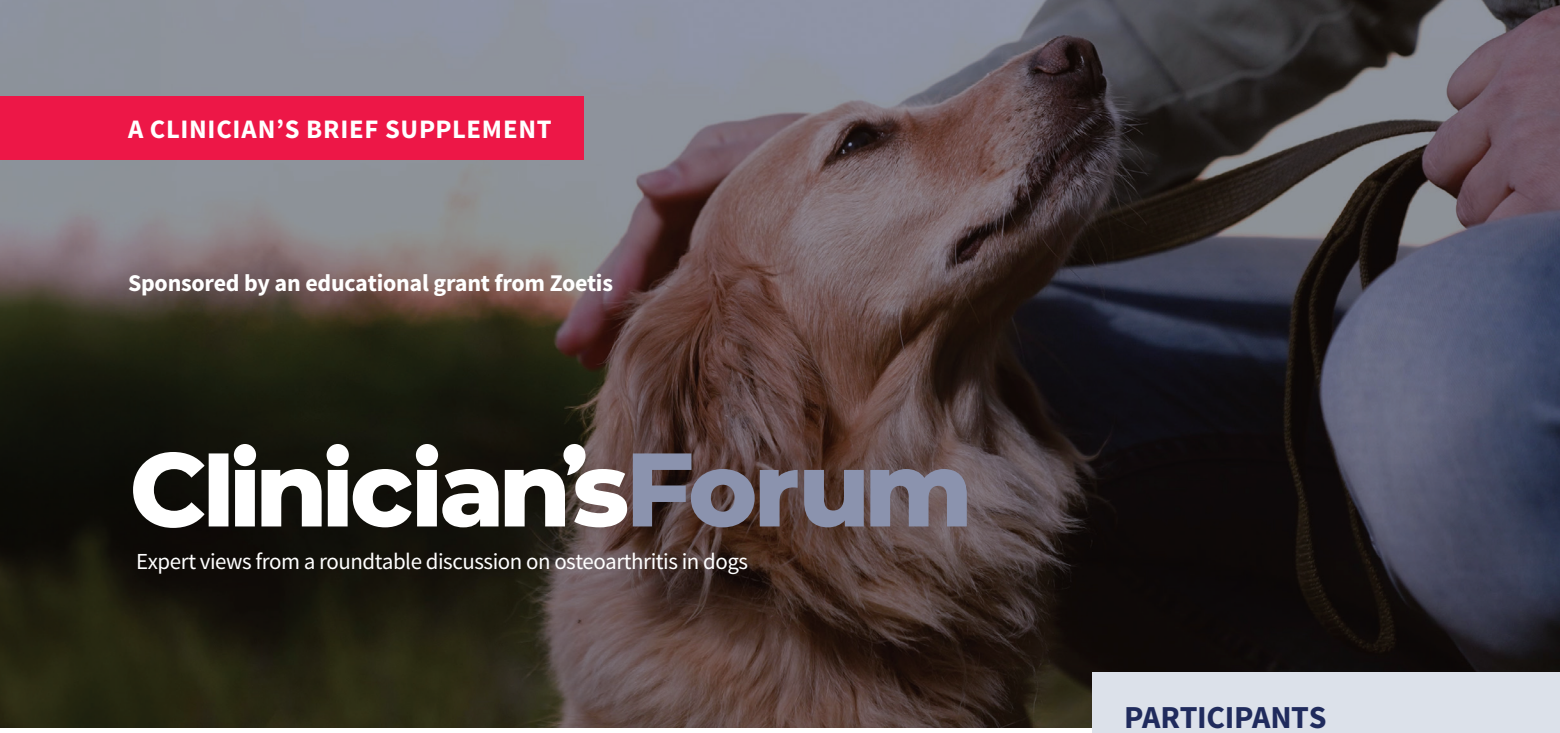

A CLINICIAN'S BRIEF SUPPLEMENT

Sponsored by an educational grant from Zoetis

Clinician's Forum

Expert views from a roundtable discussion on osteoarthritis in dogs

Evolving Approaches to Recognizing & Treating Osteoarthritis Pain

PARTICIPANTS

Ralph Harvey,[a] DVM, DACVAA
Zoetis

Duncan Lascelles, BSc, BVSC, PhD, DSAS (ST), DECVS, DACVS, FRCVS
North Carolina State University

