

A Cross-Sectional Survey: Physician Perspectives on the Clinical Utility of Diclofenac Sustained Release in Acute and Chronic Pain Management**Jeslie K. Abraham¹, Rahul Kapur², Vinay Shelar³, K. Santhosh Kumar⁴**¹MD, Dnb(Medicine), Sr Consultant Physician, Baby Memorial Hospital, Thodupuzha, Kerala, India.²M.B.B.S, MD (Medicine), Consultant Physician & Diabetologist, Dr. Raj Memorial Clinic, Kanpur Nagar, Uttar Pradesh³MD (Medicine), Consultant Physician, Shelar Hospital, Panvel, Maharashtra, India⁴MD (Gen. Med), Consultant Physician, Dwaraka Medical College, Visakhapatnam, India

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Abstract:**Background:** Non-steroidal anti-inflammatory drugs (NSAIDs) are central to the pharmacological management of acute and chronic musculoskeletal pain, and diclofenac sustained-release (SR) formulations are widely prescribed in routine practice. Real-world data on how practising physicians perceive the efficacy, safety and clinical utility of diclofenac SR remain limited.**Objective:** To assess physicians' perceptions regarding the clinical utility, efficacy, safety, tolerability and prescribing preferences of diclofenac SR in the management of acute and chronic pain.**Methods:** A cross-sectional, questionnaire-based, anonymous survey was administered to 92 practising physicians across India. The 14-item, multiple-choice instrument captured perceptions of indication, comparative efficacy, mechanism-related beliefs, tolerability and prescribing frequency. Responses were summarised descriptively; no patient-level data were collected and no intervention was performed.**Results:** Most respondents (89.1%) identified joint and back pain with an inflammatory component as the principal indication for diclofenac SR. Effectiveness in chronic musculoskeletal pain was rated excellent or very good by 94.6% of physicians, and 98.9% considered diclofenac SR comparable to or better than other NSAIDs for sustained pain control. Agreement that sustained-release technology improves gastrointestinal tolerability was reported by 98.9% of respondents, whereas agreement that diclofenac is safe in renal impairment was more modest (67.4%). Most physicians (83.7%) prescribed diclofenac SR frequently or very frequently.**Conclusion:** Surveyed physicians expressed broadly favourable perceptions of diclofenac SR for musculoskeletal pain, particularly regarding sustained analgesia and treatment adherence. These perceptions should nonetheless be interpreted alongside independent pharmacoepidemiological evidence on cardiovascular and renal safety, and the survey's methodological limitations warrant caution before generalising these findings to prescribing guidance.**MeSH Keywords:** Diclofenac; Anti-Inflammatory Agents, Non-Steroidal; Chronic Pain; Practice Patterns, Physicians'; Surveys and Questionnaires; Physicians.**DOI:** 10.25258/ijcpr.18.9.186

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Introduction

Acute and chronic musculoskeletal pain, including osteoarthritis, low back pain and soft-tissue inflammatory conditions, are among the most frequent reasons for outpatient physician consultation worldwide. Non-steroidal anti-inflammatory drugs (NSAIDs) remain first-line pharmacological agents for these conditions because of their combined analgesic and anti-inflammatory activity, mediated principally through inhibition of cyclooxygenase (COX) enzymes and consequent suppression of pro-inflammatory prostaglandins such as PGE₂. According to PubMed-indexed real-world data, a substantial proportion of patients with osteoarthritis carry coexisting cardiovascular, renal

or gastrointestinal conditions that can influence NSAID selection, yet NSAID utilisation nonetheless increases markedly following diagnosis, underscoring the everyday clinical relevance of these agents [1]. Musculoskeletal pain of this kind generates a very large volume of ambulatory visits, with pharmacological treatment consistently favoured over non-pharmacological approaches across age groups [2].

Diclofenac is among the most extensively prescribed NSAIDs internationally, and its sustained-release (SR) formulations were developed to provide a prolonged duration of action, a more convenient

once- or twice-daily dosing schedule, and, in principle, improved adherence for patients requiring long-term pain control. A real-world longitudinal survey of patients using topical diclofenac reported measurable improvements in pain severity and health-related quality of life during treatment, together with high rates of continued use rather than switching to alternative topical NSAIDs, illustrating sustained patient-level engagement with diclofenac-based therapy in practice [3]. Sustained-release oral technologies, including wax-matrix and controlled-release platforms, have similarly been evaluated for other NSAIDs, with controlled-release formulations shown to achieve efficacy comparable to standard NSAID regimens over short-term use [8].

Despite this extensive clinical experience, independent pharmacoepidemiological evidence has raised safety considerations that temper enthusiasm for any single NSAID, including diclofenac. Contemporary meta-analyses of observational studies have found that diclofenac carries one of the higher cardiovascular risk profiles among commonly used NSAIDs, with risk estimates approaching those previously associated with withdrawn cyclooxygenase-2 selective agents [4], and a separate meta-analysis linked NSAID use, including diclofenac, to an increased incidence of atrial fibrillation [5]. Comparative randomised evidence has also suggested that diclofenac may be associated with a higher incidence of gastrointestinal adverse events than aceclofenac at equi-analgesic doses [7], and network meta-analyses of oral pharmacotherapy for knee osteoarthritis have not consistently ranked diclofenac above etoricoxib, celecoxib or aceclofenac for pain relief [9]. Renal considerations are also pertinent: NSAIDs as a class, particularly when combined with diuretics and renin-angiotensin system inhibitors, have been associated with acute kidney injury risk in vulnerable populations [10], and NSAIDs are frequently co-administered with cardiovascular medications in older patients, a population in which careful risk-benefit assessment is essential [3].

