Clinical Intelligence

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Diagnosis and management of spondyloarthritis in the over-16s:

NICE guideline

INTRODUCTION

The National Institute for Health and Care Excellence (NICE) has developed guidelines on the diagnosis and management of spondyloarthritis (SpA) in patients aged >16 years.[1]

SpA encompasses a group of inflammatory conditions with some shared features, which may be predominantly axial or peripheral (Box 1) and can include extra-articular manifestations. Only 15% of cases receive a diagnosis within 3 months of presentation, and diagnosis takes 8 years on average as health providers in non-specialist settings do not always recognise SpA. The guideline aims to raise awareness of the features of SpA and provides advice on what action to take when patients with signs and symptoms first present in a healthcare setting. The terminology around SpA has changed in recent years and may be unfamiliar to non-specialists. Before the nomenclature was updated, spinal disease was called ankylosing spondylitis, whereas the new term is axial SpA. Disease affecting areas other than the spine is called peripheral SpA and the commonest form of this is psoriatic arthropathy.

Pathology

In SpA the inflammatory process occurs primarily in the enthesis (patients with rheumatoid arthritis have synovitis and tenosynovitis). Entheses are the attachment points for tendons onto bones. There are many entheses in the body, for example, Achilles at the heel, elbow where inflammation can produce tennis and golfer's elbow, sacroiliac joints where inflammation of the entheses produces a typical appearance on X-ray, and also the plantar fascia. Dactylitis is inflammation of a whole digit (toe or finger), involving the tendons, entheses, and joints, and is diagnostic of SpA. It produces a 'sausage' digit.

RECOGNITION

Box 2 shows some of the main signs and symptoms that should raise the suspicion of SpA. SpA affects a similar number of females and males.

The diagnosis of SpA requires an understanding of the difference between mechanical back pain and inflammatory back pain. The vast majority of patients will have mechanical back pain, which comes on after a recognised trauma and is worse after exercise or at the end of the day. Inflammatory back pain (IBP) in contrast is rare, has a gradual onset without a known trauma, causes stiffness in the morning, sometimes disturbs sleep due to stiffness, and responds well to exercise. Enquiry into these aspects of back pain are required if IBP is to be suspected.

Although sacroilitis can be identified on X-ray the typical AS changes take years to develop and this can lead to a delay in diagnosis. It is possible to see changes much sooner on MRI but a specialised imaging protocol is required.

Box 1. Types of spondyloarthritis

Axial[a]

- Radiographic axial spondyloarthritis (SpA) (ankylosing SpA).
- Non-radiographic axial SpA.

Peripheral

- Psoriatic arthritis.
- Reactive arthritis.
- Enteropathic SpA.

[a]Predominantly axial SpA may also have peripheral features, and vice versa.

REFERRAL CRITERIA

Axial spondyloarthritis

The guideline recommends referral using the criteria for which there was best-quality evidence. This referral tool (Box 3) not only uses some of the features of IBP but also other diagnostic features such as dactylitis, which are diagnostic of SpA, and

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Box 2. Signs and symptoms of spondyloarthritis

- Musculoskeletal (for example, inflammatory back pain, enthesitis, and dactylitis) or extra-articular (such as uveitis and psoriasis [including psoriatic nail symptoms]).
- Onset can be associated with established comorbidities (Crohn's disease or ulcerative colitis), or a gastrointestinal or genitourinary infection.
- Can occur in people who are human leukocyte antigen B27 (HLA-B27) negative.
- May be present despite no evidence of sacroilitis on plain film X-ray.

Box 3. Axial spondyloarthritis referral criteria for patients who have low back pain that started before the age of 45 years and that has lasted >3 months

- Low back pain that started before the age of 35 years (more likely to be due to spondyloarthritis [SpA] compared with low back pain that started between 35 and 44 years).
- Waking during the second half of the night because of symptoms.
- Buttock pain.
- Improvement with movement.
- Improvement within 48 hours of taking non-steroidal anti-inflammatory drugs (NSAIDs)
- A first-degree relative with SpA.
- Current or past arthritis.
- Current or past enthesitis.
- Current or past psoriasis.