Mikayla Mayland,[a] DVM, DACVS (Small Animal)
Zoetis

Melina Zimmerman, DVM, DACVAA, CVPP, CVMA, CCRP
The Doggy Gym

MODERATOR
Courtney Pierce,[a] DVM, MBA

Osteoarthritis (OA) often goes underrecognized until pain and mobility changes significantly affect quality of life. As our understanding of OA continues to evolve, with growing emphasis on early recognition and proactive pain management, so do our therapeutic options. This panel of experts convened to discuss the expanding role of therapeutic options, including NSAIDs and Librela™ (bedinvetmab injection), a monoclonal antibody therapy that controls canine OA pain and is aimed at improving comfort, mobility, and long-term outcomes for dogs with OA.

Dr. Pierce: What clinical signs lead you to prescribe pharmaceutical therapy for OA pain?

Dr. Zimmerman: When a dog starts showing any kind of mobility change—if they're hesitating on stairs, reluctant to jump into the car, have a change in gait—we're already behind the 8-ball in terms of pain control. Those subtle behavior changes can be early signs of pain. It's important to remember that OA starts in dogs younger than we think, and younger patients can exhibit pain differently than older patients. It's also important to remember that younger dogs are going to adapt their function, meaning they're still going to play ball, go on walks, and do all the things that owners think are normal activities. It's important to look for and identify subtle changes in younger dogs and have strategies for identifying pain earlier in life so we can start treatment earlier in these patients.

OA = osteoarthritis

[a] Drs. Ralph Harvey, Mikayla Mayland, and Courtney Pierce are Zoetis employees.

Dr. Lascelles: I love the use of the word "adapt," because those young dogs will adapt to try and cope with the pain, and what we need to do as a profession is realize that those adaptations are indeed reflective of pain. We also need to realize there is a wide repertoire of behavioral changes caused by pain. We're still learning that, once we have recognized a behavioral change, we need to determine whether it's OA pain or something else. These behavioral indices are not pathognomonic for OA pain, but they're indicative of something, so we need to investigate. I also believe that, if we have detected signs of OA pain, then there is pain sufficient enough to require analgesic treatment. I don't like this notion of considering it to be "mild" pain and therefore not worthy of pain relief. If it's real pain, then we need to alleviate that. That doesn't necessarily mean that treatment will always be lifelong, but coming in with an effective analgesic, something that has been proven to alleviate that pain, is important because of the cumulative deleterious effects of pain over time.

Dr. Pierce: What screening tools or scoring systems do you use in practice to detect and/or monitor pain associated with OA?

Dr. Lascelles: Using a checklist and asking clients, "Have you seen this behavior? Has this change occurred?" can be incredibly helpful. It's critical to remember the importance of these questions, because you need to open up a conversation during the appointment. These questions also serve to bring awareness to these issues and educate owners so they understand that, if they notice these concerns, they will think about making an appointment and bringing these concerns up themselves. That's why having checklists and educating owners are absolutely crucial parts of screening, because you can't screen for OA until you have the patient in front of you, and once that patient is in front of you, you need to have allowed for that conversation to open up.

Dr. Mayland: I'm a firm believer that a well-done video can be just as important in the medical record as a baseline radiograph, and it's easy to put videos into medical records. Clients can record on their phones, and you can drop the video in the chart. You then have something to go back and reference, especially if a client comes in and says, "I don't think my dog looks any different after x, y, or z intervention." I hear that a lot, because they see their dog every single day. We might see more of a change when we're seeing them 30 or 60 days later, but having that video to go back to can be really nice, because it's a type of unofficial visual scoring system.

Dr. Pierce: How can we overcome the lack of awareness that many pet owners have when it comes to signs of OA pain?

