly, with 41.2% seeing 11 to 19 patients and 22.4% attending to 20 to 29 patients. This underscores the high prevalence of OA and the considerable burden it places on healthcare providers (McKenzie & Torkington, 2010).

Physicians also reported a range of comorbid conditions associated with OA, most notably back pain (44.7%) and hypertension (38.8%), aligning with previous findings that highlight the multifaceted nature of OA and its impact on overall health (Swain et al., 2020). The identification of dyslipidemia and thyroid disorders as associated conditions by smaller percentages of physicians (9.4% and 7%, respectively) suggests the need for comprehensive management strategies that address these comorbidities (Felson, 2013).

When selecting NSAIDs for OA patients, physicians prioritize safety (38.8%), reduced drug-drug interactions (25%), and pharmacokinetic profiles (21%), with efficacy being less frequently cited (15%). These preferences align with the recommendations from the American College of Rheumatology and Arthritis Foundation, which emphasize the importance of considering patient-

specific factors and potential side effects when prescribing NSAIDs (Kolasinski et al., 2020).

The survey also highlights the perceived advantages of unichiral NSAIDs, with 28.6% of physicians noting a better pharmacokinetic profile and fewer complications, and 27% emphasizing fewer complications and a selective pharmacodynamic profile. This reflects a growing awareness of the benefits of unichiral formulations in minimizing adverse effects and enhancing therapeutic efficacy (Brocks & Mehvar, 2003). Regarding specific NSAIDs, a significant majority of physicians avoid etodolac in OA patients with high cardiovascular (CV) risk (58.8%), with etoricoxib (29.4%) and diclofenac and aceclofenac (5.9% each) also being less preferred for these patients. This is consistent with the findings of the Coxib and traditional NSAID Trialists' (CNT) Collaboration, which reported heightened cardiovascular risks associated with certain NSAIDs (Bhala et al., 2013).

Prolonged release formulations are indicated by 70.6% of physicians for OA, 22.4% for low back pain, and 7.1% for ankylosing spondylitis, suggesting a preference for sustained pain relief in chronic conditions. The effectiveness of S-Etodolac prolonged release tablets is particularly noteworthy, with 38.8% of physicians observing up to 60% pain reduction, 36.5% reporting a 70% reduction, and 24.7% noting up to an 80% reduction. This supports the efficacy of S-Etodolac in managing OA pain over extended periods (Derry et al., 2016). In terms of recommendations, S-Etodolac is favored for moderate OA cases by 56.5% of physicians, severe cases by 34.1%, and mild cases by 9.4%. This indicates a broad acceptance of the drug's effectiveness across varying severity levels of OA. The variability in the duration of S-Etodolac use, with 44% prescribing it for up to 52 weeks, 21.4% for up to 4 weeks and 24 weeks, and 13% for up to 12 weeks, reflects differing clinical approaches based on patient response and tolerance (Nelson et al., 2014).

However, there are significant concerns regarding the potential adverse effects of chronic S-Etodolac therapy on renal function. A majority of 69.4% of physicians believe that prolonged use can adversely affect renal function, aligning with previous studies that have highlighted the risks of long-term NSAID use (Jüni et al., 2015). This underscores the importance of monitoring

renal function in patients undergoing long-term NSAID therapy and considering alternative treatments where necessary (Liu et al., 2018).

In conclusion, the survey results provide a comprehensive overview of current physician practices and perceptions in the management of OA with NSAIDs. The findings highlight the need for a balanced approach that prioritizes patient safety, considers comorbid conditions, and tailors treatment strategies to individual patient needs. Future research should continue to explore the long-term safety and efficacy of NSAIDs and other therapeutic options in the management of OA.

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8 CLINICAL RECOMMENDATIONS

- Conduct a thorough assessment of each OA patient, considering the severity of symptoms, comorbid conditions, and individual risk factors. Regularly monitor patients for the effectiveness of the treatment and any potential adverse effects, particularly focusing on renal function and cardiovascular risks. Prioritize NSAIDs that have a favorable safety profile, especially for patients with high cardiovascular or renal risk. Etodolac and etoricoxib should be avoided in patients with high CV risk.
- Consider NSAIDs with reduced drug-drug interactions and a selective pharmacological profile, as these factors are important in minimizing adverse effects and enhancing patient safety. Utilize unichiral NSAIDs where appropriate, as they offer advantages such as better pharmacokinetic profiles and fewer complications. This can be particularly beneficial in reducing the likelihood of enantiomer-enantiomer drug interactions and complex drug interactions.
- Prolonged release formulations of NSAIDs can be particularly effective for sustained pain relief in chronic OA management. S-Etodolac prolonged release tablets have shown significant efficacy in reducing pain intensity and should be considered for patients requiring long-term pain management.
- Tailor the duration and type of NSAID therapy to the individual needs of each patient. S-Etodolac, for example, can be prescribed for varying durations based on patient response, with long-term use up to 52 weeks being appropriate for some patients.
- Address and manage comorbid conditions such as back pain, hypertension, dyslipidemia, and thyroid disorders alongside OA treatment. This holistic approach can improve overall patient outcomes and quality of life. For moderate cases of OA, S-Etodolac is recommended by the majority of physicians and can be considered an effective option. It is also recommended for severe cases, though less frequently for mild cases where alternative treatments might suffice. Employ a multimodal approach to pain management, incorporating physical therapy, lifestyle modifications, and other non-pharmacological interventions alongside NSAID therapy.