Given this evolving, at times conflicting, evidence base, physicians' day-to-day perceptions of diclofenac SR's efficacy, safety and place in therapy form an important, though inherently subjective, complement to controlled trial and pharmacovigilance data. Few published studies specifically describe how practising physicians perceive diclofenac SR relative to other commonly prescribed NSAIDs such as aceclofenac, etoricoxib and ibuprofen, or how these perceptions translate into prescribing frequency. This cross-sectional survey was therefore designed to capture independent physician opinion regarding the clinical utility, comparative efficacy, tolerability and prescribing preferences for diclofenac SR in acute and chronic pain management, while explicitly

acknowledging that perception-based data of this kind cannot substitute for controlled clinical or pharmacoepidemiological evidence.

Materials and Methods

Study Design: This was a cross-sectional, observational, questionnaire-based survey of physician perceptions, conducted without patient recruitment, clinical intervention, or collection of patient-level data.

Study Population and Recruitment: The questionnaire was circulated electronically to practising physicians involved in the management of acute and/or chronic pain across multiple cities and states in India, using a convenience, non-probability sampling approach. Participation was voluntary and anonymous, and physicians were informed that responses would be used in aggregate for academic and educational purposes; each respondent additionally provided electronic acknowledgement of the survey terms and conditions before participating. No patient-identifiable or patient-level data were collected at any stage; the unit of observation throughout was the responding physician, and individual patient consent was therefore not applicable. A total of 92 physicians completed the survey and were included in the final analysis; no responses were excluded. Physician names recorded in the dataset were used solely for internal data-quality tracking and are not reported. Respondents' self-reported city or town of practice spanned a broad geographic distribution across India.

Instrument: A structured, 14-item, single-best-answer multiple-choice questionnaire was administered, covering perceived first-line indication (Q1); rated effectiveness in chronic musculoskeletal pain (Q2); perceived importance of inhibiting inflammatory mediators such as PGE₂ (Q3); perceived comparative pharmacodynamic and pharmacokinetic properties (Q4-Q5); perceived renal safety (Q6); perceived comparative efficacy against other NSAIDs (Q7, Q9-Q10); perceived impact on treatment adherence (Q8); perceived benefit of sustained-release technology on gastrointestinal tolerability (Q11); perceived reasons for prescribing and tolerability advantages (Q12-Q13); and self-reported prescribing frequency (Q14).

Data Collection: Data were collected electronically and compiled into a single dataset comprising 92 valid, complete responses.

Statistical Analysis: Descriptive statistics (frequencies and percentages) were calculated for each item using Python (pandas). Cross-tabulations were generated to explore associations between selected items, such as prescribing frequency versus perceived comparative efficacy, and between

mechanistic and tolerability-related beliefs. No inferential hypothesis testing was performed, given the descriptive, perception-based nature of the survey and its non-probability sampling method. Figures were generated using Matplotlib; ordinal (Likert-type) items summarised in the composite box-plot analysis (Figure 9) were recoded numerically, with higher values assigned to the more

favourable response category, solely for visualisation of response spread.

Results

A total of 92 physicians from multiple cities across India completed the survey. Descriptive findings for each item are summarised in Tables 1-4, and are illustrated in Figures 1-10 using chart types selected to suit the structure of each result.

Table 1: Respondent Overview and Perceived Primary Indication for Diclofenac Sustained Release (N=92)

Parameter	n (%)
Total physicians surveyed	92 (100%)
Geographic spread	Multiple cities across India (pan-India convenience sample)
Perceived first-line indication for Diclofenac SR:	
Joint & back pain with inflammation	82 (89.1%)
Neuropathic pain with no inflammation	9 (9.8%)
Migraine headache	1 (1.1%)

Ninety-two physicians practising across a wide geographic spread of Indian cities and states completed the survey. When asked to identify the condition for which diclofenac SR represents the recommended first-line choice, 82 respondents (89.1%) selected joint and back pain with an inflammatory component, nine (9.8%) selected neuropathic pain without inflammation, and one

(1.1%) selected migraine headache. This distribution indicates that most surveyed physicians conceptualise diclofenac SR primarily as an anti-inflammatory analgesic for musculoskeletal conditions, consistent with its established pharmacological class, rather than as an agent for neuropathic pain, for which NSAIDs are not considered standard therapy.