Dr. Lascelles: This can be a struggle. For us, it is hard enough with older pets when the signs appear more obvious, and it's difficult with younger animals when we do not fully appreciate the signs indicative of joint pain. Getting owners to agree to treatment starts with getting them to understand that the condition is serious enough to treat. It's often easier for them to dismiss it as their pet "just getting old." I address that by reframing it and saying, "Well, actually, it's joint pain, and we can do something about that." I will often try to relate the state of their pet to their own experiences or other people who are suffering from chronic pain. I try to get them to think about the impact pain has and to also understand that it is treatable; we can take that pain away. You're still going to be left with an older person or animal, but they're going to be happier and they can move around more easily and enjoy the activities of daily life if we address their pain. It's so important to combat the idea of arthritis pain being inevitable. It's not inevitable, and it's important to remedy that, because ongoing pain has cumulative, deleterious effects over time.

Dr. Harvey: The OA checklist for me is very powerful, particularly the animated, online version (see ***Suggested Reading***, page 8). That can sometimes be more powerful than telling a client their pet is in pain, uncomfortable, or showing some signs of OA. You can show clients that online checklist and ask them if they see their pet showing similar changes in behavior. Again, I think we can have them video their pet before and after a treatment trial with Librela™ (bedinvetmab injection) or an NSAID and say, "Let's see if we see a change in how they are moving and functioning at home." Clients tend to fail to notice changes in their pets because they become desensitized to their

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>
> ***—Dr. Mayland***

OA = osteoarthritis

pet's changed behaviors over time and often don't recognize the changes when there's a slow onset.

Dr. Zimmerman: Even if an owner says, "My dog is still going up and down the stairs," asking them if their dog hesitates or takes a minute to think about it before going up those stairs can help us determine if it's more of a backend or frontend problem. Is this a vision problem? What else is going on? Is the dog playing less? Has there been any change in their squatting behavior when they go to the bathroom? Owners don't always volunteer this information, but once we start asking them, they recognize, in hindsight, that these changes are indicative of something going on in their pet. OA is something that can be debilitating and decrease function, but there is a ton of stuff we can do for it, and it starts with these first-line treatments with an analgesic trial and seeing what results we get and then making a plan for long-term management.

Dr. Pierce: Compliance with therapy for chronic OA pain can be a challenge. What strategies do you have for overcoming this?

Dr. Lascelles: I think there's a broader issue of pain not being taken seriously. As an example, if we diagnose cancer, everyone takes that seriously. Everyone is totally on board for treatment, as well as ongoing monitoring, because, of course, we have this profound fear of cancer. And why am I mentioning that? Because it's our job to communicate the importance of pain, including the way pain can kill an individual and take away their personality. These pets can't move around as easily, and they have to think before every movement as they navigate their pain. It alters social connections and interactions. It creates fear and anxiety. Somehow, without being too depressing, we've got to communicate the importance and impact of pain to get owners to take it seriously. Then we have to engage in active follow-up. We can't just say, "Well, your pet has OA. It's a painful, lifelong incurable disease. Here's some treatment."

Dr. Harvey: OA leads to changes in behavior that are just unacceptable—for example, the dog that defecates on the floor or starts biting people. Those adverse behaviors can be directly related to unmanaged pain and can lead to presentation for euthanasia. The fact that OA is a lethal disease and can lead to premature euthanasia in animals that are, in many cases, otherwise healthy and manageable is very clear. We need to help clients appreciate the severity of this problem as a lethal disease. Understanding the serious consequences of this disease is what leads me to choose first-line therapeutics, rather than a second- or third-line option. We wouldn't treat another life-threatening disease with second- or third-line options. We'd lead with something definitive. So, taking this back to compliance, educating clients on how serious this disease can be is important. Other ways I try to improve compliance would be with things like using a pill box for oral medication and prebooking appointments. Even if clients need to change their appointment, they're far more likely to come in if we've prebooked an appointment, so to improve compliance, it's callbacks, it's communication, it's leading with the type of communication our clients prefer, like texting. The experts in communication theory tell us that the primary problem in communication is the mistaken impression that communication has occurred, but for example, if an owner doesn't understand that they need to give the medication on a continued basis and not just for a month-long trial, then this pet's pain will go uncontrolled. We need to ask ourselves whether we have done an adequate job of communicating our treatment plan to owners.

Dr. Mayland: Demonstrating efficacy to owners will always lead to improved compliance. If they can see that what they're doing is working, then they'll continue to do what they're doing.

