Efficacy of rtsa-byugs vs diclofenac gel in relieving knee pain of patients with osteoarthritis of the knee

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Abstract
Purpose – Rtsa-byugs, a massage oil from Bhutan, is a traditional herbal formula known for its anti-inflammatory properties and used in osteoarthritis treatment. This study investigates the efficacy of rtsa-byugs vs diclofenacgel in relieving knee pain in osteoarthritis patients.

Design/methodology/approach – A single-blind, randomized controlled trial was conducted amongst osteoarthritis knee patients at an orthopedic outpatient department of Thammasat University Hospital. Participants were randomly allocated to the rtsa-byugs (N = 31) or the Diclofenac gel (N = 31) group. Primary outcomes were assessed by the knee injury and osteoarthritis outcome scores (KOOS), visual analog scale (VAS) and goniometer at day 0, 1, 3, 7.

Findings – 62 participants completed the study. The result of the KOOS scores demonstrated a significant improvement of symptoms at the end of the study in both treatment groups. Improvement of symptoms, pain, daily life living, sport and recreational score and quality of life assessment showed a significant difference from baseline (p < 0.001) within both groups. The quality of life score for the rtsa-byugs group increased significantly on day 3 and 7. The VAS score in both groups decreased with a significant difference from baseline to day 7. The mean value of extension of angle measurement was decreased in day 7, and the mean of flexion score increased in both groups when compared with the baseline.

Research limitations/implications – The duration of the study was very limited and included a small sample consisting of men and women.
Originality/value – Rtsa-byugs is safe and effective in relieving pain from osteoarthritis of the knee and can be used as an alternative treatment for knee osteoarthritis.

Keywords Rtsa-byugs, Diclofenac gel, Osteoarthritis

Paper type Research paper

Introduction

Osteoarthritis of the knee (OAK) is a chronic disease caused by cartilage degradation after a long progression of friction between the two knees bones, combined with a reduction of synovial fluid resulting in aggravated inflammation in the knee joint. It is associated with various factors such as aging, bone density and obesity. Although pharmaceutical managements of osteoarthritis are available, such as administration of analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs), the result of the treatment sometimes appears to cause side effects and are not effective enough to reduce patients’ pain to improve their quality of life [1]. Osteoarthritis of the knee is a leading global health problem affecting the quality of life, especially amongst the elderly population. In the United States, more than 30 million people have been affected by osteoarthritis which costs approximately 185bn US dollars of the total healthcare spend in the US per year [2].

Heidari reports that more than 10% of elderly aged 60 years and older are experiencing functional impact caused by OAK which could lead to chronic disability. The incidence of OAK tends to rapidly increase due to the increasing prevalence of risk factors such as aging and the rise in obesity [3]. In Asia, a high prevalence of both OAK and knee pain in the elderly was reported, with prevalence ranging from approximately 38–50%. [4, 5]. Thailand is one of the countries that was reported to have a high prevalence of OAK. According to a survey study of Thai elderly in the community conducted by Kuptniratsaikul et al., the prevalence of OAK was up to 40% [6]. Current diagnosis of OAK includes physical examination with x-ray, MRI scan and arthroscopy, if necessary. The European League against Rheumatism (EULAR) states that the recent symptoms for the diagnosis of OAK, i.e. persistent knee pain, limited morning stiffness and reduced function [7]. The main treatment of OAK mainly focuses on pain management using, for example, physical activity, painkillers and joint replacement [8]. However, some OAK patients still seek other ways to reduce their suffering.

The World Health Organization (WHO) stated that traditional and complementary medicine (T&CM) played an important role in the management of lifestyle-related chronic disease such as osteoarthritis, especially among the aging population, and has urged several countries to attempt to integrate T&CM into the healthcare service [9]. Bhutan, also called the valley of medicinal herbs, possesses a long history of traditional medicine embedded in society. More than a thousand herbal recipes appear in the traditional Bhutanese medicine (TBM). The TBM is based on ancient Tibetan traditions incorporated with ancient medical practices connected with Buddhism. [10, 11]. The great principles of Buddhism provide a comprehensive way of understanding the universe, man and illness. There are many traditional ways of pain management in Bhutanese traditional medicine, and rtsa-byugs, a common massage oil in Bhutan is one of them.

