NEW NICE GUIDANCE ON THE MANAGEMENT OF SPONDYLOARTHRITIS IN THE OVER 16s

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The spondyloarthropathies are an heterogenous group of inflammatory conditions with a diverse phenotype and multiple clinical manifestations involving joints, entheses, spine, skin and other tissues. Diagnosis is often delayed after symptom onset leading to significant disability and reduced quality of life in affected individuals. Emphasis therefore is given to informing and educating patients about their disease, treatment options and how to manage disease flares.

These are some of the points collected in the National Institute of Health and Care Excellence (NICE) guidelines published in February of 2017 to alert Health professionals about these group of diseases. The guidelines highlight why it is important to be able to refer to a rheumatologist, as well as describing when a referral should be made. It also includes information on diagnosis, treatment, education, and an agenda for research. Since a significant number of people affected with these conditions, in particular those suffering from psoriatic arthritis are likely to be seen in the context of the dermatology clinic, the dermatology nurse may play an active part of this process.

Introduction

The spondyloarthropathies are a group of inflammatory conditions including ankylosing spondylitis (AS), psoriatic arthritis (PsA), reactive arthritis and enteropathic arthritis. Their presentation can be varied and include either peripheral or axial symptoms or both. Due to their heterogenous nature, diagnosis may be difficult and is often delayed. Early detection is essential to prevent long-term disability in a relatively young patient cohort. A key priority of the recommendations is to alert healthcare professionals across specialties of the signs and symptoms associated with an spondyloarthropathy to prompt referral to a Rheumatologist. The guidance also includes recommendations on diagnosis/imaging, long-term management, patient/carer education and further research. Nurses practicing in the field of dermatology are ideally placed to assist both in the identification of patients who may potentially have a spondyloarthropathy and in the long-term management of these conditions.

Signs and symptoms

The recommendations categorise spondyloarthritis according to whether its presentation is axial or peripheral. The prototype of axial condition is ankylosing spondylitis (AS) or radiographic axial spondylarthritis, characterized by inflammation affecting enthesis in the spine and axial skeleton including pelvis and hips. AS is diagnosed with the aid of the modified New York criteria (mNYC), which comprises of clinical symptoms
and established radiographic changes of sacroiliitis. There are however a number of patients who may not fulfil the mNYC, as they may not have readily identifiable changes on the pelvic or spinal radiographs. This so called non-radiographic stage can be identified with the newly developed assessment called the SpondyloArthritis International Society (ASAS) classification criteria.

Psoriatic arthritis, reactive arthritis and enteropathic arthritis are defined as peripheral within the guidance. In reality, affected individuals may have both axial and peripheral disease, hence the diversity of presentation. Psoriasis is associated with joint disease in a significant proportion of patients (reported in 1 study at 13.8%), while the overall prevalence of psoriasis is around 1.3–2.2% in the UK. Delay to diagnosis is a significant problem in both axial and peripheral forms, and is generally reported as 8-10 years. Therefore it is important to enquire about additional symptoms and background history during patient contact to reduce the time between the onset of symptoms and diagnosis (see Box 1).

Suspected axial spondyloarthritis
In patients below the age of 45, the presence of lower back pain that lasts longer than 3 months should alert the dermatology nurse to the possibility of axial spondyloarthritis or axSpA. The new guidance includes a list of signs/symptoms (Box 1) that raise the suspicion of axial disease. The presence of 4 or more of these criteria warrant referral to a rheumatologist. If only 3 of the criteria are met, but the patient is human leukocyte antigen B27 (HLA-B27) positive, then a referral should also be considered. Indeed, approximately 90% of individuals with established radiographic axSpA or ankylosing spondylitis (AS) in the northern European population are HLA-B27 positive. It is important to be aware that axSpA affects a similar number of women as men and can also occur in people who are human leukocyte antigen B27 (HLA-B27) negative.

Affected individuals may have both axial and peripheral disease, hence the diversity of presentation

Suspected psoriatic arthritis and other peripheral spondyloarthritides
NICE guidance on the management of psoriasis recommends that all people with any type of psoriasis should be offered an annual assessment for psoriatic arthritis (CG153). A number of validated questionnaires are available to this end, including the Psoriasis Epidemiological Screening Tool (PEST). It should be noted, however, that PEST does not detect axial arthritis or inflammatory back pain. With regards to peripheral joint involvement, the recommendations refer to the presence of arthritis (causing pain, tenderness, stiffness and swelling in and around the joints), dactylitis (also known as “sausage fingers”) and enthesitis (inflammation at the entheses, the site where muscle, tendon and/or soft tissues join to bone) as characteristic pathologic features that should trigger a referral to the rheumatologist. Refer to Box 2 for peripheral signs/symptoms and extra-articular features warranting referral to a rheumatologist.

Patients presenting with symptoms of acute anterior uveitis, e.g. eye pain, eye redness, sensitivity to light or blurred vision, should have an immediate (same-day) ophthalmological assessment.