Dr. Zimmerman: I usually ask owners to choose a few goal behaviors when we start therapy so that, when they come back in 1, 2, or 6 months, it gives us a tangible way to measure progress. Whether that goal is getting in the car on their own again or chasing their ball, tracking behavior goals can help owners make a positive association with the treatment we've selected. When that moment happens, it's really powerful, and it helps owners feel confident that we're on the right track, which I think helps with long-term follow-through as well.

Dr. Harvey: We have relied on our clients to give medications in the past with the assumption that it's actually going to be done, but we know now that compliance is actually quite poor. The caregiver burden associated with giving a daily medication is apparently quite an obstacle to most clients, and the option of having a once-monthly injectable like Librela™ (bedinvetmab injection) may be preferable to them and may have a greater level of effect, simply because the medication actually gets into the patient. Out of 365 days a year, the average number of days that a dog actually consumes an oral NSAID medication is only 60.5 days.[1] That's just abysmal. I don't think any of us in clinical veterinary medicine would've assumed it would be so low. If supportive medications are being administered along with those NSAIDs, are they also only being administered 60.5 days out of the year? That's an important piece of information for us to reflect on and work with clients on, and that can guide our choice of therapy.

Dr. Lascelles: We don't have good data on this, but I truly believe that persistent alleviation of pain will lead to improvement, as opposed to what I call a fire brigade approach—for example, a dog with persistent OA pain is taken for a long walk on Saturday and gets an NSAID on Sunday because they are markedly less functional, but they don't receive ongoing pain relief for the persistent background OA pain. Oscillating between a painful state and a less painful state isn't helpful at all.

Dr. Harvey: That consistency in therapy is true regardless of medication choice. We see that, over a period of time, there's improvement in pain, whether with consecutive doses of NSAIDs or consecutive doses of monoclonal antibodies (mAbs).

Dr. Pierce: We often focus on the progression and worsening of chronic pain over time, but can you talk about the potential for improvement with good management and how concepts like neuroplasticity play into that?

Dr. Lascelles: We understand a lot about deterioration over time with pain, but because it's a plastic system, we can also have the opposite effect. There can be improvement over time, too. As muscle mass builds up, there will be less pain. As we continually treat pain, there will be less sensitization of the nervous system, less anxiety and fear, and so on. So, reevaluation and keeping in mind the possibility of reducing treatment as the patient improves are key. It's also important to present that information to owners and share that, if they stick with the plan, it's likely to be easier and less expensive.

Dr. Zimmerman: Neuroplasticity is one of my favorite things to explain to owners. We have positive and negative neuroplasticity. I always tell clients to not be discouraged when their dog or cat gets diagnosed with OA, because we have a ton of options, both pharmacologic and nonpharmacologic. It's so amazing to see the positive effect of good pain management and the positive neuroplasticity that can happen. That is one of the most amazing things we do when it comes to pain management—just seeing how we can change the entire way the nervous system and body react to pain.

> **"It's so amazing to see the positive effect of good pain management and the positive neuroplasticity that can happen.**
>
> ***—Dr. Zimmerman***

mAb = monoclonal antibody
NGF = nerve growth factor
OA = osteoarthritis
PGE2 = prostaglandin E2

Dr. Pierce: When we look at pain control options in canine OA, there are currently 2 FDA-approved drug classes: NSAIDs and anti-nerve growth factor (NGF) mAbs. How do you decide between these drug classes when choosing a therapy?

Dr. Zimmerman: Compliance is a big factor that impacts my decision regarding which pain control option to use. Is an owner able to give daily medication, or would they prefer to come into the clinic every 4 weeks so they can get Librela™ (bedinvetmab injection)? These are important questions to ask in the decision-making process.