The rtsa-byugs massage oil combines six herbal extracts from different species, namely crude extract from Curcuma longa, Carum carvi, Myristica fragrans, Delphinium brunoniaum, Cautleya spicata, and Sesamum indicum [12]. The word “rtsa” means nerves, and “byugs” means application/massage. This indigenous medicinal product has been traditionally used as a basic remedy in massage therapy. Rtsa-byugs is usually utilized among patients suffering from musculoskeletal et al. diseases such as arthritis, joint pain, muscle stiffness, paralysis and facial palsy. Nevertheless, the scientific evidence of its safety and efficacy are still limited.

Based on relevant literature, the medicinal plants that make up the rtsa-byugs oil is reported to possess an anti-inflammatory effect. Curcuma longa, or turmeric, is a well-known
spice belonging to the ginger family. The main chemical component of turmeric is curcumin. Many studies on the anti-inflammatory properties of curcumin included in vitro, in vivo, and human studies. The anti-inflammatory activity of curcumin extract from the root Curcuma longa has been demonstrated in the laboratory, and the result showed that curcumin can inhibit different molecules playing a major role in inflammation, namely phospholipase, lipooxygenase, cyclooxygenase 2 (COX-2), leukotrienes, thromboxane, prostaglandins, nitric-oxide, collagenase, elastase, hyaluronidase, monocyte chemoattractant protein-1 (MCP-1), interferon-inducible protein, tumor necrosis factor (TNF) and interleukin-12 (IL-12) [13]. This is in line with the in vitro study conducted by Lev-Ari et al. [14] which revealed that the anti-inflammatory activity of curcumin involves inhibition of COX-2 activity.

Another admixture is Carum carvi or caraway that is also known for its anti-inflammatory activity. Some studies revealed that carvone, the active component of caraway, can inhibit cyclooxygenase and 5-lipoxygenase activity by reducing biosynthesis of leukotriene and prostaglandin [15]. In addition, Myristica fragrans, Cautleya spicata, and Sesamum indicum, also revealed the potential to reduce inflammation. Dewi et al. [16] state that quercetin from Myristica fragrans extracts can inhibit inflammatory cytokines and nitric oxide production since quercetin tends to be the active compound. A study of the biological activity screening of an Indian plants found that Cautleya spicata rhizomes extract detected anti-inflammatory, antibacterial, antifungal, antiprotozoal and antifertility effects [17]. Similarly, Sesamum indicum also reported the presence of potent anti-inflammatory and antioxidant compounds [18, 19].

Apart from its anti-inflammation capacity, a study by Tripathee [20] reported that the Delphinium brunoniaum extract, which is mixed in rtsa-byugs, exhibits antibacterial properties. For example, the ability to inhibit bacillus subtilis, salmonella flexinariae, pseudomonas aeruginous and staphylococcus aureus.

This illustrates the potential of rtsa-byugs in reducing pain from inflammation. However, its efficacy, complications and adverse effects have not yet been reported. This study aimed to investigate the efficacy of rtsa-byugs vs 1% diclofenac gel in relieving osteoarthritis knee pain for short-term effects.

Materials and method
Study area and population
This study was a prospective, randomized, evaluator-blind, controlled trial. Participants were enrolled from the orthopedic outpatient department of Thammasat University Hospital, Pathumthani Province of Thailand, between April to June 2019. Osteoarthritis of the knee was diagnosed by an orthopedic physician. The Kellgren Lawrence grading scale (from X-ray image) and visual analog scale (VAS) were used to assess the severity of OAK to recruit participants. Tools of assessment during the experiment included the knee injury and osteoarthritis outcome scores (KOOS), visual analog scale (VAS) and goniometer for measurement of the joint angle (extension and flexion positions). The experimental period was seven days, and all participants were assessed four times (baseline, Day 1, 3 and 7). The inclusion and exclusion criteria are explained below:

Inclusion criteria
(1) Ability to give informed consent
(2) Age 45–75 years old
(3) OAK patients with minimum visual analog scale (VAS) score of 4–6 (mild to moderate)

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(4) OAK patients with grade 1–2 of Kellgren Lawrence grading systems
(5) Participants oriented to the risks and benefits of the research and willing to sign the consent form.

