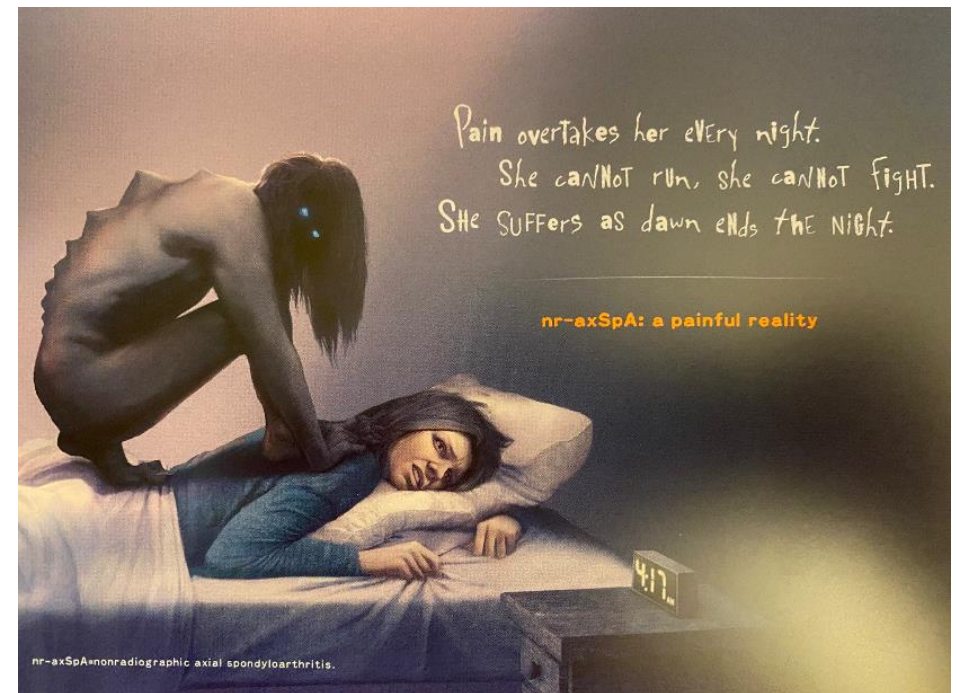


Spondylarthropathies et entités apparentées

Dr. Michael Nissen
Médecin adjoint agrégé
Service de Rhumatologie, HUG

mjni@hcuge.ch





Rachialgies : mécaniques vs. inflammatoires

■ Mécaniques

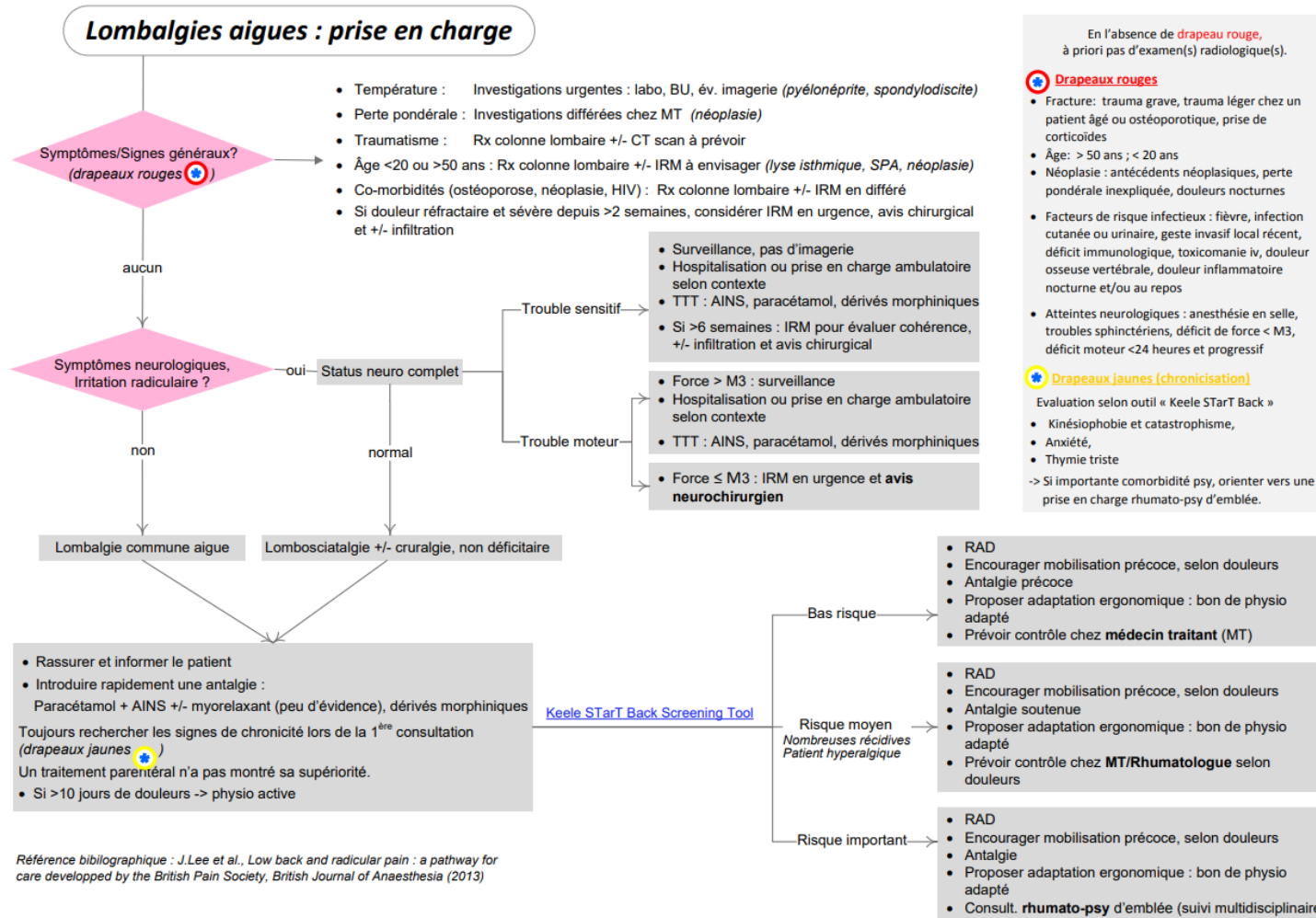
- Début brutal
- Pire en fin de journée
- Pire après activité
- Parfois nocturnes (mais avec mouvement)
- Pas ou peu de raideur matinale (<30 mins)
- AINS peu efficaces

■ Inflammatoires

- Symptômes généraux : fatigue, perte de poids, fièvre
- « Poussées » inflammatoires
- Raideur matinale (>30 mins)
- Soulagées par l'activité
- Rachialgies, souvent nocturnes (2^{ème} partie de nuit) et réveil nocturne «spontané»
- Douleurs du bassin (pseudo-sciatalgies) avec irradiations unilatérales, bilatérales, ou à bascule
- AINS souvent très efficaces

Lombalgies mécaniques vs. inflammatoires

Auteur: Dr Hervé Spechbach, Service de médecine de premier recours, HUG
 Expert: Dr S. Genevay, Service de rhumatologie, HUG
 Relecteur: Dr I. Guessous, Service de médecine de premier recours, HUG



Spondyloarthritides (SpA)

Ancien



- Spondyloarthrites
- Spondylarthropathies
- Spondyloarthritides
- « **SpA** »
- **Maladie de Bechterew**



Concept of Spondyloarthritides (SpA)

Nouveau

Non-radiographic
axial SpA

Ankylosing Spondylitis

Maladie de Bechterew =
spondylarthrite axiale «radiographique»

Predominantly Axial
SpA

Reactive arthritis

Psoriatic Arthritis

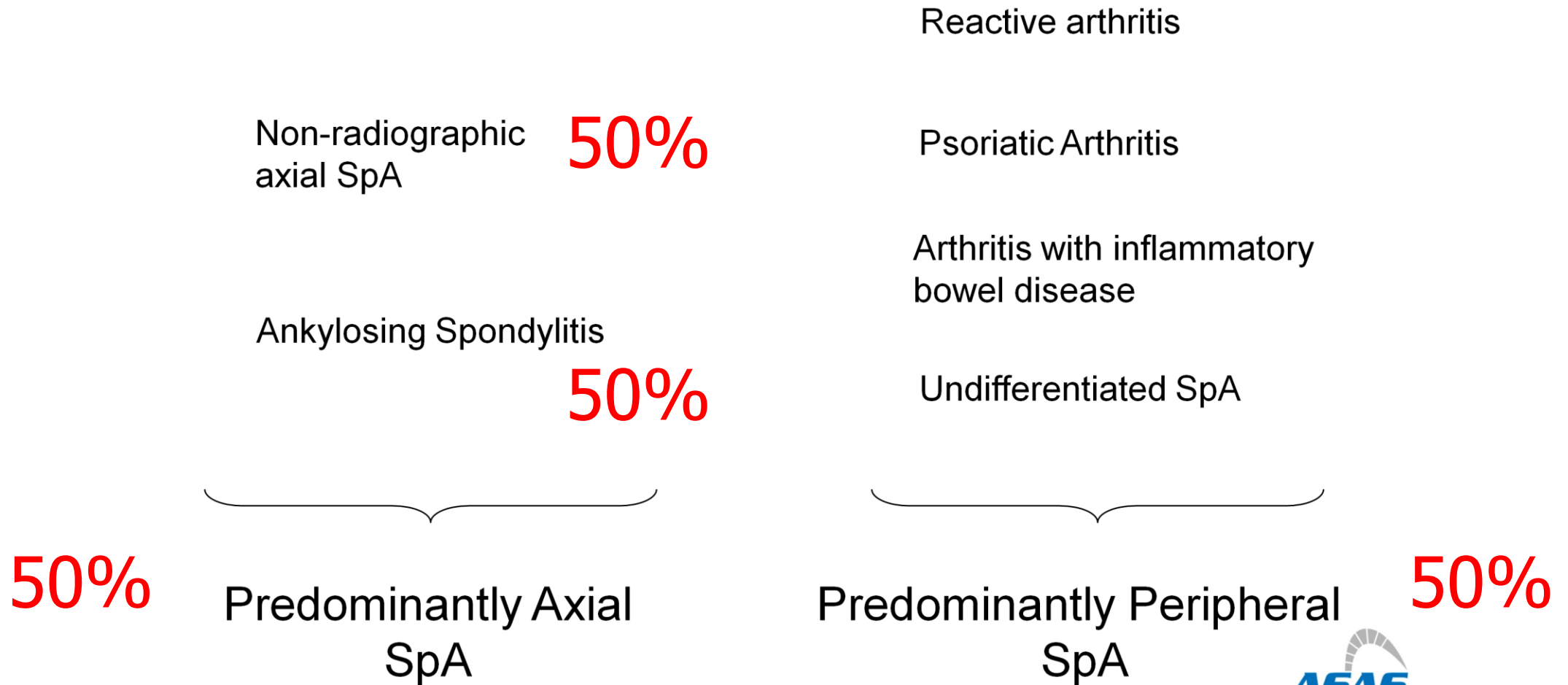
Arthritis with inflammatory
bowel disease