Dr. Lascelles: It's important to start with 2 questions. Does the dog in front of us suffer from OA pain? And will alleviating that OA pain significantly improve that dog? We've all seen complex cases that, for example, have both neurologic disease and some OA pain, and in those cases, we need to determine whether an analgesic will make an observable difference. Alleviating OA pain may not make any functional difference in a patient if most of the signs are actually stemming from neurologic disease. Knowing this and communicating this to owners are critical. And before we start thinking about what to use, it's important to make sure that we know what else is going on in that patient, including what other diseases the dog may have. Owner preference regarding treatments is a really important thing to be respectful of, and we should not persuade owners to do something they don't feel comfortable doing. Sometimes, there are some simple, logical considerations, like avoiding use of Librela in dogs <1 year of age or avoiding NSAIDs if there is GI disease, if steroids are being given, et cetera.

Dr. Mayland: OA is a chronic disease, which means the pain it causes doesn't take a day off, and we know one of the most important parts of managing chronic OA is keeping the patient moving so they can maintain muscle mass and an optimal body condition. That hinges on the pet being consistently pain-free, not a day here and there. And sadly, as Dr. Harvey shared, compliance with NSAIDs is not great. So, although NSAIDs are a first-line option, I've had success with Librela. That's at least in part because the pain control is consistent—we prebook patients for their next injection, and I find that really helps with compliance. There are owners who prefer a daily

medication, but in my experience, many of them welcome the ease of once-monthly administration.

Dr. Pierce: How do you evaluate and/or prioritize adjunctive therapies for OA pain, whether it be supplements, off-label medications, joint injections, lasers, stem cell therapy, et cetera?

Dr. Mayland: One of the first things we have to do in order to initiate all the other steps of OA management is have a comfortable pet. Picking an effective analgesic is the most important thing to me. You can't start to undo the snowball that is OA pain and the debilitation that follows if you don't have a pet comfortable enough to start initiating your other therapies. The 2022 AAHA Pain Management Guidelines recommend an NSAID or anti-NGF mAb as our first-line analgesic for dogs with OA.[2] So it's important to utilize these medications to get pets comfortable and then consider other therapeutic interventions.

Dr. Lascelles: I think the first question is: is something else truly needed? Historically, when we have talked about OA in veterinary medicine, we have often focused on more severe cases. Therefore, appropriately, the conversations have included discussions of what other adjunctive therapies we could have used when our single analgesic, the NSAID, wasn't cutting it. It's really important to ask if something else is actually needed.

Dr. Harvey: Among the most effective adjunctive therapies for dogs with OA are graded exercise and effective weight management. They go hand in hand with an animal that now feels well enough to actually start doing a bit of gentle exercise. That gentle exercise then contributes to increased range of motion, muscle mass, and stability, as well as potentially strengthening the human–animal bond.

Dr. Zimmerman: My favorite thing to teach clients is some at-home massage techniques with a heating pad. It makes huge, game-changing differences with chronic OA pain.

Dr. Pierce: Regarding the role of inflammation in OA pain, to what degree do we need to treat inflammation to effectively manage OA pain? How should we think of the anti-inflammatory properties of NSAIDs versus anti-NGF mAbs?

Dr. Lascelles: Firstly, there's this idea that inflammation somehow is separate from pain. It absolutely is not. I would even go as far as to posit that all inflammation will produce pain. Inflammation produces pain, and pain can be produced separate from inflammation, but inflammation most certainly drives pain. It is not separate. Secondly, we need to understand that OA is not overtly inflammatory like immune-mediated or infective arthropathies are. OA is a lower-grade inflammatory process. Then, thirdly, there's this idea somehow that an anti-NGF treatment is just dealing with pain and NSAIDs are just dealing with inflammation—that's not true. Both NGF and PGE2, the key mediators targeted by anti-NGF mAbs and NSAIDs, respectively, sensitize sensory nerves, making them more reactive to painful stimuli. Both also activate immune cells that drive inflammation, and both contribute to neurogenic inflammation, in which activated nerves release inflammatory chemicals like substance P and calcitonin gene-related peptide. There are some differences as well, though. For example, NGF strongly promotes nerve sprouting and increased nerve density, which can heighten pain signaling, whereas PGE2 has only a minor effect there. PGE2 is a stronger driver of vascular permeability, which leads to swelling. For angiogenesis, or new blood vessel growth, NGF seems to have a greater role than PGE2. So there's a lot of overlap, and we cannot parse out the effects of NGF and PGE2 as just being associated with inflammation or pain.