Figure 1. Physician-Perceived First-Line Indication for Diclofenac Sustained Release (N=92)

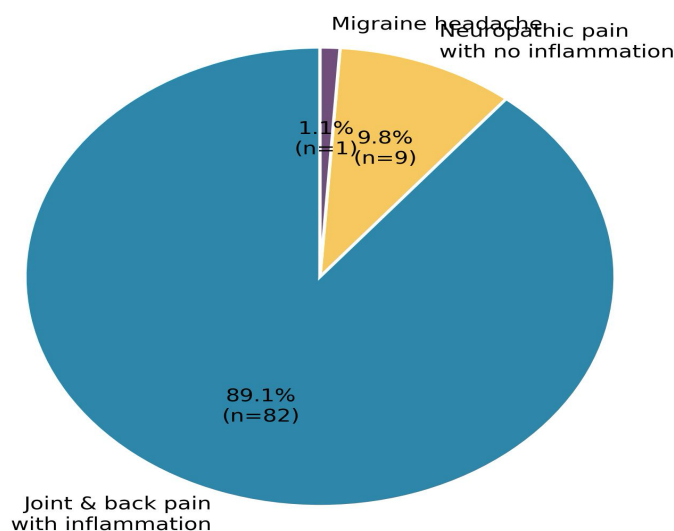


Figure 1 presents the distribution of physicians' perceived first-line indication for diclofenac sustained release, displayed as a pie chart. The overwhelming majority, 82 respondents (89.1%), identified joint and back pain accompanied by an inflammatory component as the principal indication, a response consistent with the drug's established anti-inflammatory and analgesic pharmacology. A

smaller subset, nine physicians (9.8%), selected neuropathic pain without inflammation, a response difficult to reconcile with current evidence, since NSAIDs are not generally regarded as first-line agents for neuropathic pain. One respondent (1.1%) selected migraine headache, indicating that most, though not all, surveyed physicians appropriately

situate diclofenac SR within its recognised therapeutic class.

Table 2: Physician-Rated Effectiveness and Self-Reported Prescribing Frequency (N=92)

Effectiveness rating (chronic MSK pain)	n (%)
Excellent	45 (48.9%)
Very Good	42 (45.7%)
Good	5 (5.4%)
Prescribing frequency	n (%)
Very Frequently	35 (38.0%)
Frequently	50 (54.3%)
Occasionally	6 (6.5%)
Rarely	1 (1.1%)

Effectiveness of diclofenac SR in chronic musculoskeletal pain was rated excellent by 45 physicians (48.9%), very good by 42 (45.7%), and good by 5 (5.4%); no respondent rated effectiveness as fair or poor. With respect to prescribing behaviour, 35 physicians (38.0%) reported prescribing diclofenac SR very frequently, 50

(54.3%) frequently, 6 (6.5%) occasionally, and 1 (1.1%) rarely. The concentration of responses in the favourable and high-frequency categories suggests that, within this sample, positive perception of effectiveness paralleled higher self-reported prescribing frequency, although this descriptive association does not establish a causal relationship.

Figure 2. Physician-Rated Effectiveness of Diclofenac Sustained Release in Chronic Musculoskeletal Pain (N=92)

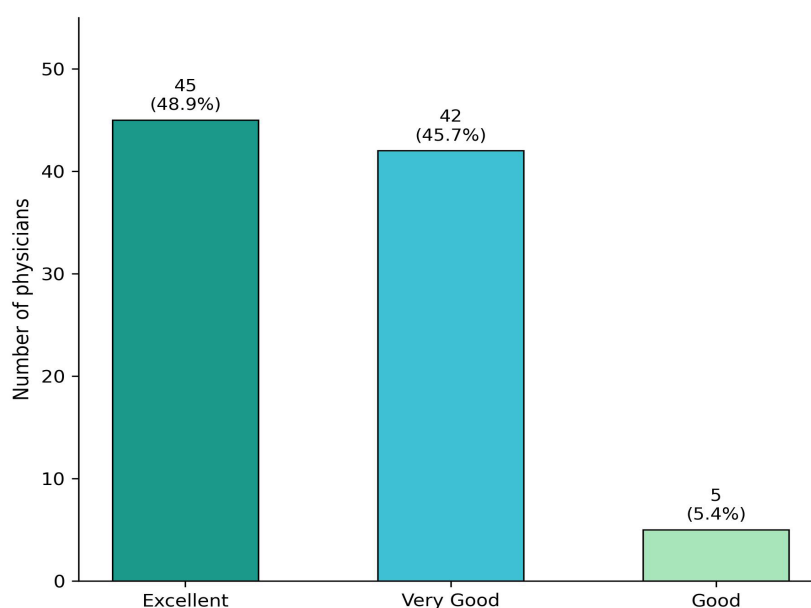


Figure 2 summarises, as a bar chart, physician ratings of diclofenac SR effectiveness in chronic musculoskeletal pain. Effectiveness was rated excellent by 45 physicians (48.9%) and very good by 42 (45.7%), together accounting for 94.6% of responses, while five physicians (5.4%) rated it good; no respondent selected fair or poor. The near-complete absence of unfavourable ratings suggests a

strongly positive collective impression of clinical effectiveness within this sample. Because the rating relies on subjective recall rather than standardised outcome measures such as validated pain scales, this finding should be regarded as an indicator of prescriber confidence rather than objective evidence of comparative efficacy.