Exclusion criteria

(1) Patients who had herbal sensitivity to Curcuma longa, Myristicafragrans, Carumcurvi, Delphinium brunoniaum, Cautleya spicata and Sesamum indicum.
(2) Patients who had undergone lower extremity surgery in the past six months.
(3) Pregnant or breastfeeding women.
(4) Patients who planned to be admitted for surgery or move to another place during the study.
(5) Those already using other topical medicine on the knee.
(6) Patients with inflammatory arthropathy, gout, pseudogout and recent knee injury on the side affected by OA.

Sample size
The sample size was calculated by the G * Power program with a type I error rate of alpha of 0.05, a power of 90%, and an effect size of 0.8. As a result, the appropriated number of samples was 56 plus a 10% drop out. Hence, the total sample size was 62 people [21]. A simple random technique using a computer-generated method was applied to allocate participants into two groups: (1) the rtsa-byugs group (N = 31) and (2) the diclofenac group (N = 31).

Preparation and analysis of rtsa-byugs
Rtsa-byugs was obtained by the water extraction method using the following plants: Curcuma longa rhizome (3.4 g), Carumcurvi seed (3.4 g), Myristicafragrans seed (1.7 g), Cautleya spicata rhizome (1 g) and the whole plant of Delphinium brunoniaum (0.3 g) which were mainly collected in India and Bhutan. Crude drugs were soaked in a sufficient volume of water for eight hours in a steam jacket kettle and then filtered and evaporated. The 6.86 g. of the extract was yielded (70% yield) and then mixed with sesame oil (Sesamum indicum) (20 g) in a steam-jacket kettle. In this study, rtsa-byugs oil was produced in Bhutan by Menjong Sorig Pharmaceutical Corporation limited under the subsidization of the Ministry of Finance, and the finished product was qualified by the Drug Regulatory Authority of the Royal Government of Bhutan. The finished product of rtsa-byugs oil was analyzed by Gas Chromatograph Mass Spectrometer (GC-MS) as part of the quality control process.

Treatment procedure
The study was carried out for seven days on each participant. After informed consent was given, the researcher performed a physical examination and assessment of OAK by using the assessment tools mentioned above. A total of 31 patients in group 1 were given rtsa-byugs as a treatment of OAK, while participants in group 2 received 1% diclofenac gel. Both remedies were put in an identical tube to avoid bias, and all participants were given demonstrations and practice of how to use the rtsa-byugs oil or diclofenac gel correctly. Importantly, all participants were prohibited from taking any medicine during the study period.

The procedure for applying treatment was as follows:

(1) Participants sat comfortably on a chair
(2) Participants applied the intervention on the knee area (three drops of rtsa-byugs in group 1 and 3 mm. of 1% diclofenac gel in group 2)

(3) Participants massaged the intervention into the knee for 10 minutes twice a day (morning and before bedtime) every day for one week.

(4) Participants remained seated for five minutes to allow the intervention to absorb

(5) Participants did not take any medicine during the study period.

Statistical analysis
Analysis of data was performed by SPSS (version 10) statistical software. Results were expressed as mean ± standard error of the mean (SEM). Characteristic differences were calculated by an independent-sample-t-test and \( \chi^2 \)-test. Statistical differences of KOOS, VAS, and goniometer tests within the group were calculated by repeated measure ANOVA test for within-group comparison and calculated by independent-sample-t-test for between-group comparison. The minimal level of significance was identified at \( p < 0.05 \).

Ethical considerations
This study received ethical approval from the Human Research Ethics Committee of Thammasat University, Faculty of Medicine Approval number MTU-EC-OO-0-029/62. This research project was registered in the Thai Clinical Trial Registry (Trial registration identification number: TCTR2019062300). All participants were asked to sign an informed consent before conducting the study and the risks and benefits of the research were acknowledged beforehand.