Undifferentiated SpA

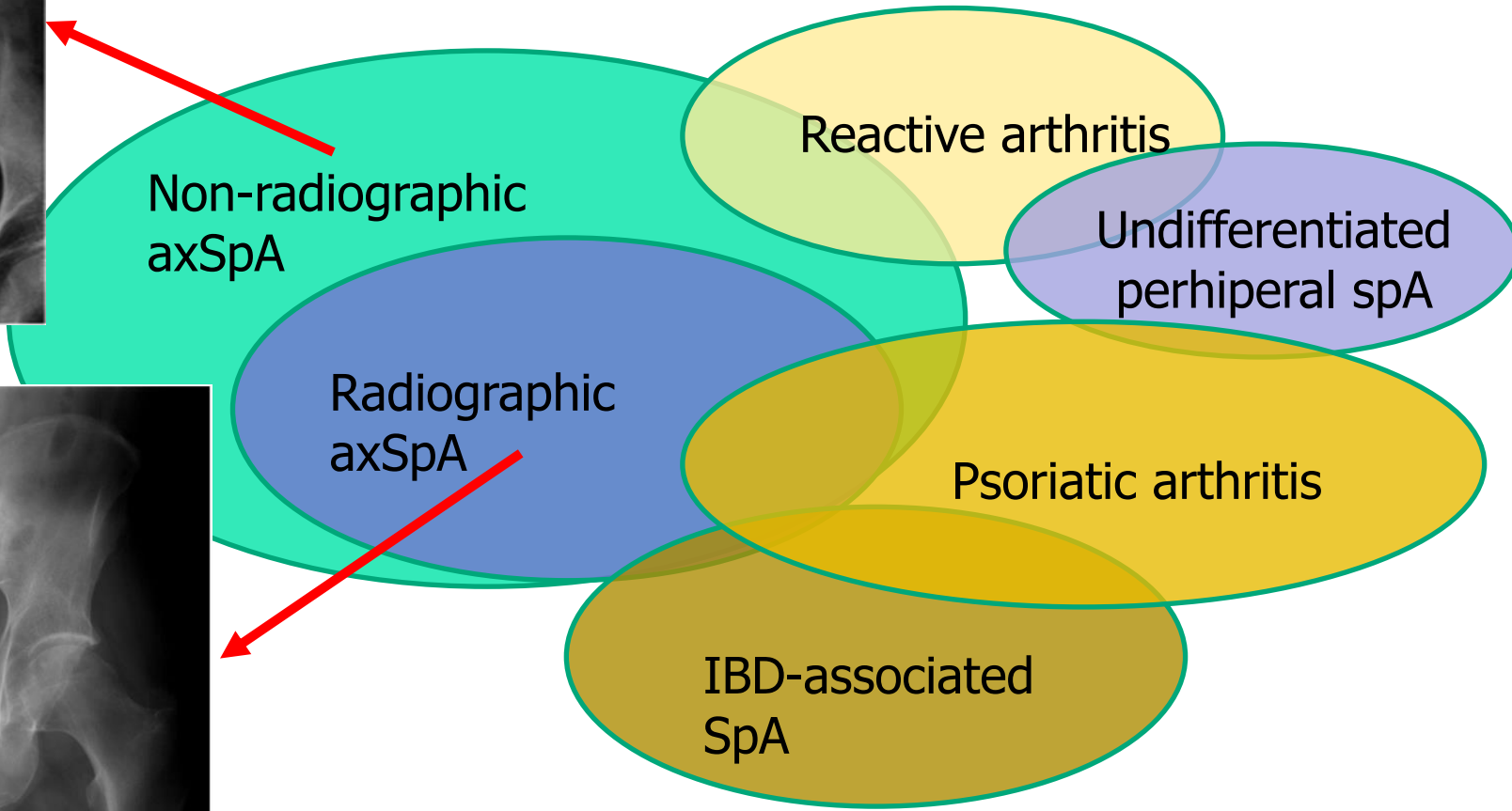
Predominantly Peripheral
SpA



Prévalence : 1 à 2%



Radiographic vs. nr-axSpA – does it matter ?



Axial Spondylarthritis

Peripheral Spondylarthritis

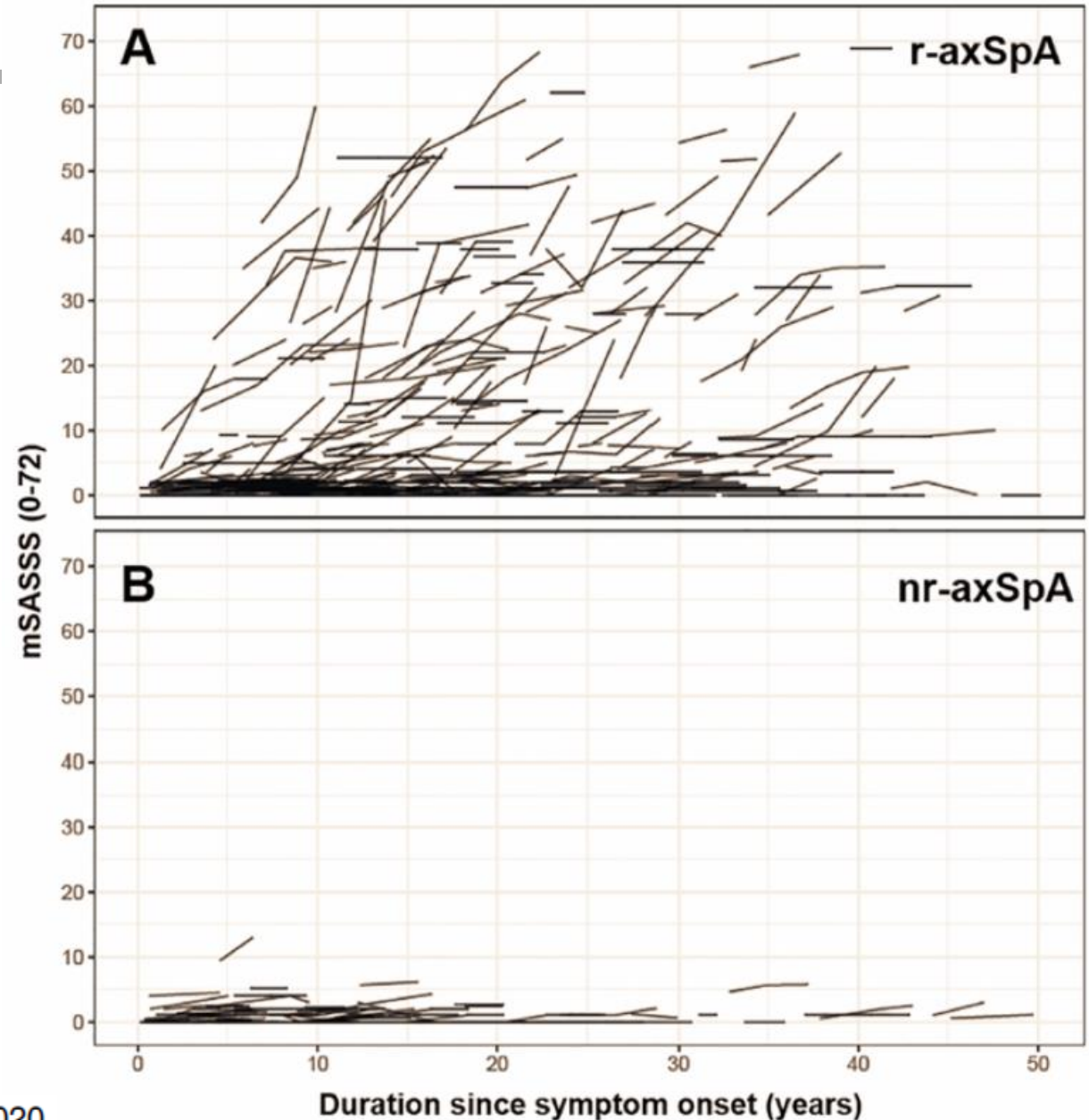
A certain dichotomy – but lots of overlap !

RESEARCH ARTICLE

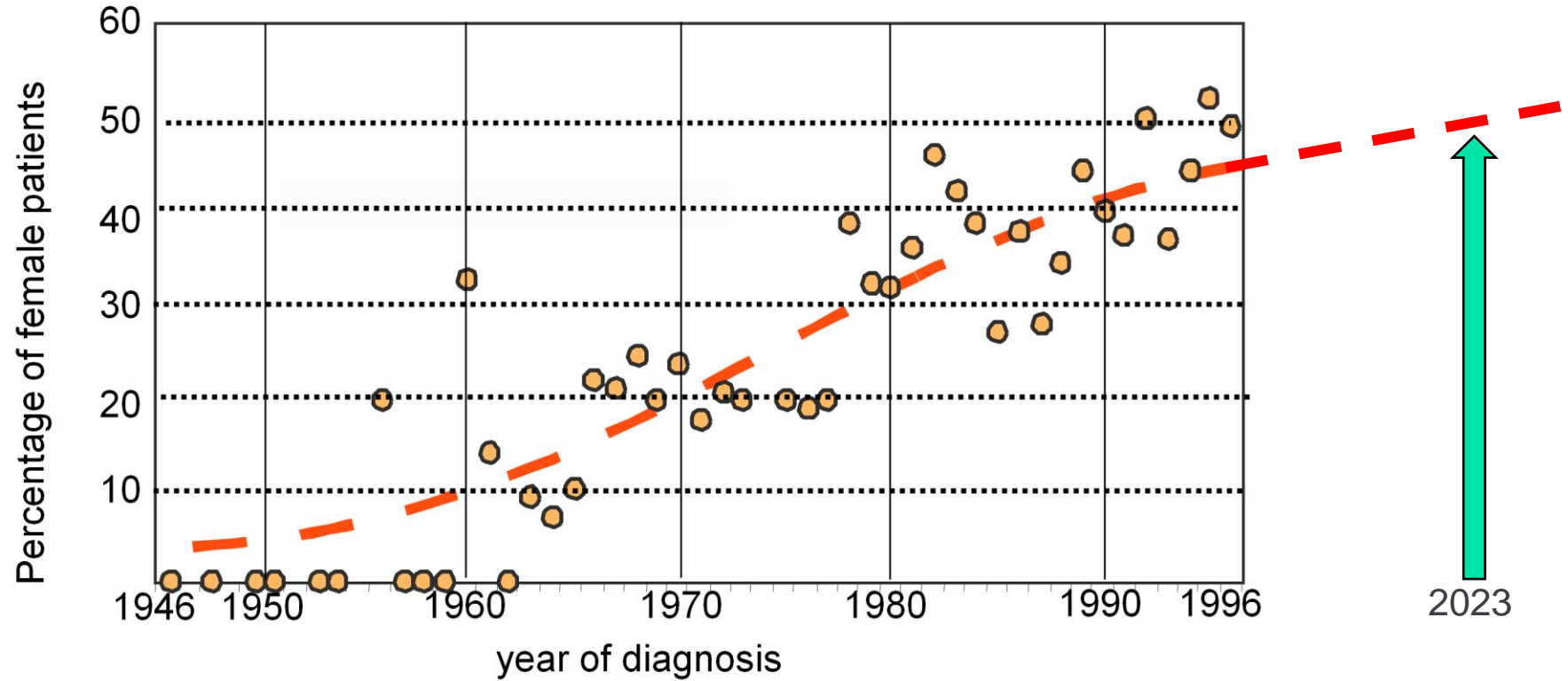
Spinal radiographic progression in axial spondyloarthritis and the impact of classification as nonradiographic versus radiographic disease: Data from the Swiss Clinical Quality Management cohort

Monika Hebeisen^{1,2}, Raphael Micheroli¹, Almut Scherer², Xenofon Baraliakos³, Manouk de Hooge^{4,5}, Désirée van der Heijde⁵, Robert Landewé^{6,7}, Kristina Bürki¹, Michael J. Nissen⁸, Burkhard Möller⁹, Pascal Zufferey¹⁰, Pascale Exer¹¹, Adrian Ciurea^{1*}

**Unadjusted mean (SD) change
in the mSASSS over a period of 2y:
nr-axSpA versus r-axSpA
0.16 (0.62) vs. 0.92 (2.78), $p=0.01$.**



Percentage of Female AS Patients is Dependent on Year of Diagnosis



In recent years, the gender ratio approached 1:1.