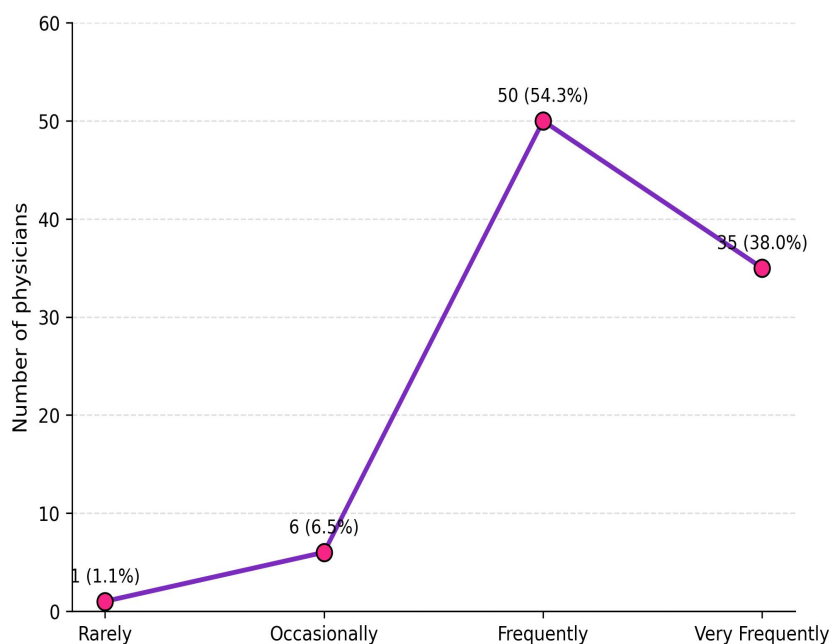
Figure 7. Ordinal Trend in Self-Reported Frequency of Diclofenac Sustained Release Prescribing (N=92)

Figure 7 depicts, as a line chart, the ordinal distribution of self-reported prescribing frequency for diclofenac SR. Thirty-five physicians (38.0%) reported prescribing it very frequently and 50 (54.3%) frequently, together representing 92.3% of the sample, while six (6.5%) prescribed it occasionally and one (1.1%) rarely. This distribution demonstrates that diclofenac SR occupies a

prominent, routinely used position within the surveyed physicians' therapeutic repertoire for musculoskeletal pain, consistent with the generally favourable effectiveness and tolerability perceptions reported elsewhere in this survey, though prescribing frequency alone does not establish comparative clinical superiority over alternative agents.

Table 3: Comparative Efficacy and Mechanism-Related Perceptions (N=92)

Item	Top response (n, %)
Q4: Highest PGE2 inhibition	Diclofenac: 80 (87.0%)
Q5: Higher site-of-action concentration	Diclofenac: 86 (93.5%)
Q7: Superior pain relief at max. doses	All comparators (aceclofenac/ibuprofen/etoricoxib): 76 (82.6%)
Q9: Rating vs other NSAIDs (sustained control)	Much Better: 64 (69.6%); Better: 27 (29.3%); Inferior: 1 (1.1%)
Q10: Superior potency vs aceclofenac	Strongly Agree/Agree: 91 (98.9%); Disagree: 1 (1.1%)

When asked which agent achieves the highest inhibition of PGE2, 80 physicians (87.0%) selected diclofenac, 9 (9.8%) etoricoxib, 2 (2.2%) aceclofenac, and 1 (1.1%) none of the above. For site-of-action concentration and pain relief, 86 (93.5%) favoured diclofenac. Concerning comparative pain relief at maximum doses, 76 physicians (82.6%) selected "all of the above" (aceclofenac, ibuprofen and etoricoxib), while

smaller numbers selected individual comparators. For sustained pain control relative to other NSAIDs, 64 (69.6%) rated diclofenac SR "much better," 27 (29.3%) "better," and 1 (1.1%) "inferior." On the Q10 mechanistic comparison with aceclofenac, 50 (54.3%) strongly agreed and 41 (44.6%) agreed that diclofenac demonstrates superior potency, with only 1 (1.1%) disagreeing.

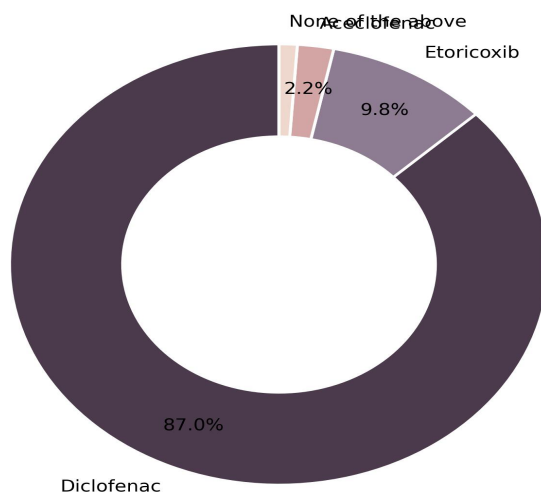
Figure 4. Physician Perception of the NSAID with the Highest Inhibitory Effect on PGE2 (N=92)

Figure 4 depicts, as a doughnut chart, physician beliefs regarding which NSAID achieves the greatest inhibition of PGE2. Diclofenac was selected by 80 physicians (87.0%), substantially exceeding etoricoxib (9, 9.8%), aceclofenac (2, 2.2%) and 'none of the above' (1, 1.1%). While diclofenac is indeed a potent non-selective COX inhibitor, comparative pharmacodynamic ranking of PGE2

suppression across NSAID classes is not straightforward and depends on dose, tissue compartment and assay conditions. The near-uniform selection of a single agent may therefore reflect confidence shaped by clinical experience and familiarity rather than direct comparative pharmacological data, a distinction worth bearing in mind when interpreting this item.