Dr. Pierce: What adverse events have patients experienced with anti-NGF mAbs?

Dr. Zimmerman: I've personally experienced very few adverse events secondary to Librela™ (bedinvetmab injection). I think polyuria/polydipsia has probably been the most common one that I've encountered, and in most cases, it seems to be self-limiting and decreases over time.

Dr. Mayland: If we look at the recent pharmacovigilance publication by Bea Monteiro that contains postapproval data after 18 million doses, 17,000 adverse events were reported.[3] The 3 most common were lack of efficacy, polyuria/polydipsia, and ataxia.[3] Lack of efficacy is interesting, because if you're looking at a medication that can take up to 2 months to reach steady state, I almost expect some lack of efficacy in some patients within that first month. Interestingly, ≈45% of the patients that were reported for lack of efficacy only ever received 1 dose.[3] Reports of polyuria/polydipsia are also interesting. Reports run the full spectrum from dogs that were so profoundly affected that they had to come off the medication to others where the owner said, "Hey, if I need to let my dog out 2 more times a day, my dog can go outside 2 more times a day. I want them to stay on the medication." For one, we know that, as pets get older, they are more likely to develop comorbidities throughout their treatment duration, and the median age of patients with a reported adverse event was 12 years.[3,b] I think that,

[b]The mean age of dogs with a reported adverse event was 11.4 years, with a median (interquartile range) of 12.0 (10.0–13.0) years. Approximately 10% of dogs were listed as age unknown.

sometimes, we will naturally see ataxia develop during that time because of patient age. Another factor is, if you take a pet that is fairly significantly muscle atrophied—and a lot of these pets are at the time we're initiating treatment—then they begin to feel comfortable because their joints feel better.

Dr. Zimmerman: Regarding ataxia, educating not only owners but veterinary professionals as well on the differences between weakness and ataxia could be beneficial, because I do think that's a huge thing when we have patients with chronic OA. As we help patients feel better and take the pain away, now this weakness is a problem and needs to be dealt with.

Dr. Harvey: Several observations can be made after pain management is underway. If it's effective pain management, we now have animals that, again, want to walk. If they were previously immobile, then signs like ataxia, for instance, would not have been observable. I don't want to make light of ataxia to say it's always an uncovering of an underlying disorder, but I suspect it plays some role in those adverse event reports. Speaking to the polyuria/polydipsia, I can echo what Dr. Mayland said. I had a veterinarian convey to me that one of their clients had a pet that was experiencing moderate polyuria/polydipsia but that they considered it an equitable exchange with it being tolerable given the level of mobility improvement they saw in their pet. And they opted to continue Librela™ (bedinvetmab injection).

Dr. Lascelles: Adverse events have been uncommon in my experience as well. If you look at the recent pharmacovigilance publication and look at the chart of different adverse events, at the highest rate, you are looking at 1 to 2 dogs reported with each sign per 10,000 doses distributed.[3] It's important to remember what those numbers mean. It's one thing to look at a bar chart, but you've got to put it in perspective. It is appropriate to call the frequency of these adverse events rare, as the pharmacovigilance publication did. Then we have to talk a little bit about that Farrell paper.[4] In the Farrell paper, they were looking at musculoskeletal adverse events. They compared bedinvetmab data with collective data across NSAIDs over a long time period. What they either didn't account for or didn't realize was that the reporting—and therefore the data included—was not consistent over time. Prior to 2022, there was only a requirement to report *serious* adverse events to this particular database, but since 2022, there *is* a requirement now. I believe a more appropriate approach would be to use the same database to compare adverse events following the introduction of NSAIDs as a new class of analgesics for OA pain with adverse events following the introduction of the latest class of analgesics, the anti-NGF monoclonal antibody.

mAb = monoclonal antibody
NGF = nerve growth factor
OA = osteoarthritis

Dr. Pierce: In light of rare reports of suspected accelerated joint destruction, how do we make clinical decisions around the use of Librela in a patient population? How do we put that potential into an appropriate context when selecting a therapy?

