

Axial Spondyloarthritis:

Expert Answers to FAQs



Atul Deodhar, MD, answers common questions from the video program on *Expert Recommendations for the Diagnosis and Treatment of Axial Spondyloarthritis*

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When should axial spondyloarthritis be suspected, and when is referral to a rheumatologist warranted?

When an individual younger than 45 years of age presents with insidious onset, chronic backache (ie, lasting > 3 months) where neither an obvious cause nor an exact starting point can be identified, axial spondyloarthritis should be considered.

Ask the following key questions:

1. Why is this young person experiencing back pain when no obvious trauma has occurred? Be sure to rule out recent falls.
2. Is their pain better with activity and worse with rest? A common way to query for this is to ask, "If your back is hurting, would you rather get out of bed or your chair and move around to gain some relief, or would you rather rest?" If they would rather move around, this might be inflammatory back pain.
3. Does their pain occur concomitantly with peripheral inflammatory arthritis, inflammatory bowel disease, uveitis, psoriasis, or enthesitis? These may also point to inflammatory back pain

If the patient's answer to these questions are consistent with inflammatory back pain, or if the patient has incidental HLA-B27 positivity or an x-ray with changes of sacroiliitis, it is time to refer to rheumatology.

Should classification criteria be used to diagnose axial spondyloarthritis?

No. Both axial spondyloarthritis and ankylosing spondylitis have classification criteria, the purpose of which is to provide unique language to evaluate patients in whom a diagnosis has already been made. This facilitates comparisons across clinical or experimental studies. Assessing classification criteria is clear-cut, with "yes" or "no" answers. The patient either fulfills a criterion or does not.

Included in the ASAS classification criteria for axial spondyloarthritis is a list of spondyloarthritis features. These same clinical parameters are used when making a diagnosis, and the more spondyloarthritis features present, the more confidence a clinician may have in that diagnosis. However, getting lost in the act of ticking boxes and failing to rule out common causes of backache such as mechanical back pain or fibromyalgia increases the risk of overdiagnosing axial spondyloarthritis.

Is axial spondyloarthritis a man's disease?

Women are as *likely* as men to have nonradiographic axial spondyloarthritis. Diagnosis is often delayed in women, but the disease itself is prevalent across sexes.

In terms of differences, women demonstrate less structural damage, a higher burden of disease, and a greater loss of function compared with men. Women may also experience more enthesitis. Of note, the first presenting symptom in a woman may be neck or thoracic back pain. In general, pain tends to be more widespread in women, so multiple areas may be involved (eg, heel pain due to Achilles' tendonitis, chest wall pain, epicondylitis, insertional pain of the patellar tendon).



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When should an MRI of the sacroiliac joint be ordered?

An MRI of the sacroiliac joint should only be ordered when some “pretest probability” of axial spondyloarthritis already exists. Without this clinical suspicion, an MRI of the sacroiliac joint should not be ordered. Often, the first imaging investigation is a plain x-ray that, when positive for sacroiliitis, renders an MRI superfluous.

Bone marrow edema, a feature captured with high sensitivity on MRIs as a proxy for sacroiliac joint inflammation, is not uncommon in healthy volunteers, degenerative pathology, or athletes. Therefore, depending solely on the observation of edema may lead to overdiagnosis.

Should x rays or MRIs be repeated?

In daily practice, there is no reason to repeat spinal radiographs after a patient has started biologic therapy. No evidence points to a clinical benefit of serial examination, and we want to limit the patient's exposure to radiation.

MRI of the sacroiliac joint may be repeated in select circumstances such as in the case of a question about underlying disease activity. For instance, if a patient complains about new back pain, an MRI may provide evidence of inflammation and change the therapeutic approach. Per guidance from the ACR/SAA/SPARTAN, MRI is not recommended when disease is known to be active or stable or when results would not affect treatment decisions.

What role do csDMARDs play in the treatment of axial spondyloarthritis?

Conventional synthetic disease-modifying antirheumatic drugs such as methotrexate and sulfasalazine are very useful during treatment of rheumatoid or psoriatic arthritis. However, they should not be used to treat the *axial* component of axial spondyloarthritis. Instead, reserve consideration of their use for prominent *peripheral* arthritis or when TNF inhibitors are unavailable. Greater evidence supports the use of sulfasalazine vs methotrexate for peripheral arthritis.

How do you choose among biologics?

There are no head-to-head studies comparing biologic classes among patients with axial spondyloarthritis. In adults with active disease despite treatment with NSAIDs, the ACR/SAA/SPARTAN recommend initiation of a TNF inhibitor (ie, infliximab, etanercept, adalimumab, certolizumab, or golimumab), given the extended clinical experience with this class and its long-term record of safety and efficacy.

If primary nonresponse to the first TNF inhibitor occurs, move to an IL-17 inhibitor—namely secukinumab or ixekizumab.

In the case of secondary nonresponse to the first TNF inhibitor, switching to a different TNF inhibitor is recommended.

Do biologics stop radiographic progression?

There are no prospective, placebo-controlled studies to show that biologics prevent radiographic progression. However, retrospective analysis of several large cohorts has shown that long-term exposure to TNF inhibitors (≥ 4 years) or IL-17 inhibitors (≥ 2 years) may reduce the rate of new bone formation.

Should we treat to target?

Adequate control of inflammation is paramount, as a patient's long-term outcome depends on it. However, ACR/SAA/SPARTAN do not recommend treating to target in patients with axial spondyloarthritis because no prospective studies have yet shown this approach to be better than usual care based on physician assessment.

Data from the cluster-randomized TICOSPA trial failed to show a significant difference between a “tight control/treat-to-target” strategy and care provided at the discretion of a treating rheumatologist. The proportion of patients demonstrating $> 30\%$ improvement in ASAS-HI score during 1 year of follow-up was 47% vs 36%, respectively.

What new treatment options are being investigated?

Phase II/III data are emerging for several novel modalities of treatment for ankylosing spondylitis. Included on this list are JAK1/3 inhibitor tofacitinib, selective JAK1 inhibitors upadacitinib and filgotinib, and bimekizumab, a dual inhibitor of IL-17A plus IL-17F. Across trials of these agents, the frequency of response has been significantly enhanced with treatment vs placebo.

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