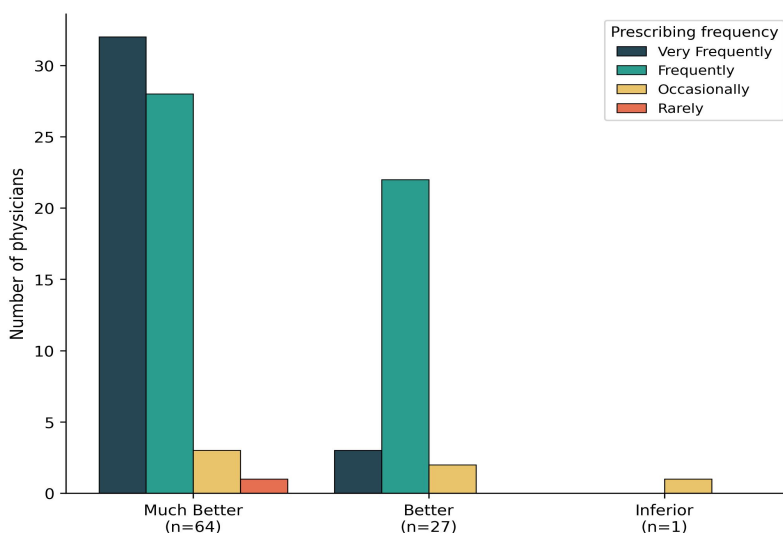
Figure 6. Rating of Diclofenac SR for Sustained Pain Control Stratified by Prescribing Frequency (N=92)

Figure 6 cross-tabulates, as a grouped bar chart, physicians' comparative rating of diclofenac SR for sustained pain control (Q9) against their self-reported prescribing frequency (Q14). Among the 64 physicians who rated diclofenac SR 'much better' than other NSAIDs, most reported prescribing it very frequently or frequently, whereas physicians rating it merely 'better' were more evenly distributed

across frequency categories. The single respondent who rated it 'inferior' reported only occasional prescribing. This pattern suggests a plausible, descriptive association between comparative efficacy perception and prescribing behaviour, although the cross-sectional design precludes any inference about which factor, if either, drives the other.

Table 4: Safety, Tolerability and Adherence-Related Perceptions (N=92)

Item	Response distribution (n, %)
Q3: Importance of PGE2 inhibition	Extremely Important: 55 (59.8%); Important: 37 (40.2%)
Q6: Diclofenac safe in renal impairment	Strongly Agree: 34 (37.0%); Agree: 28 (30.4%); Neutral: 10 (10.9%); Disagree: 15 (16.3%); Strongly Disagree: 5 (5.4%)
Q8: SR formulation improves adherence	Strongly Agree: 49 (53.3%); Agree: 39 (42.4%); Neutral: 4 (4.3%)
Q11: SR technology improves GI tolerability	Very Likely: 56 (60.9%); Likely: 35 (38.0%); Unlikely: 1 (1.1%)
Q12: Key reasons for prescribing	All of the above: 61 (66.3%); Long duration: 22 (23.9%); Proven efficacy: 8 (8.7%); Onset: 1 (1.1%)
Q13: Tolerability advantage summary	GI + renal + CV composite: 77 (83.7%); GI only: 9 (9.8%); Renal only: 5 (5.4%); CV only: 1 (1.1%)

With respect to the importance of PGE2 inhibition in NSAID selection, 55 physicians (59.8%) rated this "extremely important" and 37 (40.2%) "important." On renal safety, 34 (37.0%) strongly agreed and 28 (30.4%) agreed that diclofenac is safe in renal impairment, while 15 (16.3%) disagreed, 10 (10.9%) were neutral, and 5 (5.4%) strongly disagreed — the most heterogeneous response pattern in the survey. Belief that sustained-release

wax-matrix technology confers better gastrointestinal tolerability was reported by 56 (60.9%) as "very likely" and 35 (38.0%) as "likely." For reasons underlying prescribing choice, 61 (66.3%) selected "all of the above," and for tolerability advantages, 77 (83.7%) selected the composite option combining gastrointestinal, renal and cardiovascular benefit.