- Given the concerns about the potential adverse effects of chronic NSAID use on renal function, it is essential to monitor renal function regularly and consider alternative therapies or dose adjustments for patients at risk of renal impairment. Educate patients about the potential risks and benefits of NSAID therapy, emphasizing the importance of adherence to prescribed regimens and the need for regular follow-up appointments.
- Encourage patients to report any side effects or concerns promptly to enable timely adjustments to their treatment plan. Follow established guidelines such as those from the American College of Rheumatology and Arthritis Foundation, which provide evidence-based recommendations for the management of OA, ensuring that clinical practices are aligned with the latest research and expert consensus.

9 CONSULTING OPINION

It is crucial to conduct a thorough assessment of each patient's OA severity, comorbid conditions, and individual risk factors. This will guide the selection of the most appropriate NSAID therapy. Regular monitoring for efficacy and adverse effects, particularly on renal function and cardiovascular health, should be a standard practice.

Given the varying risk profiles of different NSAIDs, prioritize those with favorable safety profiles, especially for patients with high cardiovascular (CV) or renal risk. Etodolac and etoricoxib should be avoided in high CV risk patients. Unichiral NSAIDs, which offer advantages such as better pharmacokinetic profiles and fewer complications, should be considered where appropriate. Prolonged release formulations, such as S-Etodolac, have shown significant efficacy in reducing pain intensity and are beneficial for sustained pain relief in chronic OA management. They also improve patient adherence due to less frequent dosing.

Treatment plans should be tailored to the individual needs of each patient. This includes varying the duration of NSAID therapy based on patient response and

tolerance. Long-term use up to 52 weeks may be appropriate for some patients. S-Etodolac is highly recommended for moderate OA cases and is also suitable for severe cases. However, for mild OA, alternative treatments may be considered to manage less severe pain and symptoms.

Address and manage comorbid conditions such as back pain, hypertension, dyslipidemia, and thyroid disorders alongside OA treatment. This comprehensive approach will improve overall patient outcomes and quality of life.

Educate patients about the potential risks and benefits of NSAID therapy, the importance of adherence to prescribed regimens, and the need for regular follow-up appointments. Encourage open communication, enabling patients to report side effects or concerns promptly for timely adjustments to their treatment plan. Ensure that clinical practices align with established guidelines, such as those from the American College of Rheumatology and Arthritis Foundation. These guidelines provide evidence-based recommendations for the management of OA.

10 MARKET OPPORTUNITIES

The increasing incidence of OA, particularly among the aging population, presents a significant market opportunity. As more individuals seek effective pain management solutions, the demand for NSAIDs is expected to rise. With better awareness and improved diagnostic techniques, more patients are being diagnosed with OA at earlier stages. This creates a broader patient base requiring long-term management strategies, including NSAIDs.

The development of advanced drug formulations, such as prolonged release NSAIDs, unichiral NSAIDs, and those with improved safety profiles, can capture a larger market share by addressing patient and physician concerns about efficacy and side effects. Leveraging digital health platforms for patient education, monitoring, and adherence can enhance patient outcomes and satisfaction, creating a competitive edge. Digital tools can facilitate personalized treatment plans and real-time adjustments.

Emerging markets with growing healthcare infrastructure and increasing healthcare expenditure present substantial growth opportunities. Marketing strategies tailored to these regions can help tap into these expanding markets. Collaborating with healthcare providers, insurance companies, and patient advocacy groups can enhance market penetration. Partnerships can help in better positioning NSAIDs as a preferred choice for OA management through joint educational and promotional efforts. Targeting NSAID formulations that also address comorbid conditions associated with OA (e.g., hypertension, back pain) can create niche markets. Combination therapies or NSAIDs with dual benefits can attract more prescribers and patients.

11 MARKET POSITIONING

Position NSAIDs as safe and effective options for long-term OA management, emphasizing their proven efficacy in pain reduction and improved quality of life. Highlight advanced formulations that minimize common side effects, such as gastrointestinal and cardiovascular risks. Promote the unique benefits of prolonged release and unichiral NSAIDs.

Emphasize their superior pharmacokinetic profiles, reduced complications, and improved patient adherence. Market S-Etodolac prolonged release tablets as a

leading option for sustained pain relief. Position S-Etodolac and similar NSAIDs as the go-to choice for moderate to severe OA cases. Highlight their effectiveness in managing more advanced stages of OA, which aligns with the needs of a significant portion of the patient population.

Emphasize a patient-centric approach that integrates personalized treatment plans, regular monitoring, and holistic management of OA and its comorbidities. This approach can differentiate NSAIDs as part of a comprehensive care strategy. Promote the suitability of certain NSAIDs, such as S-Etodolac, for long-term use in chronic OA management. Highlight their sustained effectiveness and tolerability over extended periods, addressing concerns about chronic pain management.

Invest in physician education and engagement programs to keep healthcare providers informed about the latest advancements, safety profiles, and best practices in NSAID use for OA. This can foster trust and preference for specific NSAID brands.

Utilize real-world evidence and robust clinical data to support marketing claims. Present case studies, patient testimonials, and comparative studies that demonstrate the advantages of the marketed NSAIDs over competitors.

Develop comprehensive patient support programs that include educational resources, adherence tools, and direct lines of communication with healthcare professionals. These programs can enhance patient satisfaction and loyalty.

By capitalizing on these market opportunities and positioning NSAIDs effectively, companies can expand their market share and meet the growing needs of OA patients. A strategic focus on safety, efficacy, innovative formulations, and patient-centric approaches will be key to achieving sustained success in this competitive landscape.

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