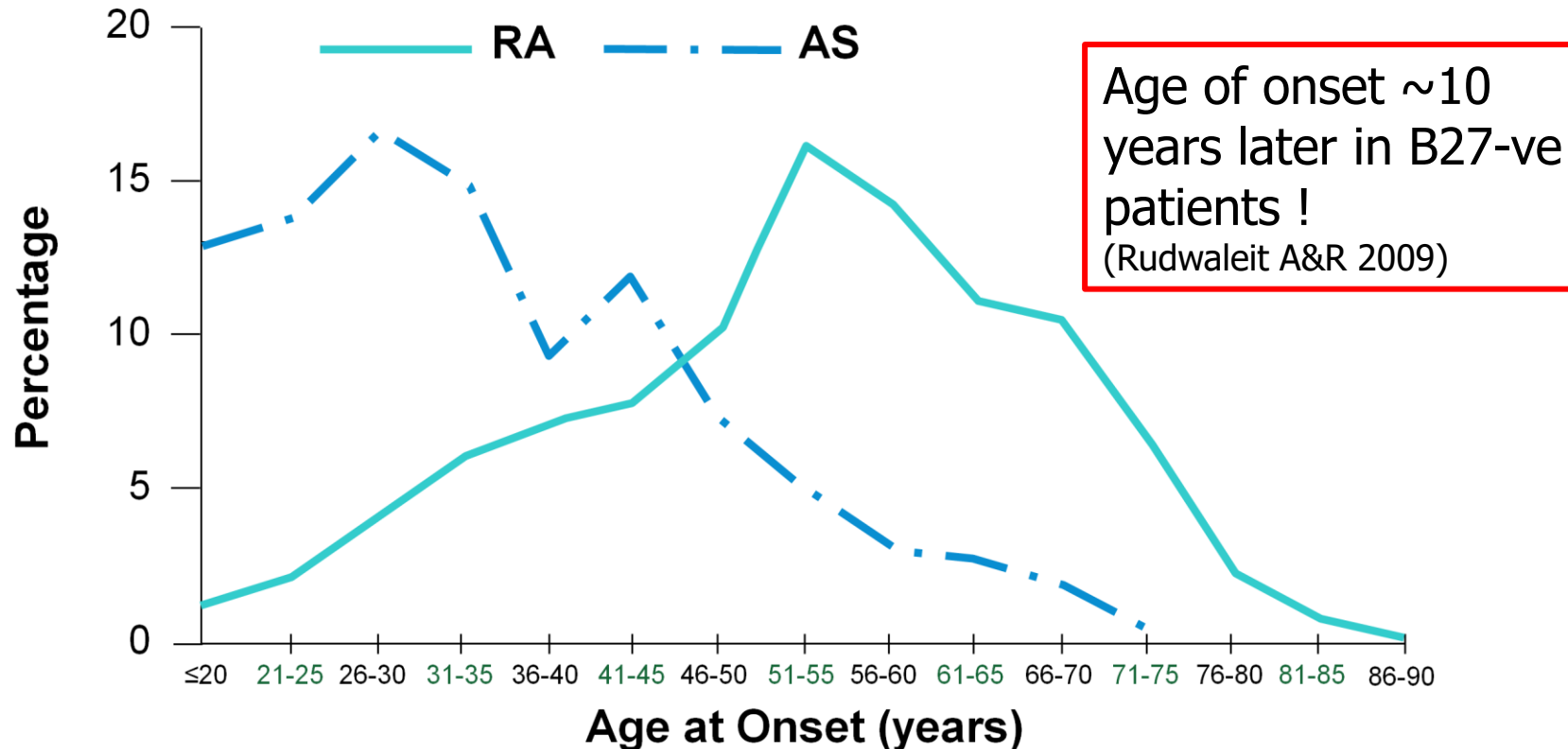
F > M si nr-axSpA !

Feldtkeller E. Aktuelle Rheumatologie 1998;23:176-81
Feldtkeller E et al. Curr Opin Rheumatol 2000;12:239-47



Axial SpA Usually Starts in the Third Decade of Life

- An onset after 45 years of age is exceptional.



Disease duration ≤5 years; data from 1993 to 1998, national database of the German Collaborative Arthritis Centres

Adapted from: Zink A et al. Ann Rheum Dis 2001;60:199-206 (with permission)

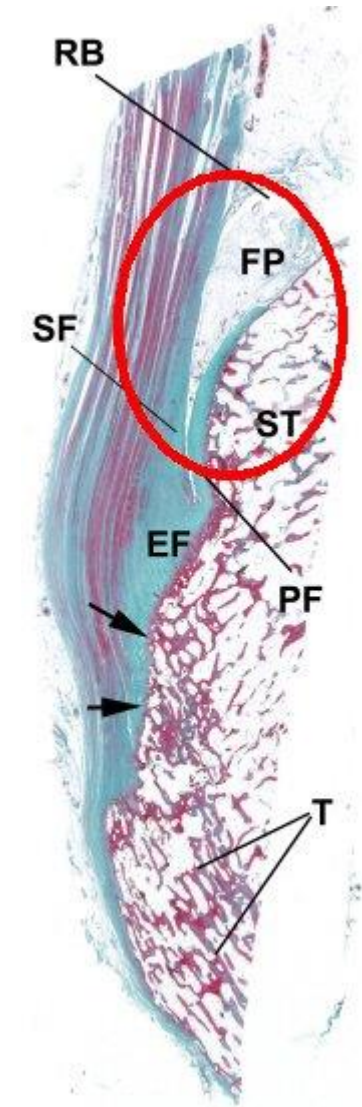


Pathogenèse = « enthésite »

Enthésite = inflammation d'une **enthèse**

Insertion sur l'os

- **D'un tendon**

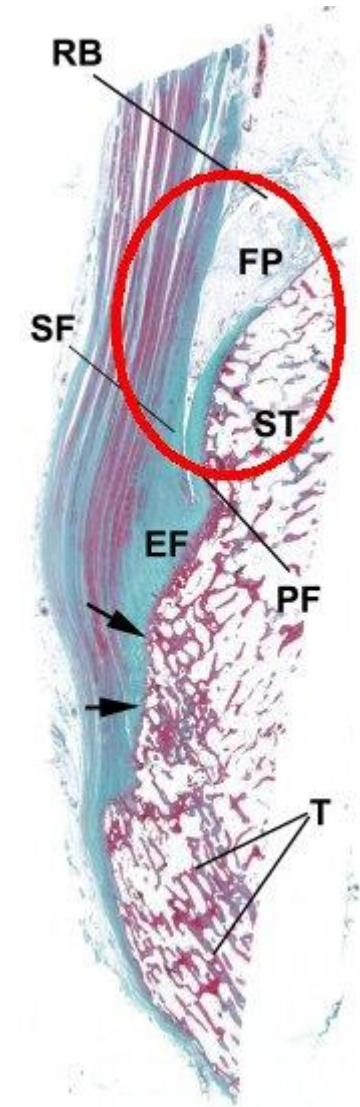
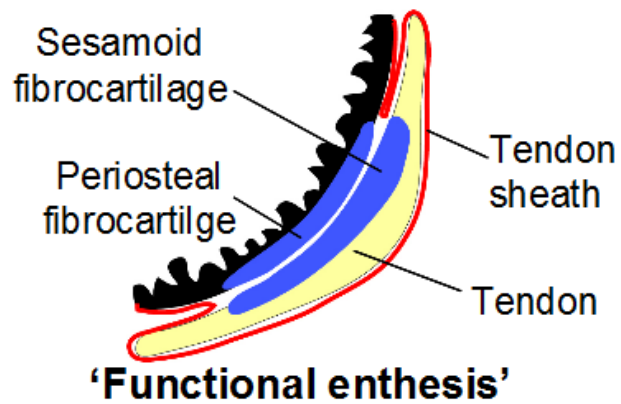


Enthésite

Enthésite = inflammation d'une **enthèse**

Insertion sur l'os

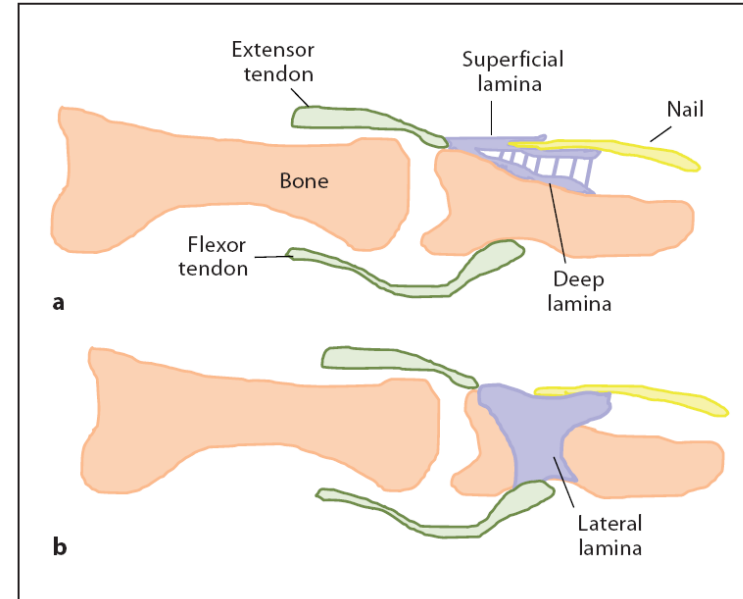
- D'un tendon
- D'un ligament



Enthésite

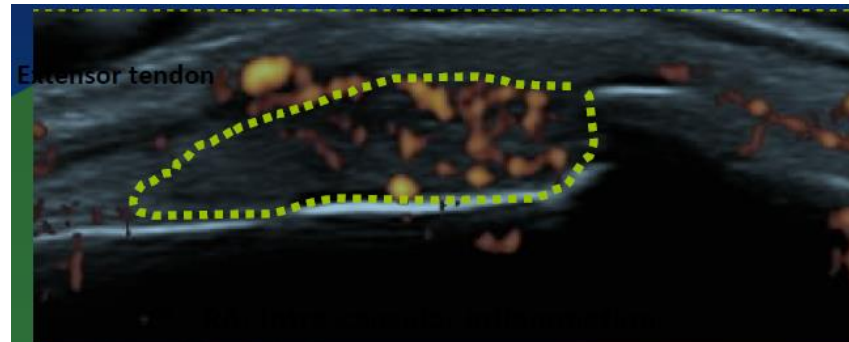
Insertion sur l'os

- D'un tendon
- D'un ligament
- De cartilage
- D'un ongle

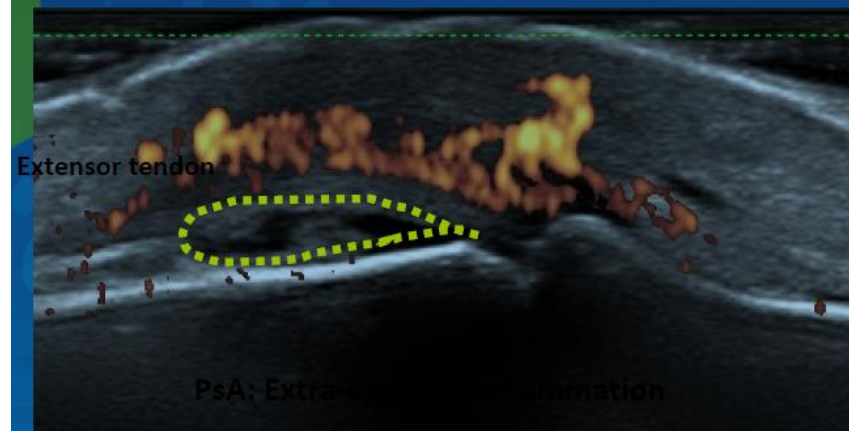


Synovitis VS. Extra-capsular inflammation

RA



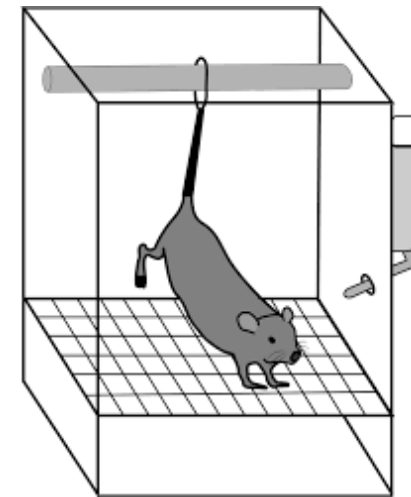
SpA



Enthésites

Favorisées par :