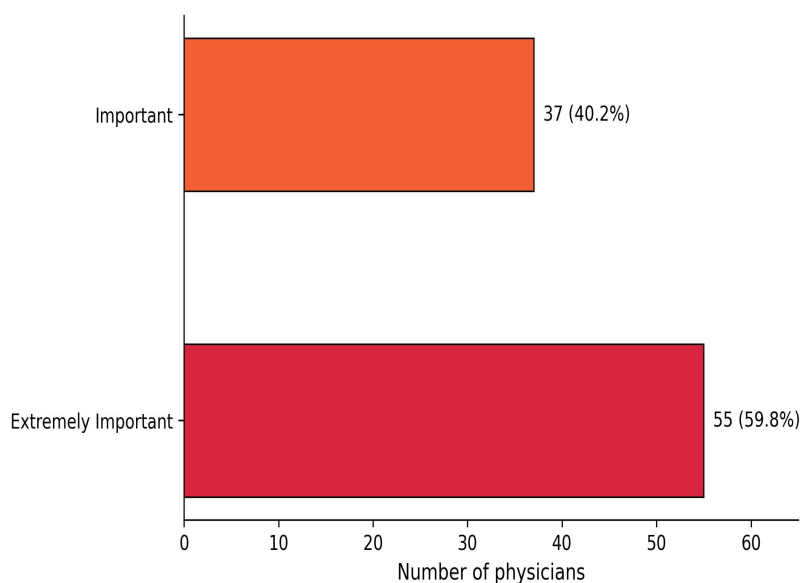
Figure 3. Perceived Importance of Superior Inhibition of Inflammatory Mediators (e.g., PGE2) in NSAID Selection (N=92)

Figure 3 illustrates, as a horizontal bar chart, how physicians weighed the importance of inhibiting inflammatory mediators, such as PGE2, when selecting an NSAID. Fifty-five respondents (59.8%) considered this attribute extremely important, while the remaining 37 (40.2%) rated it important; no physician regarded it as unimportant. This emphasis on prostaglandin suppression aligns with the

accepted mechanistic basis of NSAID action in inflammatory pain and indicates that mechanistic reasoning, rather than empirical outcome data alone, plays a substantial role in prescribing rationale. The absence of any low-importance response nonetheless limits the discriminative value of this item and may partly reflect the framing of the question.

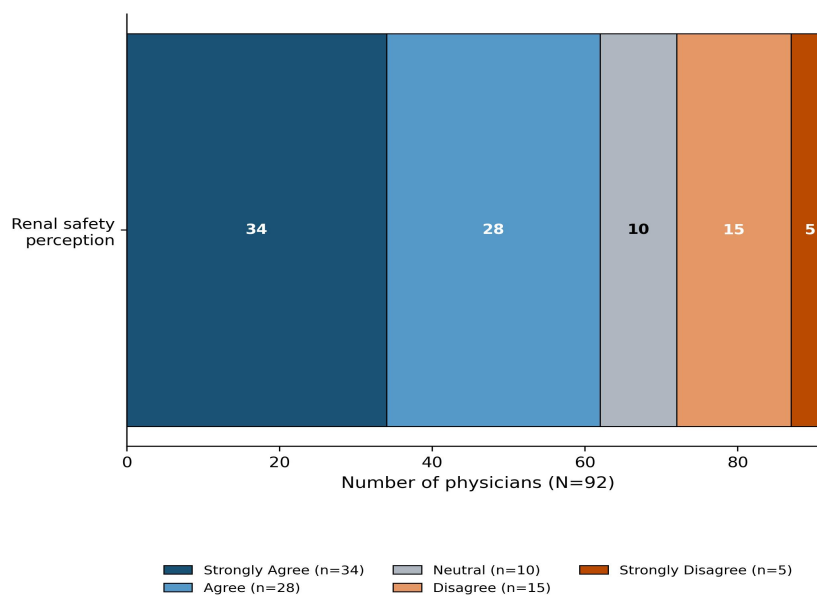
Figure 5. Physician Agreement Regarding the Renal Safety of Diclofenac in Patients with Renal Impairment (N=92)

Figure 5 presents, as a stacked bar chart, the full five-point distribution of agreement that diclofenac is safe in patients with renal impairment. Responses were considerably more heterogeneous than for other items: 34 physicians (37.0%) strongly agreed and 28 (30.4%) agreed, whereas 15 (16.3%) disagreed, ten (10.9%) were neutral, and five (5.4%) strongly disagreed. This spread indicates genuine clinical divergence rather than consensus, and likely reflects appropriate caution given that hepatic elimination does not eliminate renal risk in patients with reduced renal reserve, volume depletion or

concurrent nephrotoxic therapy. Renal safety emerged as the most contested and least uniformly endorsed item in the survey.

Composite and Cross-Item Analyses

In addition to the item-level results above, three figures present composite or cross-tabulated views spanning multiple questionnaire items, allowing patterns of internal consistency and divergence across domains to be examined directly.