Results
A total of 62 participants were recruited to participate in this study. 31 patients received rtsabyugs, and 31 patients received 1% diclofenac gel as a treatment. All participants stayed for the duration of the 7-day experiment. Demographic characteristics of the initial two allocation groups were compared at baseline for sex, age, body mass index (BMI) and severity of OAK using the Kellgren–Lawrence (K&L) grading system, as shown in Table 1.

This experimental study utilized three measurements for the investigation of OAK treatment outcome, namely KOOS, VAS and angle of joint using goniometer. As shown in Table 2, KOOS indicated an improvement of symptoms, pain, dairy life living score, sport and recreational score and quality of life during seven days of treatment in both groups. The KOOS increased significantly from baseline to day 7 in almost every aspect of the two treatment groups, except for the quality of life in the diclofenac group that did not show a significant difference at the end of the study. Comparison of KOOS between the rtsa-byugs and diclofenac group at the end of the treatments was made, and the results revealed that patients receiving rtsa-byugs showed higher scores at day 7 of the treatment in all subscales with a statistical significance in terms of difference as the score at baseline was comparable.

The mean visual analog scale (VAS) scores of the rtsa byugs group and the diclofenac gel group at baseline, day 1, 3 and 7 of the treatment showed that VAS scores in both groups decreased with a significant difference at the end of the experiment. The VAS scores of the rtsa-byugs group were less than the diclofenac group at day 3 (\( p = 0.002 \)) and day 7 (\( p < 0.001 \)) with a significant difference, as shown in Table 3.

For the measurement of the angle of joints by a goniometer, the average score of extension decreased significantly after receiving treatment in both groups. Furthermore, the mean flexion score of the two groups increased with statistically significant differences between
pretreatment and posttreatment. There is no significant difference when comparing the score between the two groups. The results of extension and flexion scores are shown in Table 4.

**Discussion**

To the researcher’s knowledge, this is the first recorded clinical trial of rtsa-byugs massage oil which, according to the result, appears to be safe and effective in relieving the pain of osteoarthritis of the knee.

This effectiveness is probably due to the principal components of rtsa-byugs that is composed of the crude extract of anti-inflammatory herbs such as Curcuma longa.
Carum carvi, Myristica fragrans and Sesamum indicum. Several studies claimed that the active compound obtained from turmeric (Curcuma longa) is curcumin which is capable of inhibiting the translocation of NF-κB into the nucleus. The study conducted by Shep et al. [22] also reported that the oral administration of curcumin exhibits a similar efficacy in OAK patients as diclofenac with better tolerance. Similar results were found in studies by Sahebkar and Henrotin [23] and Haroyan et al. [24] whose research reported curcumin’s ability to reduce pain via clinical trials, and therefore it can prevent the inflammation response of the cell [25]. Hence, the positive results in this study are probably due to the combination of curcumin and other herbs.

Furthermore, the results have shown that rtsa-byugs helps improve OAK complications significantly as it reduces symptoms and pain, improves daily activity, sport and recreational, as well as the quality of life scores when measured by the KOOS. The improvement in patients’ pain and other symptoms in the diclofenac gel group appears to conform to the previous studies [26, 27]. When comparisons were made between the rtsa-byugs and diclofenac gel groups, the improvement of the KOOS scores at the end of the study showed significant differences suggesting that that rtsa-byugs is more effective. Moreover, a visual analog scale in both groups decreased significantly. When comparing VAS of the rtsa-byug to diclofenac groups, the result showed that rtsa-byug tends to reduce pain better than the diclofenac gel group.

The mean score of extension measured by goniometer decreased in day 7 and the mean score of flexion increased in both groups when compared with the baseline. This suggests that the movement of the knee is better after the treatment. This result is similar to the clinical study conducted on the efficacy of topical administration of sesame oil in OAK patients. Askari et al. demonstrated that sesame oil can improve knee pain when compared to diclofenac and that it also reduced stiffness of the knee [28].