The clinician should refer if the patient fulfils four of the criteria. If three criteria are fulfilled, an HLA-B27 test should be performed and the patient referred if the test is positive.

associated features such as inflammatory bowel disease and psoriasis. Referral is recommended if a patient has low back pain that started before the age of 45 years and has lasted >3 months, and four or more of the additional criteria in Box 3 are also present. If three of the additional criteria are present, an HLA-B27 test should be performed and the patient referred if the test is positive. If the patient does not meet the criteria for referral in Box 3, but clinical suspicion of axial SpA remains, the patient should be advised to seek repeat assessments if any of the signs, symptoms, or risk factors listed in Box 2 develop. This may be especially appropriate if the patient has current or past inflammatory bowel disease (Crohn's disease or ulcerative colitis), psoriasis, or uveitis.

The referral pathway may seem complicated but it was designed to improve the specificity of referrals into the rheumatology services and prevent referrals for mechanical back pain, which are better dealt with in the musculoskeletal service.

Psoriatic arthritis and other peripheral spondyloarthritides

The recommendations for referral for psoriatic arthritis (PsA) and peripheral arthritis follow existing NICE guidance for referral for rheumatoid arthritis and psoriasis.[2,3]

Patients with dactylitis should be referred to a rheumatologist for an assessment. Patients with enthesitis without apparent mechanical cause should be referred if it is persistent, is in multiple sites, or is associated with back pain without apparent mechanical cause or extra-articular features such as current or past uveitis, current or past psoriasis, gastrointestinal or genitourinary infection, inflammatory bowel disease, or a first-degree relative with SpA or psoriasis.

MANAGEMENT

Non-steroidal anti-inflammatory drugs (NSAIDs) are the initial treatment for SpA and may be started in primary care before confirmation of diagnosis. Prolonged courses of NSAIDs can be disease modifying and may be suggested by specialists. Disease-modifying antirheumatic drugs (DMARDs) or biological treatments can be initiated in specialist settings. The guideline includes recommendations for the management of flares including the consideration of a flare management plan that is tailored to the individual patient's needs. This should include access to care during flares (including details of a named person to contact), advice about self-care (for example, exercises, stretching, and joint protection), pain and fatigue management, potential changes to medication, and management of the impact on daily life and ability to work. Patients having frequent flares should be referred back to the specialist because frequent flares are an indication that the disease is not well controlled.

Long-term complications

Patients with SpA require care for complications of the disease and its treatment as well as for common comorbidities. Inflammatory conditions are known to increase cardiovascular risk so attention to other risk factors for cardiovascular disease is important. Patients with axial SpA may be prone to fractures, and should be advised to consult a healthcare professional after a fall or physical trauma, particularly in the event of increased musculoskeletal pain. The assessment of fracture risk is important but bone mineral density measures may be elevated on spinal dual-energy X-ray absorptiometry (DEXA) due to the presence of syndesmophytes and ligamentous calcification so hip measurements may be more reliable. NSAIDs and DMARDs need to be monitored in the usual way for adverse effects.

COMMENT

NICE has set out clear criteria that should support GPs in the diagnosis of SpA as well as providing a defined pathway for specialist referral. For many practitioners there will be challenges in considering who might have SpA among the many patients they see with low back pain. It is also likely that most practices will have patients who have fallen through the net, who are not on any treatment and not under review by specialists. These patients would benefit from review of risk for complications or for consideration of disease-modifying treatments. The guidelines identify a number of areas where research is required, which include the incidence of long-term complications, the effectiveness of educational interventions for healthcare professionals, and evaluation of the optimal referral criteria for patients with suspected axial SpA. Further detail on these and on more specialised aspects of assessment and management can be found in the full guideline.[1]

Provenance

Freely submitted; externally peer reviewed.

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Competing interests

The authors have declared no competing interests.

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