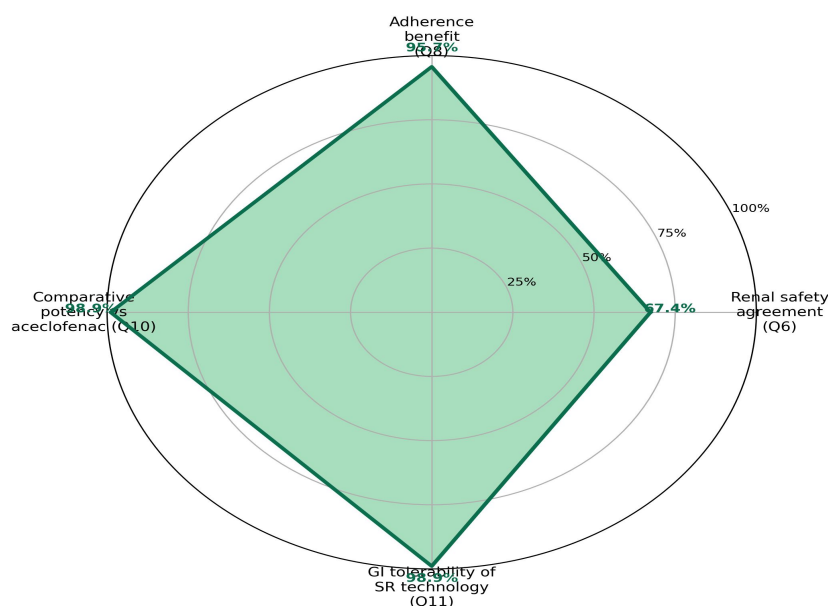
Figure 8. Composite "Top-Box" Agreement/Favorability Across Four Perception Domains (N=92)

Figure 8 presents a radar chart comparing composite 'top-box' agreement across four perception domains:

renal safety (Q6), adherence benefit (Q8), comparative potency versus aceclofenac (Q10), and

gastrointestinal tolerability of sustained-release technology (Q11). Agreement exceeded 95% for adherence, comparative potency and gastrointestinal tolerability, producing a markedly asymmetric shape, whereas renal safety agreement was comparatively lower, at 67.4%. This visual

asymmetry highlights renal safety as the one domain in which physician opinion diverged meaningfully from the otherwise uniform favourability expressed elsewhere in the survey, reinforcing the pattern already evident in the individual item-level results.

Figure 9. Distribution of Normalized Likert-Type Responses Across Seven Perception Items (N=92)

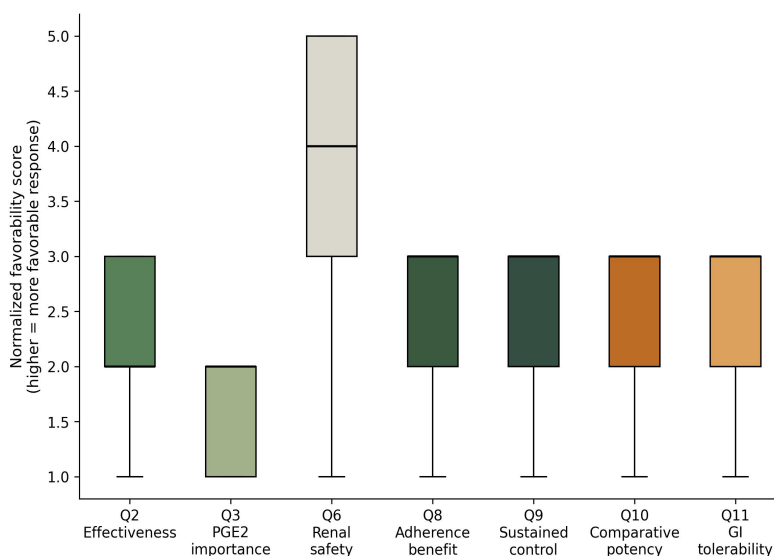


Figure 9 displays box-and-whisker plots for seven Likert-type items (Q2, Q3, Q6, Q8, Q9, Q10 and Q11), each recoded numerically so that higher values represent more favourable responses. Most items show compact interquartile ranges clustered toward the favourable end of the scale, reflecting general consensus among respondents. Renal safety

(Q6) is a clear exception, exhibiting a visibly wider spread and a lower median, consistent with the more heterogeneous agreement distribution reported for that item elsewhere in this article. This visualisation complements the individual bar and pie charts by allowing direct comparison of response consistency across multiple survey domains simultaneously.

Figure 10. Relationship Between Perceived Importance of PGE2 Inhibition and Belief in GI Tolerability of SR Technology (N=92)

