

Letter to the Editor

Letter to the editor: integrative approach to knee osteoarthritis management

Sir,

I read with great interest the recently published article by Raghav et al.¹ The study provides compelling evidence supporting the synergistic benefit of combining physiotherapy with pharmacologic therapy for managing knee osteoarthritis (OA). The authors have appropriately highlighted that monotherapies-whether pharmacologic or rehabilitative-may offer limited benefit in comparison to a structured dual-modality approach.

As a physician practicing in the field of sports medicine, managing a diverse patient population with chronic OA and musculoskeletal complaints, I wish to commend the authors for addressing a clinically underemphasized reality: the under-treatment of OA patients due to fragmented or mono-dimensional care. The findings align with my clinical observations, where integrated therapy often yields more sustained pain reduction and functional gains. However, I would like to respectfully add that the effectiveness of such integrative approaches can be enhanced further through pre-therapeutic musculoskeletal assessment, which the article briefly alludes to but does not explore in depth. Prior to initiating physiotherapy or pharmacologic regimens, evaluating parameters such as limb range of motion (ROM), axial muscle activation, flexibility, and inter-limb muscle girth asymmetry offers valuable insight into the underlying biomechanical contributors to pain. Patients often exhibit functional compensation patterns, poor ergonomics, or unilateral overuse-factors that perpetuate degenerative joint overload and myofascial tenderness. Myofascial tenderness typically occurs at sites of maximal muscle strain, leading to the formation of taut bands and tenderness upon palpation.² Reduced range of movement is often attributed to diminished muscle fiber activation, which in turn causes overuse and strain of the remaining active muscle groups.³ Reduced axial muscle involvement results in a compensatory increase in peripheral muscle activation, contributing to muscle fiber overuse and restricted axial muscle function.⁴ Interlimb girth differences may arise due to lifestyle factors or ergonomic adaptations that selectively engage specific muscle groups, ultimately leading to muscular imbalances and associated pain.⁵

In my practice, incorporating sports medicine principles such as neuromuscular prehabilitation, ergonomic retraining, and progressive core-muscle conditioning has shown not only to expedite pain reduction but also to

minimize the duration of pharmacotherapy. A phased transition from medication to functionally oriented physical therapy once inflammatory symptoms are controlled has enabled patients to adhere better to self-directed rehabilitation protocols, thus enhancing long-term outcomes. Therefore, author believe this research could be further strengthened by including detailed guidelines or a proposed framework for physical therapy initiation, including assessment benchmarks, staging criteria, and objective musculoskeletal parameters. Such contributions would guide clinicians in standardizing integrative treatment pathways and customizing therapy based on individual patient needs.

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