Imaging and diagnosis
The section on diagnosis and imaging relates to management in specialist settings. It contains recommendations with regards to the use of a validated tool such as the newly developed Assessment of Spondyloarthropathies International Society (ASAS) classification criteria to aid clinical judgement by the Rheumatologist plus the need for plain radiography and/or MRI according to disease presentation.

Management of spondyloarthritis
Information and support
The overarching goals of treatment in spondyloarthritis are to reduce pain, stiffness and swelling in order to inhibit the disease progression and optimize function, which will, in turn, reduce its psychological impact and improve quality of life. It is important that people with spondyloarthritis are fully educated about their condition including the risks and benefits of available treatment options. This information should be tailored to each individual’s needs and be provided on an ongoing basis according to the stage
of their condition. This is essential to allow shared decision making about their care.

The recommendations provide examples of explanations and information which may be of benefit to affected individuals. These include an explanation of the condition, how it is diagnosed, symptoms and prognosis.

The treatment of patients with spondyloarthritis should be individualised according to the current signs and symptoms of the disease

Pharmacological management

The treatment of patients with spondyloarthritis should be individualised according to the current signs and symptoms of the disease (axial, peripheral, extra-articular manifestations) and the individual patient’s characteristics including comorbidities and psychosocial factors. The pharmacological management of spondyloarthritis is divided within the guidance into management of axial disease and of psoriatic arthritis plus other peripheral spondyloarthritides. The recommendations should be read in conjunction with the appropriate technology appraisal guidance (TA) for the individual medicines (Box 3). The prescriber should consider the long-term complications of any medication prescribed particularly with regards to the risk of skin cancer, cardiovascular risk and osteoporosis.

Axial disease

Provided there are no contra-indications, non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as the first line pharmacological treatment for axial disease. Response to NSAIDs varies in different individuals. If the NSAID has been taken at the maximum tolerated dose for 2–4 weeks and does not provide adequate pain relief then an alternative NSAID should be tried. All NSAIDs should be prescribed in conjunction with a gastro-protective agent and the person should be monitored for adverse effects throughout treatment. Biological disease modifying agents (bDMARDs) are recommended for active AS (radiographic and non-radiographic) in adults whose disease has responded inadequately to, or who cannot tolerate, NSAIDs. Current approved tumour necrosis factor inhibitors (TNFi) for severe radiographic disease include adalimumab, certolizumab pegol, etanercept, golimumab and infliximab. In severe non-radiographic disease adalimumab, certolizumab pegol, etanercept and golimumab are recommended. Use should be in accordance with TA383 and TA497 (see Box 4). Treatment with another TNFi is recommended for people who cannot tolerate, or whose disease has not responded to treatment with the first TNFi (also called primary non-response), or whose disease has stopped responding after an initial response (referred to as secondary non-response).

The Interleukin-17 inhibitor secukinumab is recommended as an option for the treatment of active ankylosing spondylitis in adults whose disease has responded inadequately to conventional therapy (NSAIDs or TNFi). Use should be in accordance with TA407 and the drug is recommended only if the company provides it with the discount agreed in the patient access scheme. Treat-to-target (T2T) has emerged as a new treatment paradigm in inflammatory arthritis, aimed to direct therapy to a clear target, such as disease remission or low disease activity, which should be sustained over time. This approach has shown clear benefits in rheumatoid arthritis with prevention of damage, maintenance of physical function, and reduction of comorbidity risks.

Although there is no date on treat-to-target (T2T) in axial SpA, it has been suggested that such an approach could also improve outcomes in this condition, given the correlation between damage progression with disease activity. T2T studies are currently ongoing in axial SpA.

Psoriatic arthritis and peripheral spondyloarthritides

NICE recommends that conventional synthetic DMARDs (csDMARD) such as methotrexate, sulfasalazine or leflunomide are offered to people with peripheral polyarthritis, oligoarthritis or persistent/progressive monoarthritis, provided there are no contra-indications. However, the lack of robust clinical trials data preclude any specific recommendations with regards to which csDMARD to select, so choice should be based on patient preference and the presence of co-morbidities. Local corticosteroid injections and NSAIDs may be used as adjunctive therapies.

The phosphodiesterase 4 inhibitor (PDE4) apremilast, alone or in combination with csDMARDs is recommended as an option for treating active PsA. Use is only permitted in the context of peripheral arthritis with
3 or more tender joints and 3 or more swollen joints and whose disease has not responded to adequate trials of at least 2 csDMARDs, given either alone or in combination and the company provides apremilast with the discount agreed in the patient access scheme (TA433).

The use of TNFis is permitted in PsA if the person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints, and their PsA has not responded to adequate trials of at least 2 csDMARDs, administered either individually or in combination. Current recommended TNFis include adalimumab, certolizumab, etanercept, golimumab and infliximab. Use should be accordance with current technology appraisals (TA199 TA220 and TA445).20-22

The Interleukin 12 and 23 inhibitor ustekinumab, may be considered in individuals with PsA who fulfil NICE treatment criteria for a TNFi but where treatment is contra-indicated.21 Use is also permitted where there has been treatment failure with 1 or more TNF-alpha inhibitors (TA340). Following the publication of the management guidelines, NICE subsequently approved the use of the secukinumab in active PsA. According to TA445 secukinumab is recommended with or without methotrexate in individuals who have failed to respond to TNFi, have lost response to TNFi or where the use of a TNFi is contra-indicated.