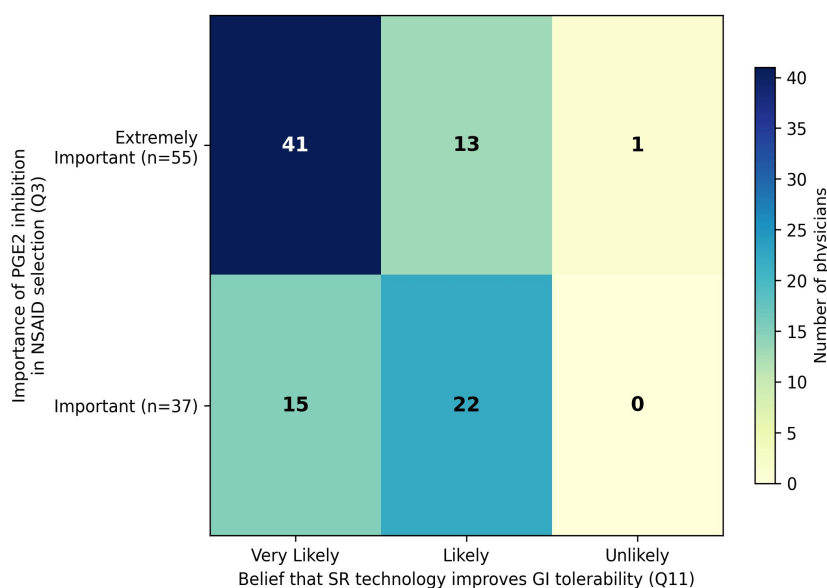


Figure 10 presents a heatmap cross-tabulating the perceived importance of PGE2 inhibition (Q3) against belief that sustained-release technology improves gastrointestinal tolerability (Q11). Physicians who considered PGE2 inhibition 'extremely important' most frequently also regarded gastrointestinal tolerability benefit as 'very likely' (41 of 55 respondents), whereas those rating PGE2 inhibition merely 'important' were more evenly divided between 'very likely' and 'likely'. This concentration of responses along a coherent pattern suggests an internally consistent mechanistic belief linking perceived pharmacological potency to expected tolerability, rather than two independently reasoned judgements about efficacy and safety, respectively.

Discussion

This cross-sectional survey found that practising physicians hold broadly favourable perceptions of diclofenac sustained-release (SR) formulations for musculoskeletal pain, with high self-reported effectiveness ratings, strong agreement regarding sustained pain control and treatment adherence, and frequent prescribing in routine practice. These perceptions are, in several respects, consistent with the pharmacological rationale for diclofenac and for sustained-release drug-delivery technology: prolonged, steadier plasma concentrations are intended to sustain COX inhibition and reduce peak-related gastrointestinal irritation, and controlled-release NSAID formulations have demonstrated efficacy comparable to standard regimens in randomised comparative trials [8].

Several findings nonetheless warrant cautious interpretation alongside independent controlled and pharmacoepidemiological evidence, some of which does not fully support the more favourable comparative beliefs expressed by respondents. Most notably, while 83.7% of physicians in this survey associated diclofenac SR with a composite advantage encompassing gastrointestinal tolerability, renal safety and cardiovascular safety, large meta-analyses of observational data have consistently identified diclofenac as carrying one of the higher cardiovascular risk profiles among commonly used NSAIDs, with pooled relative risk estimates comparable to those previously associated with rofecoxib, an agent withdrawn from several markets for cardiovascular safety reasons [4]. An independent meta-analysis has similarly linked diclofenac use to an increased incidence of atrial fibrillation relative to non-users [5]. These findings suggest that the cardiovascular component of physicians' composite tolerability beliefs may not be fully aligned with the independent evidence base, and prescribing decisions, particularly in patients with pre-existing cardiovascular disease, should continue to be guided by established risk-

stratification principles rather than by comparative perception alone.

Regarding gastrointestinal tolerability, a randomised, double-blind comparative trial found that aceclofenac was associated with significantly fewer gastrointestinal adverse events than diclofenac at clinically equivalent analgesic doses [7], and a network meta-analysis of oral pharmacotherapy for knee osteoarthritis did not consistently rank diclofenac above aceclofenac, celecoxib or etoricoxib for pain relief [9]. These data temper the near-uniform belief among surveyed physicians (Q7) that diclofenac SR is superior to all listed comparators at maximum doses, and highlight that comparative NSAID efficacy and tolerability are agent- and dose-specific rather than uniformly favouring a single molecule.

By contrast, the more divided responses on renal safety (67.4% agreement) likely reflect appropriate clinical caution regarding NSAID use in renal impairment. NSAIDs as a class have been associated with acute kidney injury, particularly in combination with diuretics and renin-angiotensin-system inhibitors ("triple whammy" prescribing) [10], and this more cautious response pattern is reassuring from a patient-safety perspective. The high perceived importance of PGE2 inhibition (Q3) is mechanistically plausible, since prostaglandin suppression underlies both the analgesic action and the gastric mucosal effects of NSAIDs, but perception of mechanism should not be equated with demonstrated comparative outcome data [1].

Taken together, this survey adds physician-perspective data to a therapeutic area in which substantial real-world adherence and satisfaction data already exist for diclofenac formulations [3]. It should nevertheless be read as a snapshot of prescriber opinion rather than as evidence of comparative efficacy or safety.

Conclusion

In this cross-sectional survey of 92 physicians, diclofenac sustained-release formulations were widely perceived as effective, well-tolerated and adherence-friendly options for musculoskeletal pain, and were frequently prescribed in routine practice. Several comparative safety beliefs, particularly regarding cardiovascular and gastrointestinal tolerability, diverge from the independent meta-analytic evidence identified in this review. These perception data should complement, rather than replace, controlled clinical trial evidence and pharmacovigilance data when guiding individual NSAID selection, particularly in patients with cardiovascular, renal or gastrointestinal comorbidity. Future prospective studies using a validated instrument and random sampling, ideally linked to objective prescribing and

outcome data, are warranted to confirm whether these favourable physician perceptions translate into comparable real-world clinical benefit.

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