Dr. Mayland: There is a very low incidence of an undocumented arthropathy in pharmacovigilance reports for Librela. In a published study of all reported pharmacovigilance data (globally), it was found to occur <1 time in every 10,000 cases.[3] Zoetis has engaged a panel of specialists across different disciplines to evaluate these reported cases and is engaging in research with veterinary colleges and key researchers to better understand these cases and/or if these are also occurring in the broader population of treated dogs. Given the low incidence, I believe I can continue to treat all adult dogs with chronic OA pain with confidence.

Dr. Pierce: What adverse events do we need to keep in mind with NSAIDs, and how does our growing comfort with their use influence the way we weigh risks and benefits, especially now that these drugs have been around for a while?

Dr. Lascelles: Regarding NSAIDs, I think we all know the main concerns are the GI system, the kidneys, and the liver. Those are the organs most likely to be affected and where we see most of the adverse events we associate with NSAIDs. After a couple decades of use, I think we understand this much better now, and we're generally more accepting of the risks like we talked about in terms of frequency of adverse event reporting. There are 2 aspects here. One is that we understand NSAIDs better, so we're more aware of which patients may require more caution or should avoid them altogether. Second, we're hopefully having better conversations with owners and making more thoughtful choices about which patients to treat.

Dr. Mayland: It's important to remember that NSAIDs require hepatic metabolism and renal excretion, and blood work (pre- and postmedication) is important for screening for underlying renal disease or a hepatotoxic response to NSAIDs. Conversely, mAb elimination is not dependent upon normal hepatic or renal function, as mAbs are catabolized or excreted with minimal liver or kidney involvement. In a pet that has azotemia,

which I consider an even stronger contraindication for NSAIDs than elevated liver enzymes, I still feel comfortable using Librela™ (bedinvetmab injection), given that it is catabolized versus metabolized. Similarly, I would feel safe using Librela in a patient with elevated liver enzymes, but the apparent renal and hepatic risks associated with NSAIDs make me much more hesitant to use them in patients with underlying conditions affecting those organs. There are pros and cons to NSAIDs, and although they remain my most prescribed medication, I'm thrilled we have a new class of drugs that, in my experience, is safe and approved to control chronic OA pain.

Dr. Pierce: When it comes to long-term use of Librela, what do we know so far from the data and our clinical experience?

Dr. Zimmerman: All of the postapproval data are continuing to show us that Librela has a favorable safety profile. That matches what a lot of us are seeing clinically, and that's what helps build my confidence in recommending its use long-term now that we've had it for the last couple of years. Ongoing data and supportive findings like these really reinforce my confidence in recommending Librela for long-term use. I have patients that have been on Librela for 2 years at this point, so they're coming up on 24 to 28 doses, and those patients are still doing fantastic. Again, that clinical experience, combined with the growing postapproval safety data, to me, reinforces the safety of this drug. One of my patients, Tater Tot, is a 7-year-old pit bull with some pretty severe OA. He came to see me when he was about 5 years of age, and he had a history of a partial cranial cruciate tear in his right pelvic limb and had a brace on. His owner thought that was the majority of his orthopedic disease, but unfortunately, he had been so debilitated from his generalized orthopedic disease that he had become almost immobile. He was only able to walk very short distances, maybe 10 to 20 feet at a time, before he had to sit down and rest. He initially came in for evaluation of that right pelvic limb, but through examination and radiography, he was also diagnosed with moderate to severe OA in several joints. The owner expressed serious concerns about compliance with medications and supplements at home, so we decided to try Librela. I said, "Let's get this pain under control, and then we can talk about building his strength and muscle back up." He had gained about 20 lb in the year she adopted him, and he had become really debilitated. So, we gave him a dose of Librela, and at his recheck 2 weeks later, he was already able to walk the length of the driveway. You could tell the difference in his pain control just in that 2-week period. And now, in the past 2 years, he is down to ≈80 lb and has lost 20 to 30 lb. He's running in the backyard and has a whole new lease on life, and the only pharmaceutical intervention has been consistent Librela injections. He is a pretty amazing case. We've since done a lot of physical therapy and rehabilitation, both in the clinic and at home, and his life has completely changed.

Dr. Lascelles: I truly believe there is a real benefit to long-term consistent pain relief. I believe a monthly treatment helps us all achieve that. Hopefully, at some point, we and others will start to define and capture information on what I believe is a valuable benefit of sustained pain relief.