### Table 3.

<table>
<thead>
<tr>
<th>Group</th>
<th>Baseline</th>
<th>Day 1</th>
<th>Day 3</th>
<th>Day 7</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rtsa-byugs</td>
<td>4.74 ± 0.68</td>
<td>3.39 ± 1.15</td>
<td>2.29 ± 1.35</td>
<td>1.42 ± 1.20</td>
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<tr>
<td>Diclofenac gel</td>
<td>4.90 ± 0.75</td>
<td>3.94 ± 1.21</td>
<td>3.29 ± 1.10</td>
<td>2.74 ± 1.34</td>
<td>0.001*</td>
</tr>
<tr>
<td>p-value</td>
<td>0.37</td>
<td>0.72</td>
<td>0.002*</td>
<td>0.001*</td>
<td></td>
</tr>
</tbody>
</table>

**Note(s):** Values are expressed in mean ± standard deviation  
* p-value is calculated by repeated measure ANOVA test for within-group comparison  
* N = 31 in each group  
* *= p-value < 0.05 is considered a statistically significant difference

### Table 4.

<table>
<thead>
<tr>
<th>Group</th>
<th>ROM</th>
<th>Baseline</th>
<th>Day 1</th>
<th>Day 3</th>
<th>Day 7</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rtsa-byugs</td>
<td>4.19 ± 2.89</td>
<td>4.06 ± 0.96</td>
<td>3.35 ± 0.61</td>
<td>2.10 ± 0.91</td>
<td>0.001*</td>
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<tr>
<td>Diclofenac</td>
<td>5.29 ± 1.40</td>
<td>4.29 ± 1.51</td>
<td>3.65 ± 1.28</td>
<td>2.26 ± 1.34</td>
<td>0.001*</td>
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</tr>
<tr>
<td>p-value</td>
<td>0.06</td>
<td>0.49</td>
<td>0.26</td>
<td>0.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rtsa-byugs</td>
<td>125.90 ± 8.62</td>
<td>129.71 ± 8.39</td>
<td>134.48 ± 8.03</td>
<td>141.10 ± 7.65</td>
<td>0.001*</td>
<td></td>
</tr>
<tr>
<td>Diclofenac</td>
<td>126.16 ± 6.76</td>
<td>131.68 ± 7.21</td>
<td>135.48 ± 4.19</td>
<td>140.68 ± 4.17</td>
<td>0.001*</td>
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<tr>
<td>p-value</td>
<td>0.38</td>
<td>0.31</td>
<td>0.54</td>
<td>0.79</td>
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</tbody>
</table>

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* p-value is calculated by repeated measure ANOVA test for within-group comparison  
* N = 31 in each group  
* *= p-value < 0.05 is considered a statistically significant difference

**Efficacy of rtsa-byugs vs diclofenac gel**
When considering baseline variables of the present study which included sex, age, body mass index and grading of OAK, it tends to reveal an interesting point. According to the result, the average value of the body mass index of the patients was 25.11–25.73 which was classified as a level I of obesity. This provides supporting evidence of the correlation between body weight and incidence of OAK [29].

In conclusion, this study demonstrated that rtsa-byugs is effective as an OAK treatment when compared with the standard treatment of diclofenac gel. In addition, there are no other serious side effects that were observed during clinical observation, thus, rtsa-byugs appears to be safe to use.

Conclusion
The short-term study on the efficacy of rtsa-byugs showed that the massage oil is as effective as 1% of diclofenac gel. When comparing the efficacy of the two treatments, rtsa-byugs exhibited the capacity to reduce VAS more than diclofenac gel on the last day of the OAK treatment. Therefore, rtsa-byugs could be considered as a potential alternative treatment for osteoarthritis of the knee.

Limitations
This study included a small sample consisting of men and predominantly women in Thailand. The duration of the study was very limited. Future research could involve sample sizes that include a larger population in Bhutan to evaluate the long-term effects of the drug.

Future plan
Short-term efficacy of rtsa-byugs is compatible and found significant in reducing knee pain in osteoarthritis patients during one week of treatment. Further research into rtsa-byugs should explore the long-term efficacy in clinical trials and preclinical studies.

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