Msk?... Think SpA!

NICE guidance on recognition and referral of Spondyloarthritis

What is Spondyloarthritis (SpA)?

Spondyloarthritis is a group of inflammatory arthritis conditions with common features and associated with extra-articular inflammatory conditions:

- Psoriasis
- Inflammatory Bowel Disease
- Uveitis
- Infection trigger

A key feature is enthesitis (inflammation at tendon attachment to bone) and may also involve joint inflammation, pain and swelling

There are two main types, which can also co-occur:

- Axial Spondyloarthritis - involving SIJs/spine/costovertebral joint region
- Peripheral Spondyloarthritis - involving dactylitis (whole digit inflammation and swelling), enthesitis, peripheral joint inflammation and tendonitis

Spondyloarthritis Recognition and referral

NICE guidance[1] offers separate advice on suspecting axial and peripheral presentations, relating to evidence for different signs, symptoms and risk factors

Why is it important to screen for Spondyloarthritis?

- Average time to be diagnosed for many people is 8-9 years
- Spondyloarthritis is often mistaken as chronic back pain, or as unrelated tendonitis and joint problems
- Symptoms can move between areas, be asymmetrical, and can flare and settle
- This guidance links with NICE Guidance on Low Back Pain and Sciatica (2016) to ensure inflammatory back symptoms are not mistaken as chronic mechanical LBP

**Important – Consider spondyloarthritis before treating as NSLBP

Spondyloarthritis conditions include:

- Axial Spondyloarthritis (axSpA) / Ankylosing Spondylitis (AS)
- Psoriatic Arthritis (PsA)
- Enteropathic arthritis (related to inflammatory bowel disease-Crohn's disease/ ulcerative colitis)
- Reactive Arthritis (triggered by gastrointestinal or genitourinary infection)
- Undifferentiated Spondyloarthritis (uSpA- no identified associations)

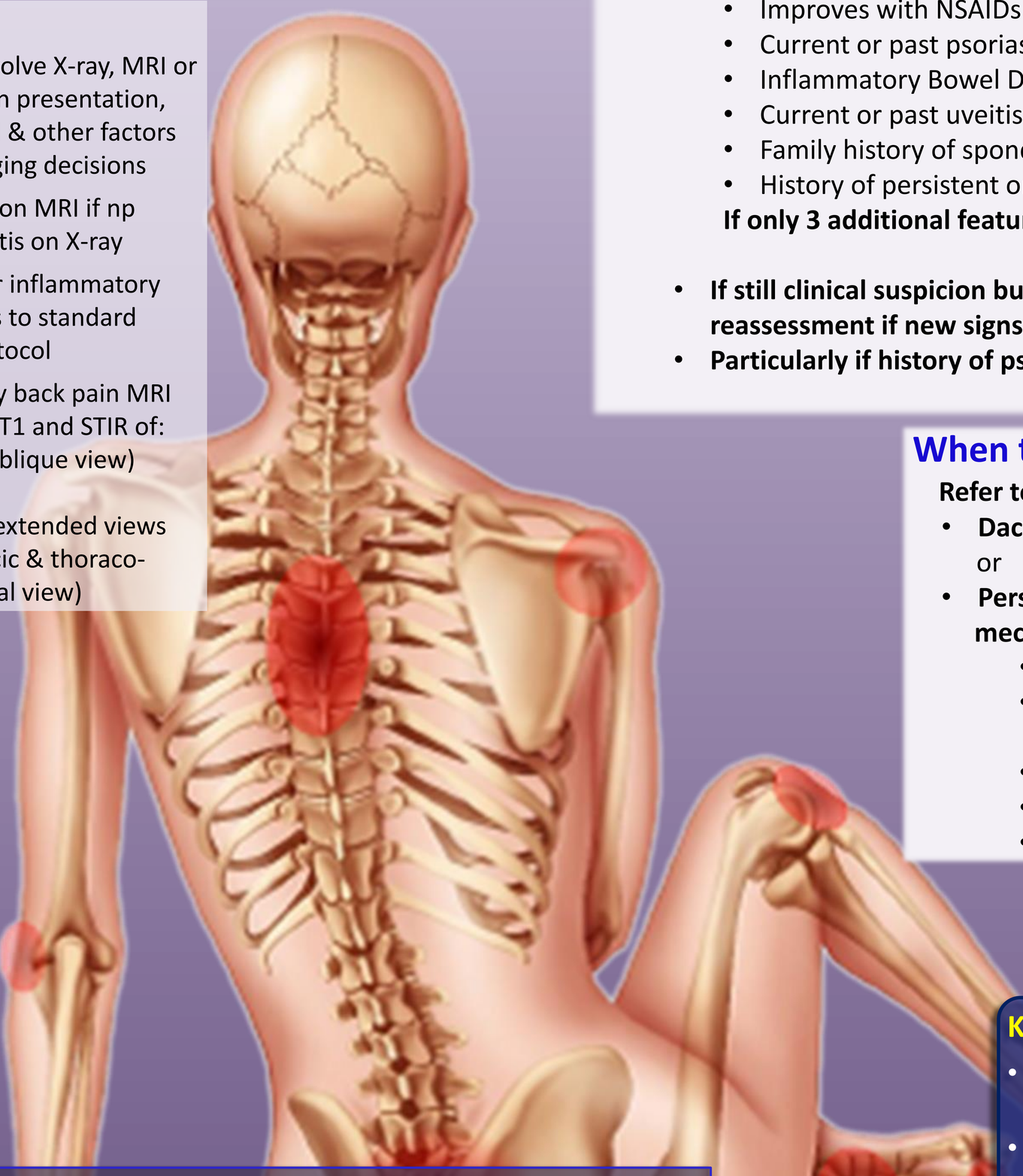
Inflammatory back pain features[2]:

- Insidious onset
- Onset before 45 years
- Buttock pain especially alternating sides
- Improvement with exercise & activity
- No improvement with rest
- Woken second half of night by back pain
- Good response to NSAIDs
- Prolonged morning stiffness > 30 min

Imaging

- Imaging may involve X-ray, MRI or US depending on presentation, regions involved & other factors influencing imaging decisions
- may be present on MRI if np findings sacroiliitis on X-ray
- MRI protocol for inflammatory back pain differs to standard lumbar MRI protocol
- An inflammatory back pain MRI should perform T1 and STIR of:
  - SIJs (coronal oblique view)

  &
  - Whole spine extended views cervico-thoracic & thoraco-lumbar (sagittal view)



When to suspect Axial Spondyloarthritis (axSpA)

Refer to rheumatology if a person presents with:

- Back pain > 3 mths with onset before 45 years of age

And if 4 or more additional features below:

- Onset before 35 years of age (increases suspicion)
- Woken second half of night by symptoms
- Improves with movement, not improved with rest
- Buttock pain
- Improves with NSAIDs (often within 48 hours)
- Current or past psoriasis or family history of psoriasis (parent/sibling)
- Inflammatory Bowel Disease- Crohn's Disease or Ulcerative colitis
- Current or past uveitis
- Family history of spondyloarthritis (AxSpA/AS, Psoriatic Arthritis)
- History of persistent or multiple enthesitis or joint pain/swelling

If only 3 additional features and if known to be HLA B27 positive – refer

- **If still clinical suspicion but insufficient features, advise the person to seek reassessment if new signs or symptoms develop**
- **Particularly if history of psoriasis, inflammatory bowel disease or uveitis**

When to suspect Peripheral Spondyloarthritis

Refer to rheumatology if a person presents with:

- **Dactylitis** (whole swollen digit- 'sausage' finger or toe) or
- **Persistent or multiple-site enthesitis without apparent mechanical cause and with other features, including:**
  - Features of inflammatory back pain
  - Current/past psoriasis, inflammatory bowel disease (Crohn's disease/ ulcerative colitis) or uveitis
  - Family history of SpA (parent, sibling)
  - Family history of psoriasis (parent, sibling)
  - Recent infection -GIT or genitourinary infection

Morning stiffness- prolonged morning stiffness (> 30 min) is suspicious of inflammatory disease

Key points about Spondyloarthritis:

- If persisting back, tendon or joint pain – always ask about psoriasis, inflammatory bowel disease, uveitis
- AxSpA affects women and men equally
- Inflammatory markers (ESR & CRP) can be normal
- Do not exclude possibility of SpA if HLA B27 –ve
- MRI for AxSpA differs from lumbar MRI protocol

Refereces and further resources

- 1. NICE guideline on Spondyloarthritis in over 16s (2017) www.nice.org.uk/guidance/ng65
- 2. www.asas-group.org/wp-content/uploads/2020/07/ASAS-handbook.pdf
- CSP website: www.csp.org.uk/frontline/article/spondyloarthritis-part-1
- National Axial Spondyloarthritis Society: https://nass.co.uk/
- AStretch: www.astretch.co.uk
- Spade Tool: www.spadetool.co.uk
- RCGP -free eLearning module: http://elearning.rcgp.org.uk/course/info.php?id=229
- McCrum C 2019 When to suspect Spondyloathritiss Musculoskeletal Scence & Pracctice
- McMillan et al. 2021 Masterclass: Axial Spondyloarthritiss. Int J of Osteopathic Medicine

This leaflet supports implementation of recommendations in the NICE guideline on Spondyloarthritis in over 16 (National Institute for Health and Care Excellence 2017)
Prepared by Dr Carol McCrum DPT, NICE Fellow, to raise awareness of NICE Guidelines on Spondyloarthritis [NG65] [resource v4_last revised 15/08/2023]

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