Dr. Pierce: How do you field safety concerns from pet owners regarding initiating or continuing Librela?

Dr. Harvey: I think we should lead with respect and compassion whenever our clients say they are worried about something. We cannot and should not discount it. We have to respect their concerns and try to understand what has generated their fears. Once we listen to them and respond compassionately, we can address them with more information-dense material and data.

Dr. Lascelles: You have to be gentle with those conversations. I like to point out that there's going to be more focus on anything new. Then, to Dr. Harvey's point, I then move to the data, which, for Librela, very clearly indicate overall safety. I compare overall safety of Librela to NSAIDs, but at that point, I pretty much leave it. I say, "That's what I believe are the facts, but we'll use whichever treatment you feel comfortable with, and I'm supportive of that." Interestingly, that conversation often leads them to say, "Well, let me try X," and it's usually the option they weren't originally comfortable with. It's important to give them the facts in a gentle and appropriate way and then be respectful of their ultimate decision.

Dr. Pierce: For those of you who mentor newer veterinarians or work alongside colleagues, how would you respond to a colleague who is hesitant about using anti-NGF monoclonal therapies in dogs?

Dr. Harvey: It's important to balance any concerns with the moral and ethical obligation to relieve pain and suffering. Then, from there, it's about finding the best balance of safety, efficacy, and value for each patient. I like to talk to people about risk and explain that veterinarians are generally a risk-averse group. The first law of medicine is do no harm. The second is perhaps, "Well, by golly, do something." Address the client's needs and the problems in some manner to help them and their pet. A physician anesthesiologist once told me he never wanted to be the first—or the

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Key Takeaways

- Subtle mobility and behavioral changes (eg, reluctance to jump, altered gait, stair hesitation) should be recognized as early indicators of OA pain, especially because dogs often adapt and mask discomfort.
- Tools such as behavioral questionnaires, owner-recorded videos, and structured recheck assessments can help improve detection, documentation, and monitoring of OA pain.
- Librela addresses both OA pain and neurogenic inflammation, offering another option that is approved as safe and effective for control of OA pain in dogs.
- Librela has been shown to offer sustained pain control for an entire month, and continuously monitored postapproval data and clinical experience have demonstrated that adverse events have been reported as rare or very rare.[3]

last—to adopt a new therapy. We might think that, with just 2 years into the game for Librela™ (bedinvetmab injection) in the United States, it might still be early, but worldwide, it's not so early. We now have >30 million doses distributed and a wealth of data that's coming out of the pharmacovigilance process, so we don't want to miss the boat in terms of implementing new therapeutics that can offer a real benefit to patients. Each individual clinician will make that decision with regard to an individual patient, and I firmly believe that, in the future, we as a profession will be just as comfortable with mAbs as we are with other therapeutics. I hope we'll always approach the process of evaluating drugs with care and deliberation and implementation of good science and follow the process that we do to provide safe and effective medications. ●

IMPORTANT SAFETY INFORMATION

Librela is for use in dogs only. Women who are pregnant, trying to conceive or breastfeeding should take extreme care to avoid self-injection. Hypersensitivity reactions, including anaphylaxis, could potentially occur with self-injection. Librela should not be used in breeding, pregnant, or lactating dogs. Librela should not be administered to dogs with known hypersensitivity to bedinvetmab. Adverse events reported post-approval include ataxia (lack of balance/coordination), anorexia (loss of appetite), lethargy (tiredness), emesis (vomiting), and polydipsia (increased drinking). The most common adverse events reported in a clinical study were urinary tract infections, bacterial skin infections and dermatitis (skin irritation/inflammation). For complete safety information, see the brief summary of prescribing information on page 4 of the winter 2025 issue of Clinician's Brief or full prescribing information at LibrelaPI.com

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Suggested Reading

Zoetis. Could your dog be showing signs of osteoarthritis? Zoetis website. https://www.OAChecklist.com

Testimonials represent individual experience only, and the experiences and opinions herein may be unique to the patient and the speaker. Individual results may vary considering the unique characteristics of the patient.

OA = osteoarthritis

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