Identifying, referring and managing spondyloarthritis

Visual summary of NICE guidelines

Spondyloarthritis can have diverse symptoms and be difficult to identify. The presence of these key indicators might prompt you to continue through the more detailed assessments below.

Suspected axial spondyloarthritis

- Low back pain
  - Started before age 45
  - Lasting longer than 3 months
- Low back pain that started before the age of 35 years
- Waking during the second half of the night because of symptoms
- A first-degree relative with spondyloarthritis

Assess for referral criteria

- 2 or fewer referral criteria
- Exactly 3 referral criteria
- 4+ referral criteria

Consider referral to:

- HLA-B27 test
  - Negative
  - Positive

HLA-627 test results

Specialist referral
Refer to a rheumatologist for specialist diagnostic assessment

Diagnosis in specialist setting

- No single test can reliably rule out spondyloarthritis. Diagnosis in specialist care will rest on multiple signs, symptoms, and test results
- HLA-627 test results
- Imaging, using inflammatory back pain protocol

Validated SPA criteria may help to guide judgement

Unless skeleton has not fully matured

Managing axial spondyloarthritis

Pharmacological management

- NSAIDs
  - Lowest effective dose, with appropriate clinical assessment and monitoring
  - After 2–4 weeks, if maximum tolerated dose is ineffective

Non-pharmacological management

- Physiotherapy
  - Refer to a specialist physiotherapist to start a structured exercise programme
- Occupational therapy
- Orthotist
- Therapist
- Podiatrist
- Etc.

Consider switching to a different NSAID

Managing peripheral spondyloarthritis

Pharmacological management

- Non-progressive monoarthritis
  - Corticosteroid injections
- Initial DMARDs
- Biological DMARDs

Non-pharmacological management

- Consider referral to:
  - Physiotherapy
  - Occupational therapy
  - Podiatrist
  - Therapist
  - Orthotist
  - Etc.

For people having difficulty with daily activities

Managing flares

There is no ‘one size fits all’ approach to flare management, as patients’ experiences vary and multiple approaches may be appropriate.

- Offer advice on possibility of:
  - Flare episodes
  - Extra-articular symptoms

Consider developing a flare management plan, with information on:

- Access to care
- Pain & fatigue management
- Self-care
- Exercises
- Diet
- Joint protection
- Managing impact on daily life
- Recurrent or persistent flares
- People taking

Seek specialist advice as needed, particularly for:

- People with comorbidities
  - Acute uveitis flares (Ophthalmology input)

Long term management

While there is little evidence to support long term management strategies, there are a number of potential issues to be aware of.

Take into account adverse effects associated with:

- NSAIDs
- Standard DMARDs
- Biological DMARDs

Skin cancer

- Advise people on risk of skin cancer for those using TNF alpha inhibitors

Cardiovascular

- Discuss risk factors for cardiovascular comorbidities

For people with axial spondyloarthritis

- Osteoporosis
  - Consider osteoporosis assessments every two years
- Fractures
  - Advise people that they may be prone to fractures

- For people with peripheral spondyloarthritis
  - Osteoporosis
  - Fractures