Current treatment recommendations for psoriatic arthritis introduce the concept of a T2T strategy based on preliminary data, suggesting improved outcomes after tight control of disease activity. Evidence to this respect is still lacking for axial spondyloarthritis with studies currently under way to prove the concept of treat-to-target in axial disease.23

Flare management
People with spondyloarthritis often experience episodes of disease flare where there is acute worsening of symptoms. It is important that a person with spondyloarthritis is educated about disease flare and what action to take when this occurs. NICE proposes the development of a flare management plan that is tailored to the person’s individual needs, preferences and circumstances.

The dermatology nurse is ideally placed to provide education on disease flare and may, in conjunction with the patient, wish to develop an individualised flare management plan. Information provided in the flare care plan should include self-care, accessing specialist support, changes to medication during flare, pain and fatigue management (refer to Box 4 for suggested inclusions by NICE).

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When flares are being managed in the primary care setting, advice should be sought from the specialist if there is recurrent or persistent disease flare. It is also recommended that the specialist be contacted if the patient is on a biologic or has developed an additional co-morbidity which could affect therapeutic management. Acute uveitis should immediately be referred to an ophthalmologist.

**Non-pharmacological management**

The optimal management of people with Spondyloarthritis should include a combination of pharmacological and non-pharmacological modalities. This is particularly important in axial disease, as regular structured exercise is a key part of management. NICE recommends that people with axial spondyloarthritis are referred to a specialist physiotherapist with the aim of developing an individualised, structured exercise programme. This can then form the basis of a regular exercise regime in the home environment. Access to hydrotherapy can be beneficial in terms of both pain and physical function. The National Ankylosing Spondylitis Society (NASS) offers support and information for people affected by AS and axial spondyloarthritis in general including diagnosis, treatment, management and living with AS. Their website (www.nass.org) contains helpful and detailed information on appropriate exercise regimes which is easily accessible.

The need for physical aids both in the home and work environment should be assessed. Referral should be made to a specialist therapist (such as a physiotherapist, occupational therapist, hand therapist, orthotist or podiatrist) who can assess the individual’s needs and provide advice about physical aids plus arrange periodic reviews.

People with spondyloarthritis should be encouraged to stop smoking as an association has been shown between smoking and disease severity.25 Further, smoking leads to poorer response to biologic therapies, which is relevant for many subjects taking these drugs. Smoking cessation should therefore be part of the educational programme for people with SpA. Many regions in the UK have local smoking cessation services who can provide advice. It is advisable to keep information leaflets and contact cards for the service to give to people during consultations.

Surgical intervention, in the context of axial spondyloarthritis and in particular AS, is not recommended unless the spinal deformity is severe or progressive despite optimal non-surgical management, or is significantly affecting their quality of life, ie: reducing horizontal vision. A specialist surgical referral may also be considered in the event of spinal fractures. NICE guidance does not contain recommendation about peripheral joint surgery, but the ASAS recommendations for axial spondyloarthritis state that a total hip arthroplasty in patients with refractory pain or disability and radiographic evidence of structural damage, independent of age.4

**Box 4.**

**NICE – Flare Management Plan to include:**

- Named person to contact during flare – Specialist Nurse
- Self-care – Exercises, stretching and joint protection
- Dealing with pain and fatigue
- Changes to medication
- Managing impact daily life and ability to work
Co-ordinating access across care settings

The recommendations stress the need for effective communication and coordination across primary and secondary care with regards to the patient’s condition and management. Where there is cross speciality care in a secondary setting (such as dermatology, gastroenterology and ophthalmology) it is also important that there are clear lines of communication between the specialties and the patient’s care is fully co-ordinated. This is particularly important for people who may already be receiving or need to start taking csDMARDs or bDMARDs for another condition. Transition of young people with Juvenile idiopathic arthritis (JIA) to adult services is collected in specific NICE guidelines.

Research agenda

Further research is required to advance the care of patients with spondyloarthritis. The guidance includes five specific research areas covering issues such as appropriate referral criteria, long term complications of spondyloarthritis and interventions to improve healthcare professionals’ awareness of spondyloarthritis.

Summary

The NICE guidance on the management of spondyloarthritis aims to alert healthcare professionals of the signs and symptoms that may suggest an undiagnosed spondyloarthritis. Due to the heterogeneous nature of these diseases, the dermatology is likely to encounter such patients and has an important role to play in ensuring appropriate referral to ensure early diagnosis. Although the dermatology nurse is already an expert in managing and educating people with dermatological conditions the guidance supports extension of this role to people who may also have spondyloarthritis.

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