- **Stress mécaniques :**
 - Traumatismes
 - Microtraumatisme



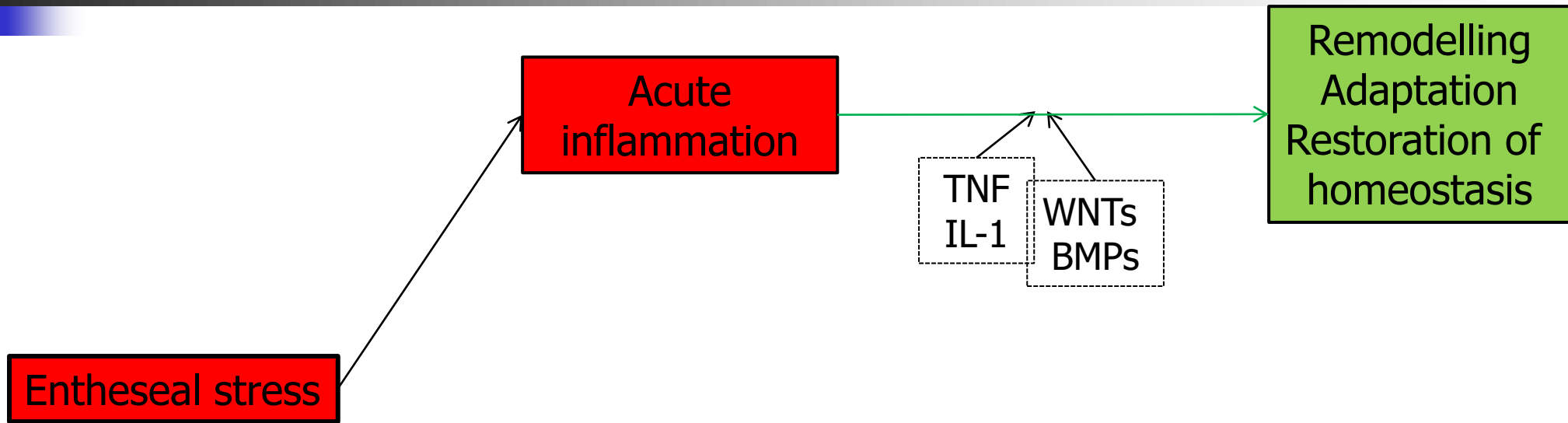
Enthésites

Favorisées par :

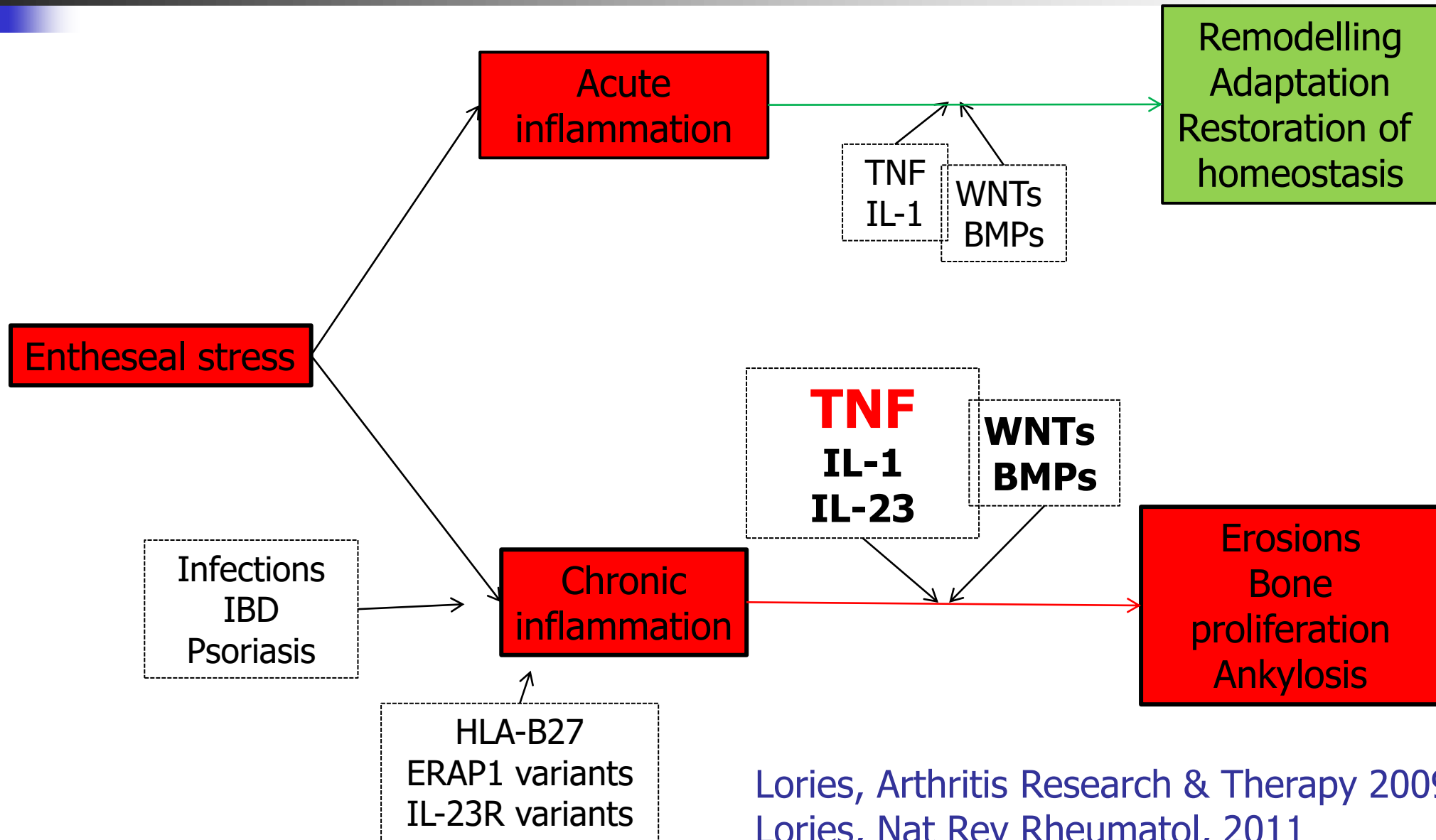
- Stress **mécaniques** :
 - Traumatismes
 - Microtraumatisme
- Stress **biologiques**
 - Infections
 - Chlamydiae, Salmonella, Shigella, Yersinia, Campylobacter
 - Autres
- Stress **psychiques**



Enthésite

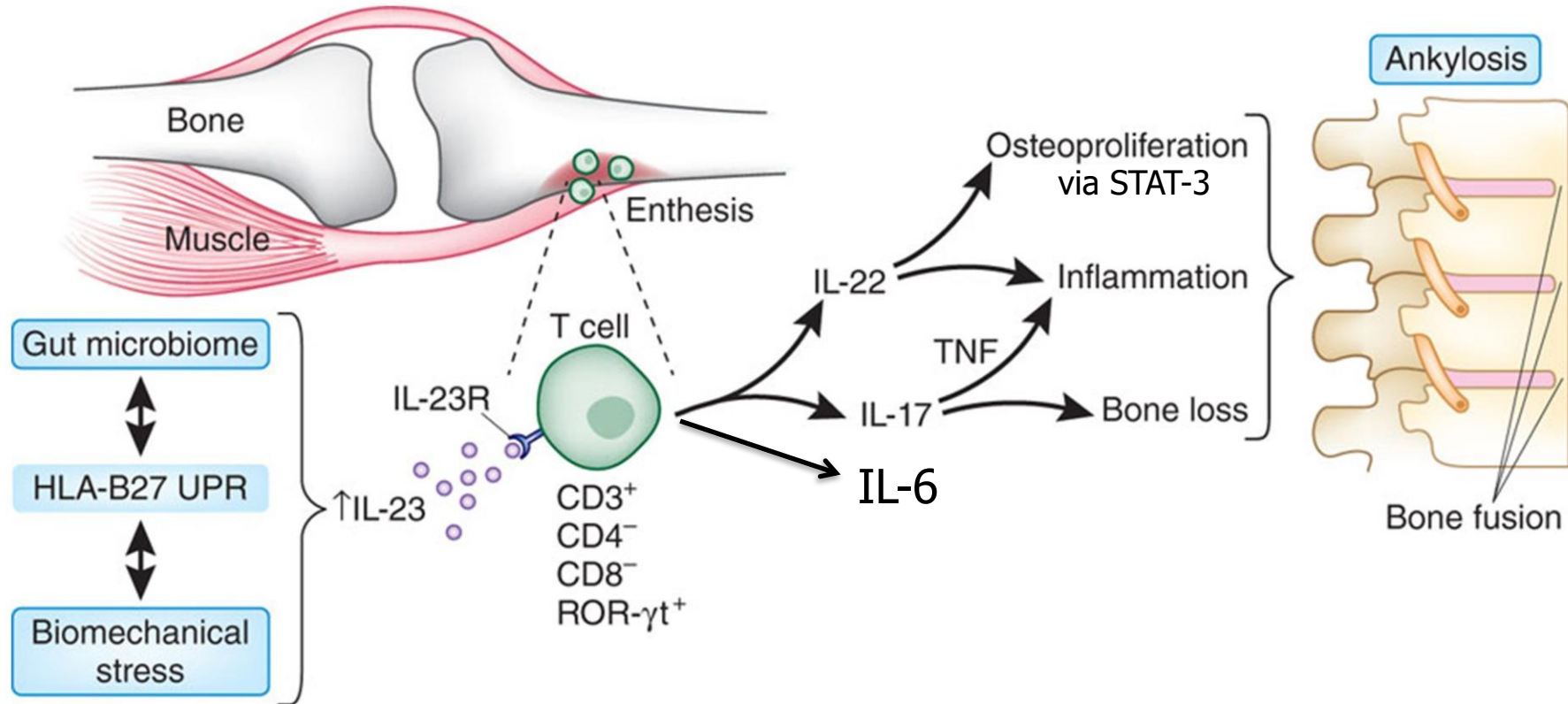


Enthésite



Lories, Arthritis Research & Therapy 2009
Lories, Nat Rev Rheumatol, 2011

IL-23 and entheseal-resident T cells promote enthesitis and osteoproliferation in spondyloarthritis



Sherlock JP Nat Med 2012

Lories RJ et al. Nat Med 2012;18:1018-9 (with permission)

ENTHESIS: site of resident immune surveillance?

