Spondyloarthritis in over 16s: diagnosis and management

This guideline covers the diagnosis and management of suspected or confirmed spondyloarthritis in adults ≥16 years.

Definition of terms

- **NSAID**: non-steroidal anti-inflammatory drug
- **TNF-alpha inhibitor**: tumor necrosis factor-alpha inhibitor
- **DMARDs**: disease modifying anti-rheumatic drugs
- **BASDAI**: Bath Ankylosing Spondylitis Disease Activity Index
- **PsARC**: Psoriatic Arthritis Response Criteria
- **PASI**: Psoriasis Area and Severity Index
- **VAS**: visual analogue scale
- **PAS**: patient access scheme

### Recognition and diagnosis

- **Spondyloarthritis** is a group of inflammatory conditions that have a range of manifestations and may be predominantly:
  - **Axial**: which mainly causes pain and stiffness in the back.
  - **Peripheral**: which mainly causes pain, stiffness and swelling in the hands, feet, arms and legs.
- **People** with predominantly axial spondyloarthritis may have additional peripheral symptoms and vice versa.
- **Axial presentations** of spondyloarthritis are often misdiagnosed as mechanical low back pain, leading to delays in accessing effective treatments. Peripheral presentations are often seen as unrelated joint/tendon problems, and can be misdiagnosed as problems that can move around between joints.

### Treatment and management

#### Axial spondyloarthritis

**Non-pharmacological treatment**

- Refer to a specialist physiotherapist to start an individualised, structured exercise programme. See NICE pathway.
- Consider referral to hydrotherapy for pain or other specialist therapists for people having difficulties with everyday activities.

**Pharmacological treatment**

**NSAIDs**

- Offer NSAIDs at the lowest effective dose to people with pain associated with axial spondyloarthritis. Consider appropriate clinical assessment, ongoing monitoring of risk factors, and use of gastroprotective treatment.
- If an NSAID taken at the maximum tolerated dose for 2 to 4 weeks does not provide adequate pain relief, consider switching to another NSAID.

**Biological DMARDs**

**TNF-alpha inhibitors**. See NICE TA383.

- In adults whose disease has responded inadequately to, or who cannot tolerate, NSAIDs:
  - adalimumab*, certolizumab pegol*, etanercept*, golimumab* and infliximab* are recommended as options for treating severe active ankylosing spondylitis.
  - adalimumab*, certolizumab pegol* and etanercept* are recommended as options for treating severe non-radiographic axial spondyloarthritis.

- Infliximab is recommended only if treatment is started with the least expensive product. People currently receiving infliximab should be able to continue with the same product until they and their NHS clinician consider it appropriate to stop.
- Choice of treatment should be made after discussion between clinician and patient about advantages and disadvantages of treatments available. This may include considering associated conditions such as extra-articular manifestations. Of available suitable treatments choose the least expensive (taking into account administration costs and PAS).
- Assess response to TNF-alpha inhibitors 12 weeks after the start of treatment. Only continue treatment if there is clear evidence of response**.
- Treatment with another TNF-alpha inhibitor is recommended for people who cannot tolerate, or whose disease has not responded to the first TNF-alpha inhibitor, or whose disease has stopped responding after an initial response.

**Interleukin inhibitor: secukinumab**. See NICE TA407

- Secukinumab* is recommended as an option for treating active ankylosing spondylitis in adults whose disease has responded inadequately to conventional therapy (NSAIDs or TNF-alpha inhibitors) only if the company provides it with the discount agreed in the PAS.
- Assess response after 16 weeks of treatment. Only continue if there is clear evidence of response***.

**TNF-alpha inhibitors**

- *response is defined as: a reduction in the BASDAI*** score to 50% of the pre-treatment value or by ≥2 units, **AND** a reduction in the spinal pain VAS*** by ≥2 cm.
- ***when using BASDAI, and spinal pain VAS scores, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect responses and make any adjustments they consider appropriate.

