We would like to thank Dr. Fallon and coauthors for their thoughtful comments on our review, and we completely agree with all the points made. We regret our omission of the important work the Centers for Disease Control and Prevention, the Osteoarthritis Action Alliance, the Arthritis Foundation, and others perform on a daily basis to ease the burden of osteoarthritis (OA) for the millions of adults with this chronic long-term disease. The healthcare provider (HCP) resource tables provided are an especially rich resource for patients and providers alike. There is emerging evidence that HCPs are unprepared to deliver appropriate care for adults with OA. A recent survey of over 1000 Australian physical therapists about their perceived capability to provide first-line care to adults with knee OA showed that approximately 25% did not have the skills, knowledge, or confidence to provide guideline-recommended education and exercise. Similarly, this was found in a qualitative study of primary care physicians, as they did not feel prepared to prescribe exercises to adults with knee OA. Hence, the HCP resource tables are a practical one-stop shop to help fill the gap in knowledge for treating OA.

We do want to highlight a potential barrier for seeking treatment for OA. Namely, there is a growing body of evidence documenting misinformation and misconceptions from both patients and providers about the benefits of exercise for OA. Qualitative studies have quoted adults with OA believing that physical therapy and exercise interventions only increase knee pain and should be avoided, and that surgery is the only real option. Even primary care providers, who manage the majority of cases of knee OA, are quoted as stating that exercise is not a “real” medical treatment and that the patient’s motivation is the main source of success or failure with exercise. In a consistent fashion, survey data for utilization shows that prescriptions for rehabilitation are declining, whereas narcotic prescriptions are increasing. Worldwide data also show disappointing proportions of patients with OA being offered exercise, for example, 17% and 38.7% in the UK and in a systematic review, respectively. It may be that the message that exercise is necessary and highly recommended for OA is simply not believable for most. Thus, it may be due to inaccurate beliefs or lack of a referral that most with arthritis are not ready for exercise, rather than physical limitations or low interest.

Addressing this and the other challenges for promoting physical activity in OA is certainly a team effort. We welcome the comments and perhaps future collaboration from Dr. Fallon et al, and others who strive to mitigate the burden of OA.