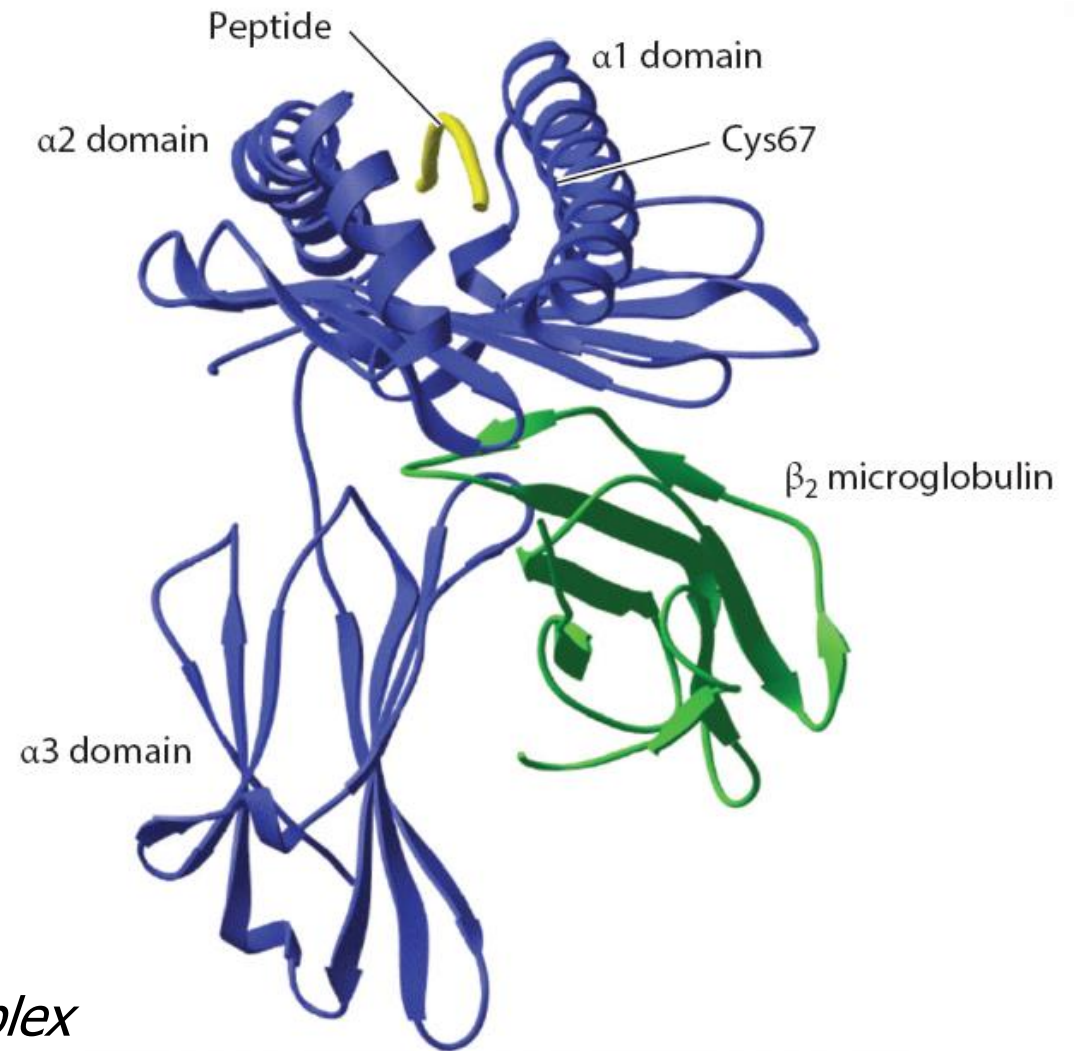
HLA-B27

L'antigène HLA-B27

- de surface de classe I
- codé par le locus B du MHC
- sur le chromosome 6.

HLA = *human leucocyte antigen*

MHC = *major histocompatibility complex*



HLA-B27

Disease	HLA-B27 approximate frequency (%)
Ankylosing spondylitis	94 (OR 171)
Reactive arthritis	30–75
Colitis-associated spondyloarthritis	33–75
Psoriatic spondyloarthritis	40–50
Juvenile enthesitis-related arthritis	76
Acute anterior uveitis	50
General population (CH)	7

Seulement 5% de la population HLA-B27+ → SpA



© Muhammad Asim Khan

Percentage Prevalence of HLA-B27 in Various Populations of the World



Khan MA Curr Opin Rheumatol 1995;7:263-9

Khan MA J Clin Rheumatol 2008;14:50-2

Khan MA. In Mehra N (Ed). The HLA Complex in Biology and Medicine. New Dehli, India 2010; 422-46.

Reveille J et al. Arthritis Rheum 2012;64:1407-11



Contribution to heritability of ankylosing spondylitis of confirmed susceptibility genes

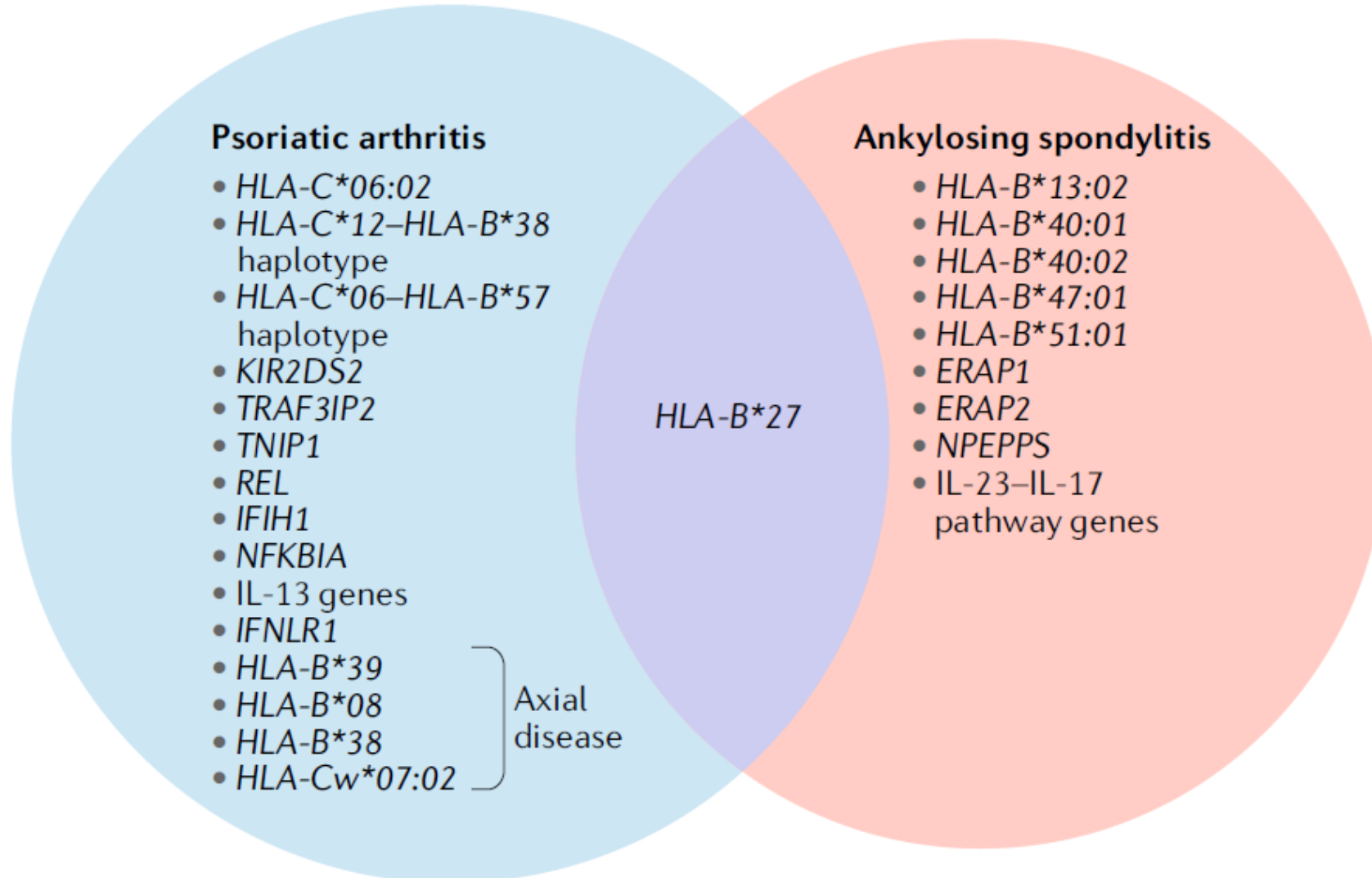


Gene name or chromosomal region	Most highly associated SNP	Odds ratio	Overall contribution to AS heritability (percent)
<i>HLA-B27</i>	rs4349859	90.4	23.3
<i>IL23R</i>	rs11209026	1.90	0.31
<i>LTBR-TNFRSF1A</i>	rs11616188	1.38	0.075
2p15	rs10865331	1.36	0.54
<i>ERAP1</i>	rs30187	1.35	0.34
<i>KIF21B</i>	rs2297909	1.25	0.25
21q22	rs378108	1.25	0.035
<i>TBKBP1</i>	rs8070463	1.24	0.054
<i>ANTXR2</i>	rs4389526	1.21	0.054
<i>PTGER4</i>	rs10440635	1.20	0.052
<i>RUNX3</i>	rs11249215	1.19	0.12
<i>IL12B</i>	rs6556416	1.18	0.11
<i>CARD9</i>	rs10781500	1.18	0.034
<i>IL1R2</i>	rs2310173	1.18	0.12
Total:			25.39

MHC-related

Non-MHC related

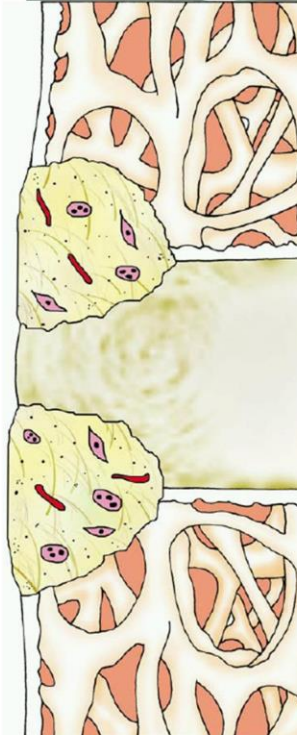
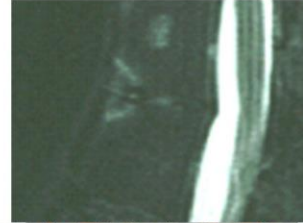
Genetics



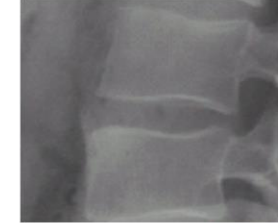
Proposed Sequence of Structural Damage in Ankylosing Spondylitis



Inflammation



Erosive damage
Repair



New bone formation

Symptômes cliniques

(souvent vagues dans la phase initiale)

- Symptômes généraux
 - Fatigue, perte de poids, parfois fièvre
- « Poussées » inflammatoires
- Raideur matinale (> 30 mins)
- Rachialgies, souvent nocturnes (fin de nuit)
 - Lombaires, cervicales ou dorsales
- Douleurs du bassin (pseudo-sciatalgies) avec irradiations unilatérales, bilatérales, ou à bascule
- Douleurs périphériques - talalgies (enthésites) ou arthrites périphériques
- Douleurs de la paroi thoraciques antérieur