### Referral criteria – see NICE pathway for suspected spondyloarthritis.
Peripheral spondyloarthritis

Pharmacological treatment

- Consider local corticosteroid injections as monotherapy for non-progressive monoarthritis.

Standard DMARDs

- Offer standard DMARDs to people with:
  - peripheral polyarthritis,
  - oligoarthritis,
  - persistent or progressive monoarthritis associated with peripheral spondyloarthritis.

- When deciding which DMARD to offer, take into account:
  - the person’s needs, preferences and circumstances (such as pregnancy planning and alcohol consumption),
  - comorbidities such as uveitis, psoriasis and inflammatory bowel disease,
  - disease characteristics,
  - potential side effects.

- If a standard DMARD taken at the maximum tolerated dose for at least 3 months does not provide adequate relief from symptoms, consider switching to or adding another DMARD.

NSAIDs

- Consider NSAIDs as an adjunct to standard or biological DMARDs to manage symptoms. Use oral NSAIDs at the lowest effective dose for the shortest possible period of time. Consider appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment.

- If NSAIDs do not provide adequate relief from symptoms, consider steroid injections (local or intramuscular) or short-term oral steroid therapy as an adjunct to standard DMARDs or biological DMARDs to manage symptoms.

- If extra-articular disease is adequately controlled by an existing standard DMARD but peripheral spondyloarthritis is not, consider adding another standard DMARD.

Psoriatic arthritis

Phosphodiesterase type-4 inhibitor: apremilast

- Apremilast, alone or in combination with DMARDs, is recommended as an option for treating active psoriatic arthritis in adults only if:
  - they have peripheral arthritis with ≥3 tender joints and ≥3 swollen joints, AND
  - their disease has not responded to adequate trials of at least 2 standard DMARDs, given either alone or in combination, AND
  - the company provides apremilast with the discount agreed in the PAS. See NICE TA433.

- Stop apremilast at 16 weeks if psoriatic arthritis has not shown an adequate response using the PsARC.

Biological DMARDs

TNF-alpha inhibitors. See NICE TA199, TA220

- Etanercept*, infliximab*, adalimumab* and golimumab* are recommended for the treatment of adults with active and progressive psoriatic arthritis:
  - who have peripheral arthritis with ≥3 tender joints and ≥3 swollen joints, AND
  - their disease has not responded to adequate trials of at least 2 standard DMARDs, given alone or in combination, AND
  - golimumab: the company provides the 100mg dose at the same cost as the 50mg dose.

- Start treatment with the least expensive drug taking into account administration costs, dose and price per dose.

- Assess response at 12 weeks. Only continue if there is an adequate response using the PsARC.

Interleukin inhibitor: ustekinumab. See NICE TA340.

- Ustekinumab is recommended as an option alone or in combination with methotrexate for treating active psoriatic arthritis in adults only when:
  - TNF-alpha inhibitors would be considered but are contraindicated, OR the person has had treatment with ≥1 TNF-alpha inhibitors, AND
  - the company provides it in accordance with the PAS.

- Assess response at 24 weeks. Only continue if there is an adequate response using the PsARC.

- Patients already on apremilast or ustekinumab may continue if a standard DMARD but peripheral spondyloarthritis is not, consider adding another standard DMARD.

- When managing flares in primary care, seek advice from a healthcare professional following falls or physical trauma, particularly in the event of increased musculoskeletal pain.

Referral for surgery – see NICE pathway

Resources

Infographic – identifying and referring spondyloarthritides
http://www.bmj.com/content/bmj/suppl/2017/02/28/bmj.j839.DC1/mcak02_0217-wi.pdf
Clinical knowledge summary - DMARDS
https://cks.nice.org.uk/dmards

This bulletin summarises key prescribing points from NICE guidance. Please refer to the full guidance at www.nice.org.uk for further detail.

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A summary of prescribing recommendations from NICE guidance

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