Rachialgies «inflammatoires»

Table 2. Characteristics of Inflammatory Back Pain.*

Characteristic

Age at onset, <45 yr

Duration, >3 mo

Insidious onset

Morning stiffness >30 min

Improvement with exercise

No improvement with rest

Awaking from pain, especially during second half of night, with improvement on arising

Alternating buttock pain

* The presence of two or more of these features should arouse suspicion for inflammatory back pain, and the presence of four or more features can be considered diagnostic. The sensitivity of inflammatory back pain for the diagnosis of axial spondyloarthritis is 70 to 80%. The specificity varies, depending on the population being studied.^{8,9}

SpA : clinical manifestations

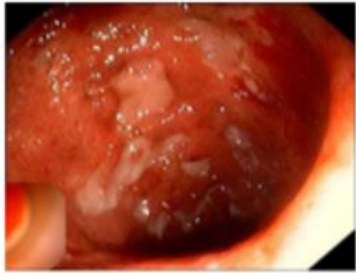


Acute anterior uveitis

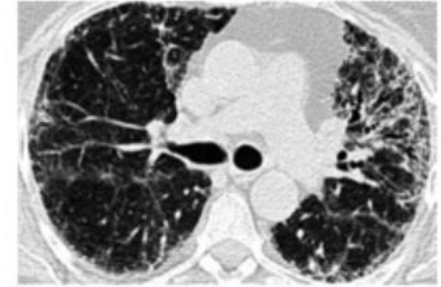
Fibromyalgia
Anxiety
Depression



Psoriasis



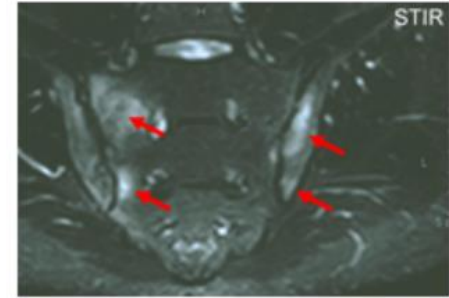
Colitis (Crohn's, UC)



Lung disease
(ex: fibrosis)



Peripheral arthritis



Inflammatory axial disease



Dactylitis



Enthesitis

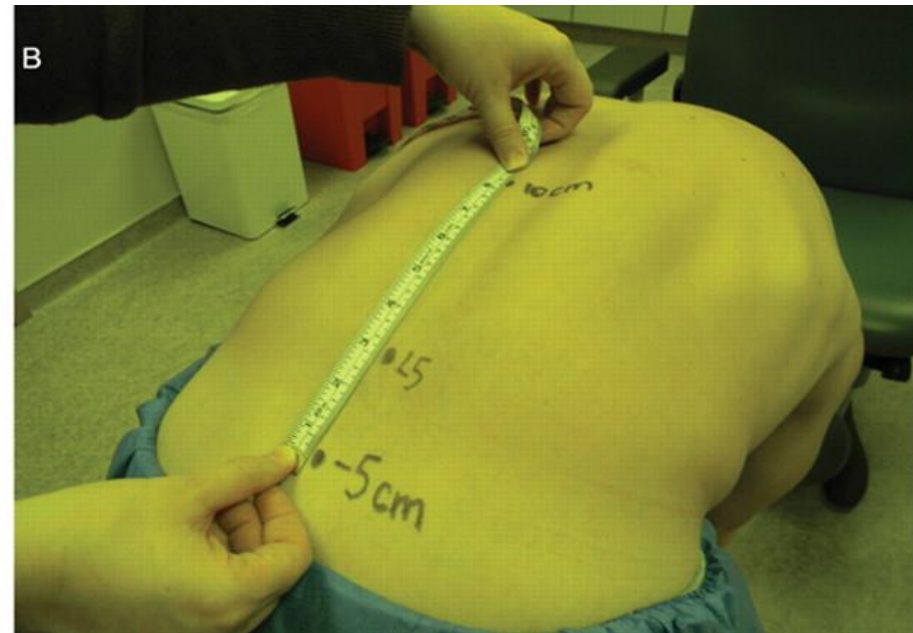
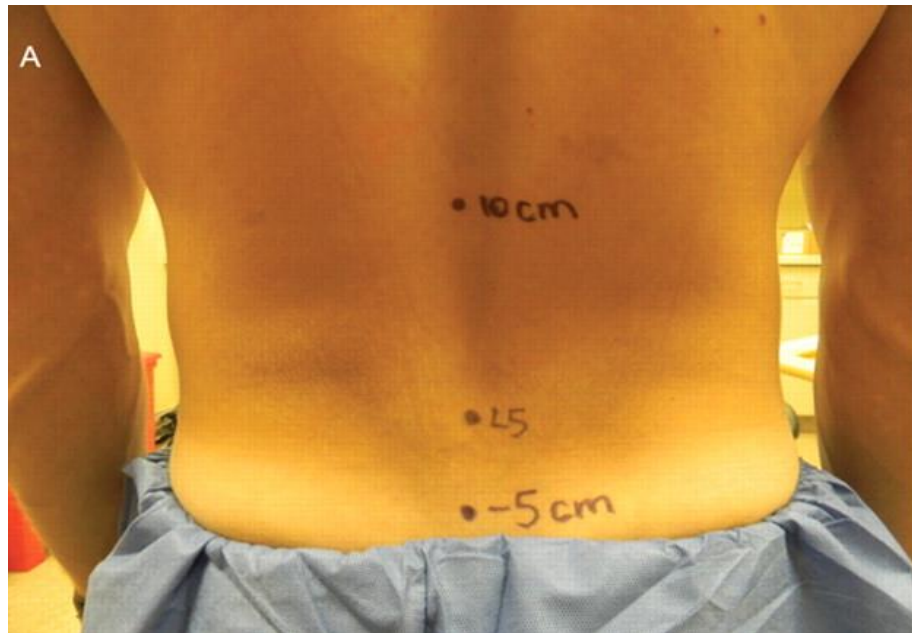
Signes cliniques

(souvent vagues dans la phase initiale)

- Diminution de la mobilité du rachis
 - Lombaire >> thoracique ou cervical
- Palpation des enthèses sensible +/- tuméfaction
- Articulations périphériques sensible +/- synovite
- Dactylites
- Psoriasis cutané
- Œil rouge (uvéite)
- Douleur abdominale (colite)

Test de Schober :

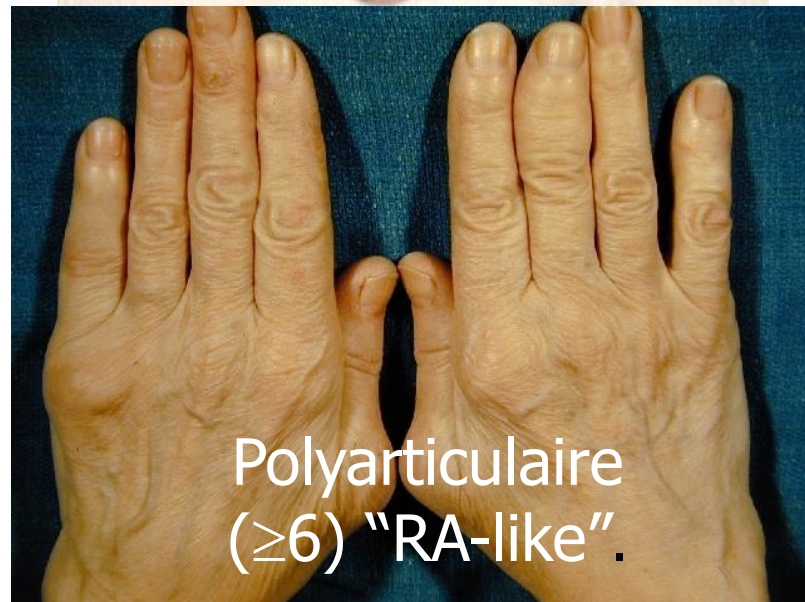
L4-L5 → 10 cm au-dessus, 5 cm en dessous



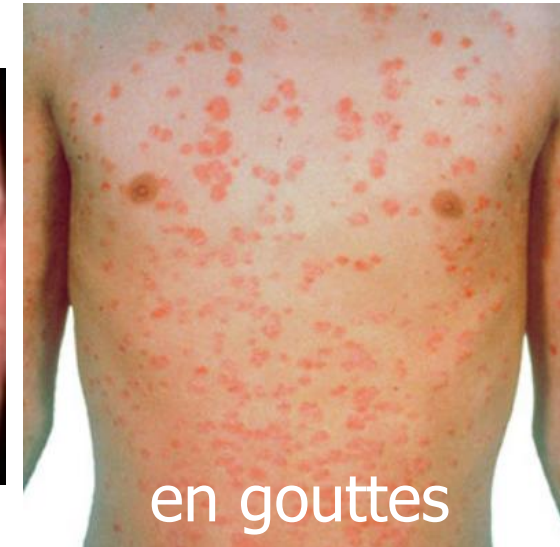
Schober lombaire

Augmentation normalement >5cm

Atteinte articulaire

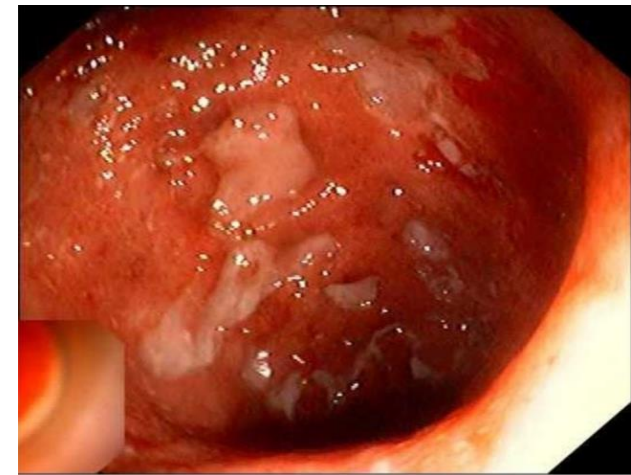


Atteinte cutanée

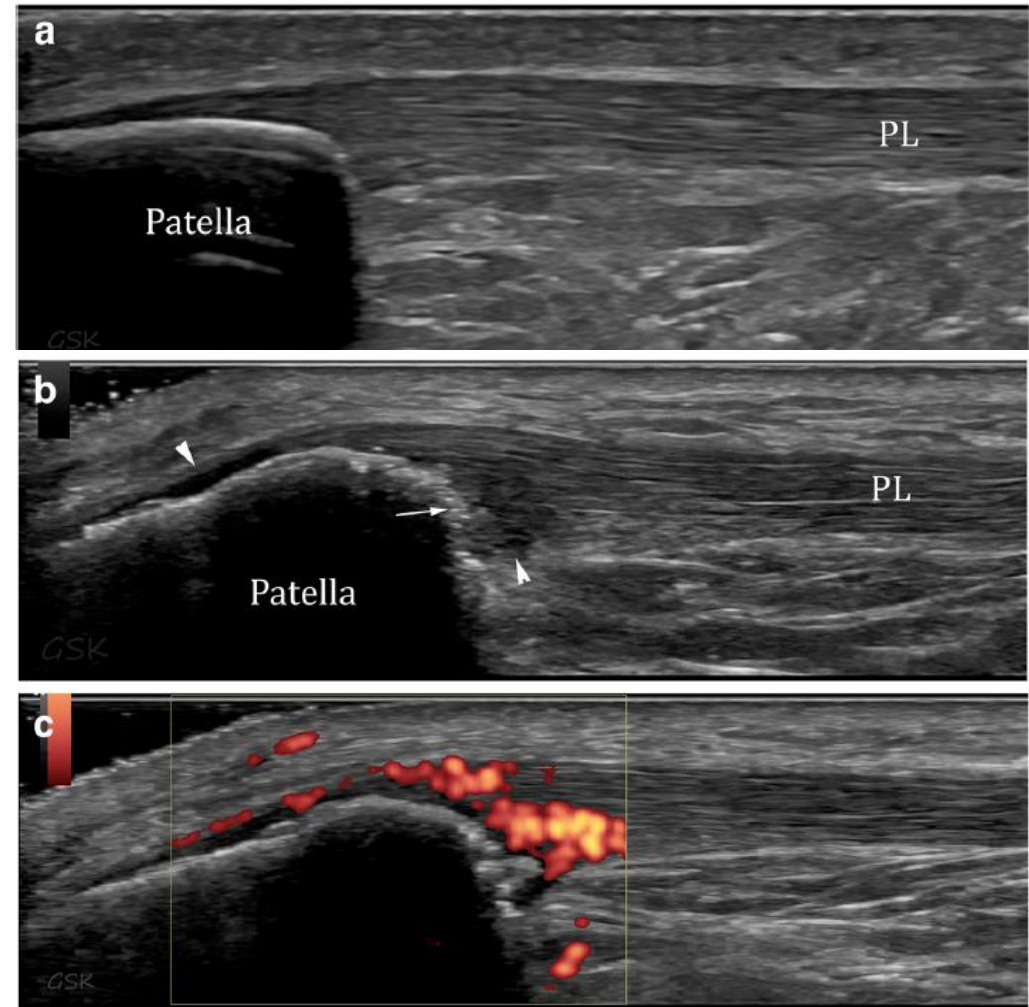
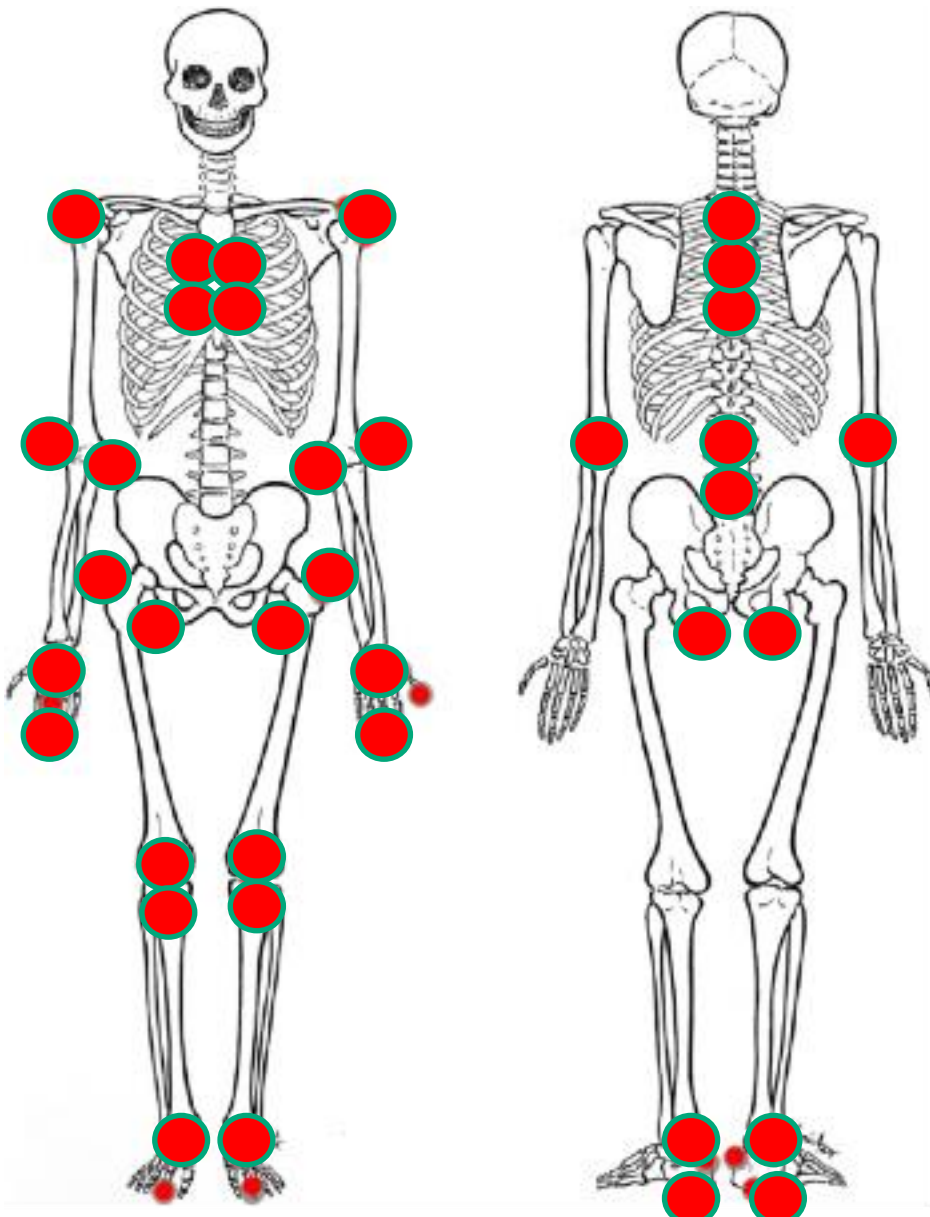


Manifestations extra-articulaires

- Psoriasis (+ ongles)
- Enthésite (+/- tendinite)
- Dactylite
- Uvéite (antérieure, aiguë, unilat)
- Colite (Crohn, RCUH)



Enthésites - enthésopathies

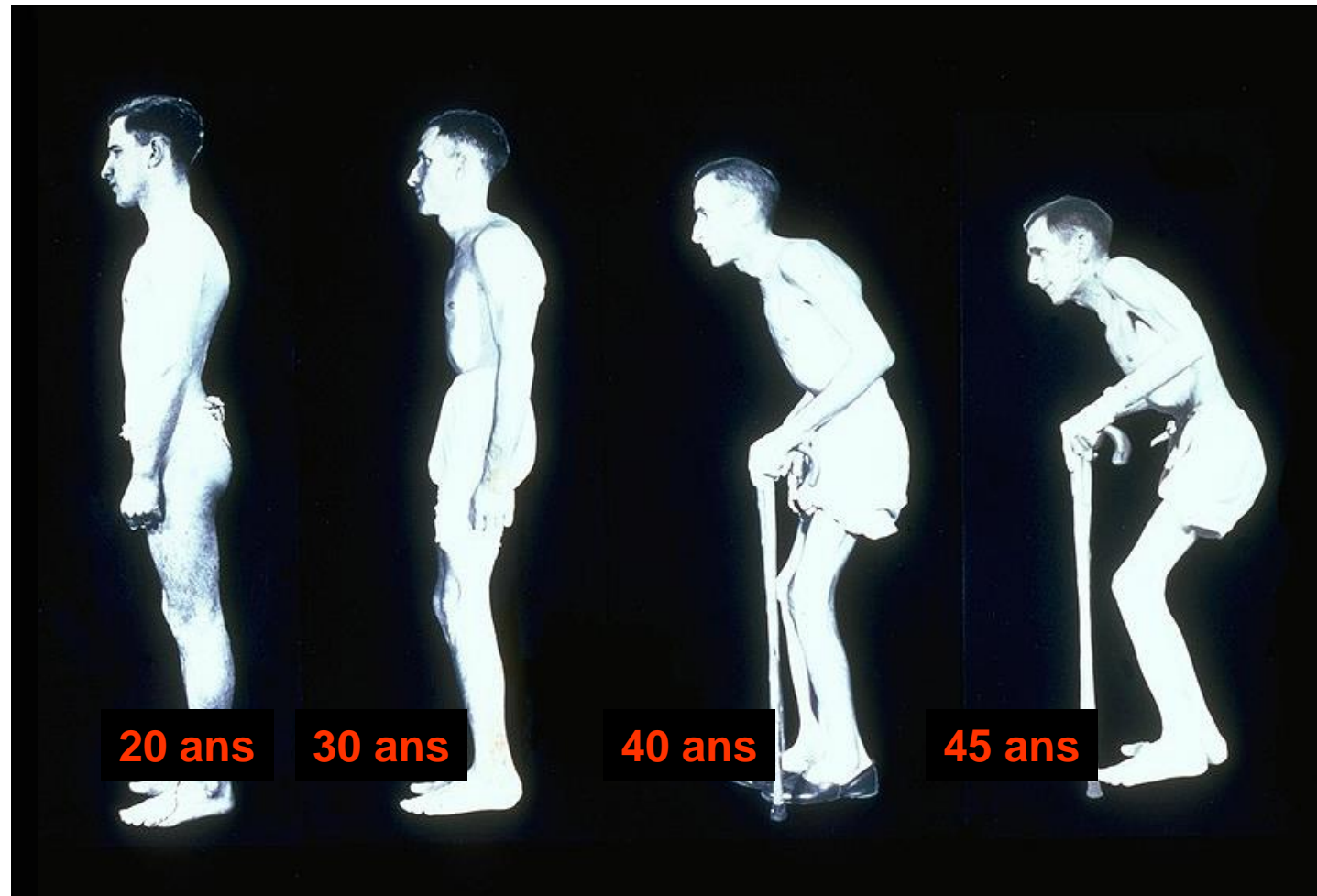


Slobodin G, Sem Arthritis Rheum 2007;
Balint PV, ARD 2018; Kaeley, GS, 2020

Enthésites - enthésopathies

Table 1 Various Medical Disorders Manifesting with Enthesopathy		
Rheumatic Disorders	Metabolic and Endocrine Disorders	Drug-Induced
Spondyloarthropathies	Hyperparathyroidism	Fluoride and fluoroquinolones
Rheumatoid arthritis	Hypoparathyroidism	Glucocorticosteroids
Chondrocalcinosis	X-linked hypophosphatemia	Retinoids
Osteoarthritis	Hypothyroidism	
DISH	Acromegaly	
SAPHO	Hemochromatosis	
	Ochronosis	
	Familial hypercholesterolemia	
	Diabetes mellitus	
	Chronic renal failure	

Evolution de la spondylarthrite ankylosante



Symptômes et signes cliniques - phase avancée

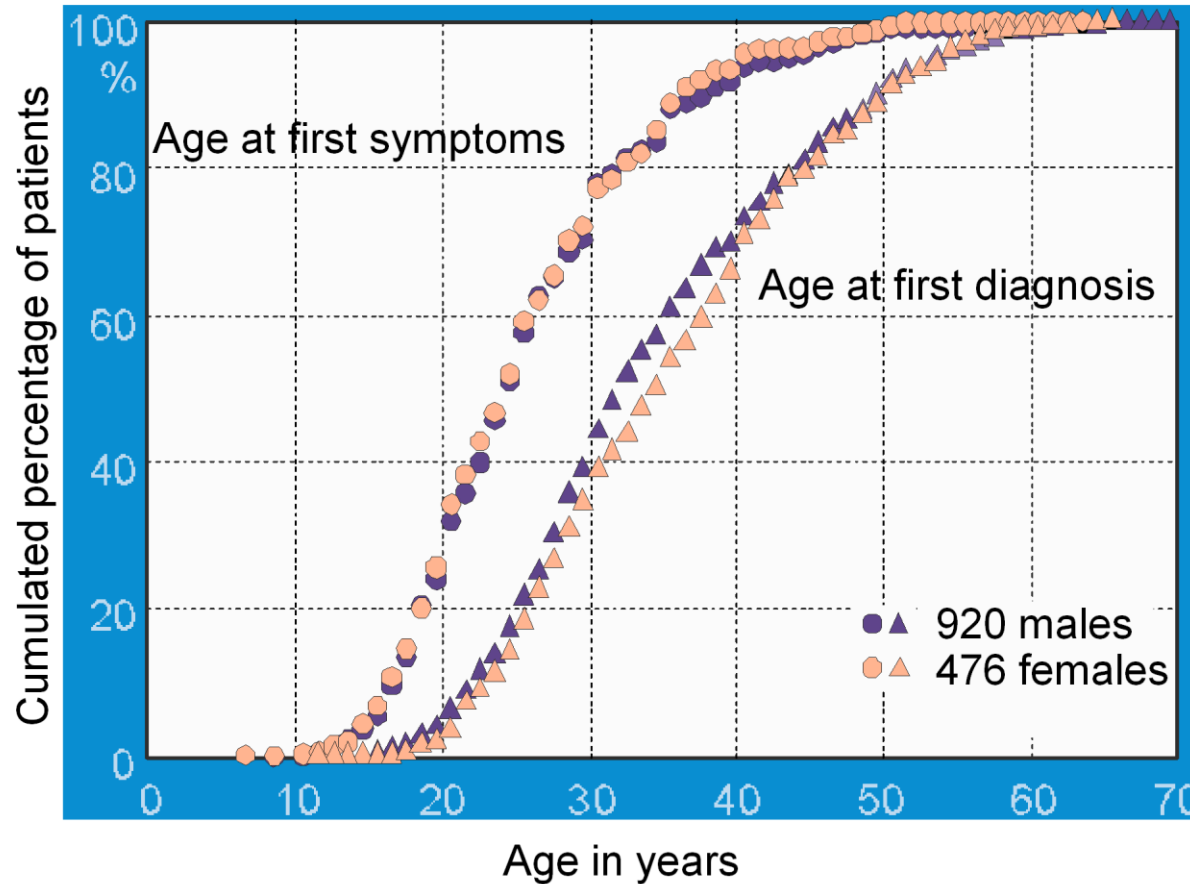
- Persistance / augmentation des douleurs
- ↓ de la mobilité globale du rachis
- Cyphose dorsale +++
- Délordose lombaire
- Délordose cervicale
- Hyperlordose cranio-cervicale
- Flexum de hanches et genoux
- Diminution de l'expansion thoracique
 - Respiration abdominale
 - Protrusion musculature abdominale





Diagnostic

Age at First Symptoms and at First Diagnosis in Ankylosing Spondylitis Patients



Average delay in diagnosis: 9 years



Délai = ~4 ans

Problème !



Modified New York Criteria for Ankylosing Spondylitis (1984)

1. Clinical criteria:

a. Low back pain and stiffness for more than 3 months which improves with exercise, but is not relieved by rest.

b. Limitation of motion of the lumbar spine in both the sagittal and frontal planes.

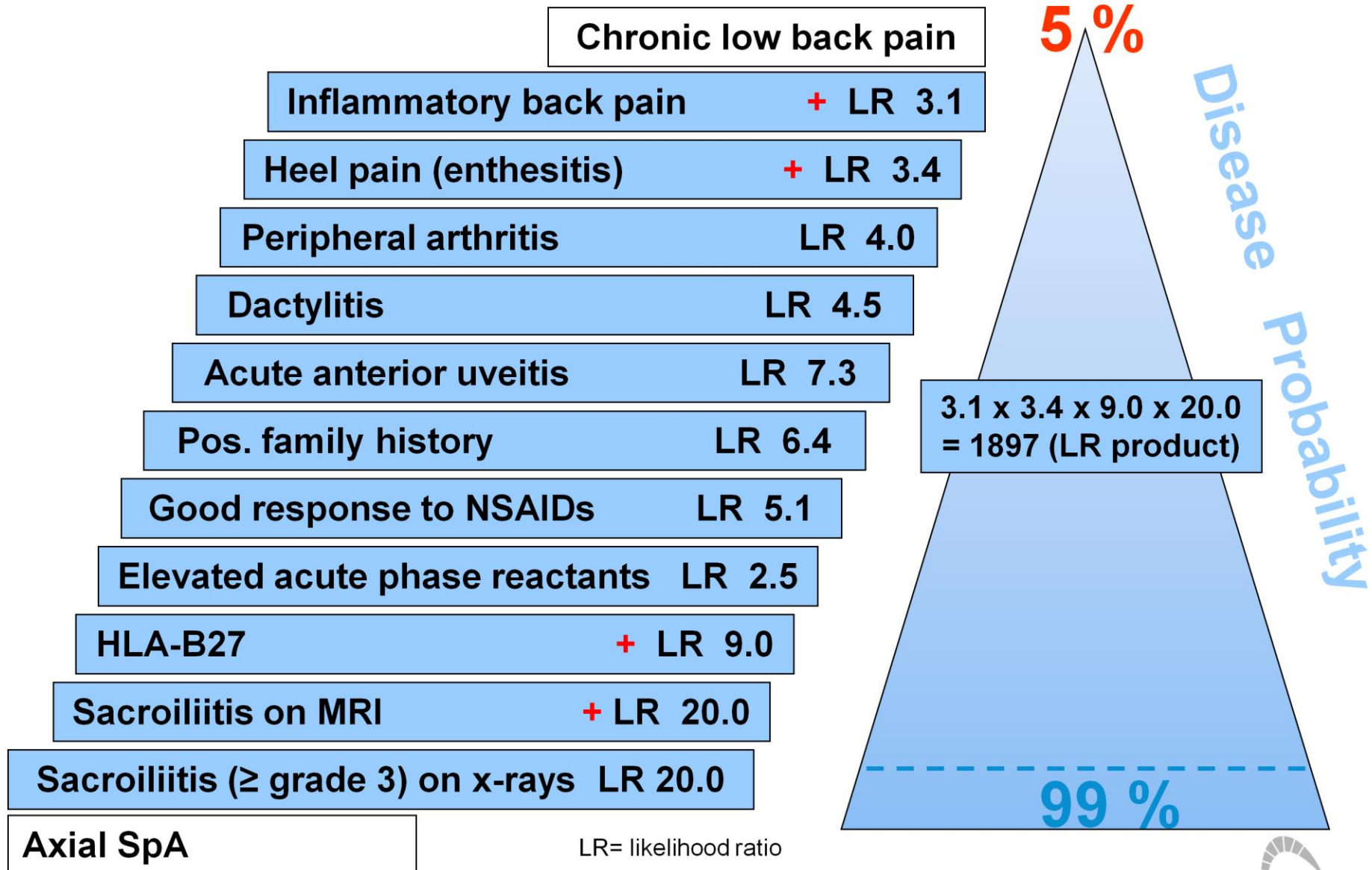
c. Limitation of chest expansion relative to normal values correlated for age and sex.

2. Radiological criterion:

Sacroiliitis grade ≥ 2 bilaterally or grade 3-4 unilaterally

Definite ankylosing spondylitis if the radiological criterion is associated with at least 1 clinical criterion.

Diagnostic Pyramid for Axial Spondyloarthritis



Modified from: Rudwaleit M et al. Arthritis Rheum 2005;52:1000-8



ASAS Classification Criteria for Axial Spondyloarthritis (SpA)

In patients with ≥ 3 months back pain and age at onset < 45 years

Sacroiliitis on imaging*
plus
 ≥ 1 SpA feature

OR

HLA-B27
plus
 ≥ 2 other SpA features

- *Sacroiliitis on imaging**
- active (acute) inflammation on MRI highly suggestive of sacroiliitis associated with SpA
 - definite radiographic sacroiliitis according to the modified New York criteria

SpA features:

- inflammatory back pain
- arthritis
- enthesitis (heel)
- uveitis
- dactylitis
- psoriasis
- Crohn's/colitis
- good response to NSAIDs
- family history for SpA
- HLA-B27
- elevated CRP

n=649 patients with back pain;

Overall

Sensitivity: 82.9%, Specificity: 84.4%

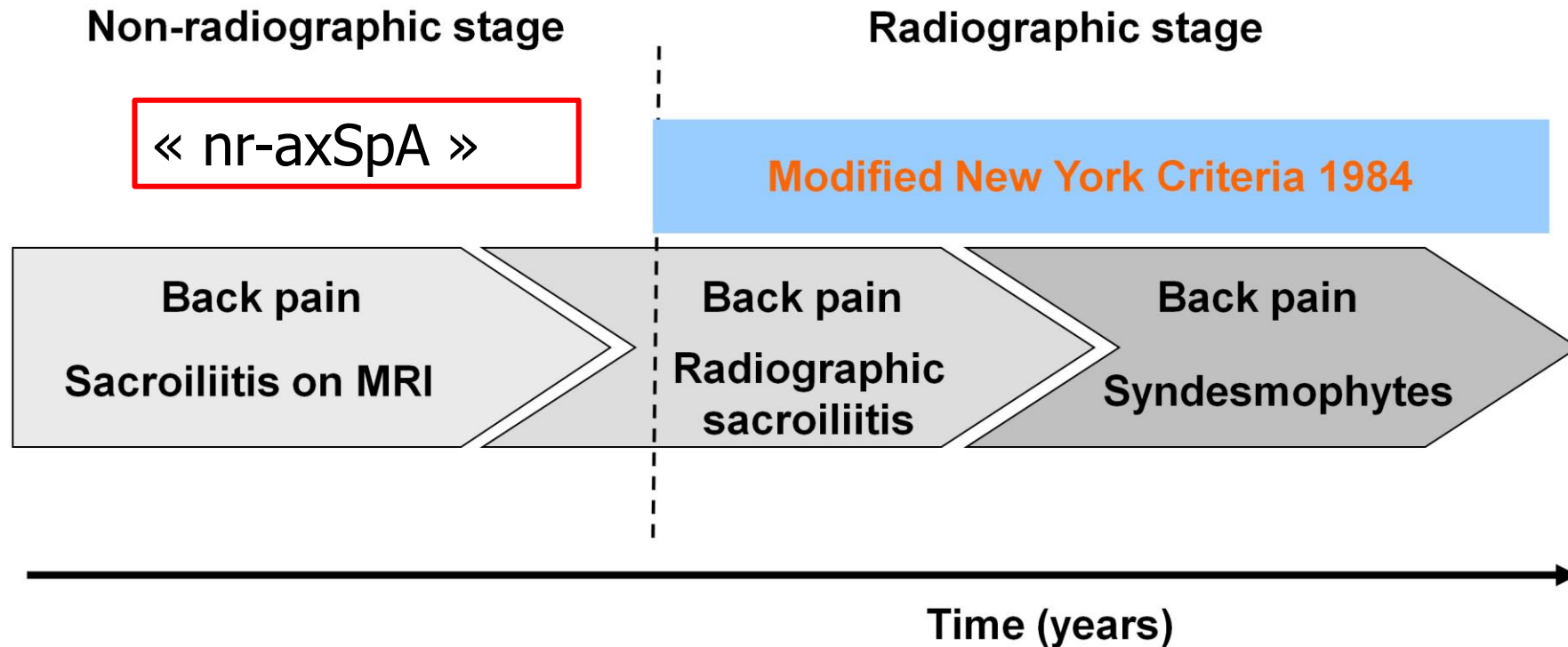
Imaging arm alone

Sensitivity: 66.2%, Specificity: 97.3%

Clinical arm alone

Sensitivity: 56.6%, Specificity: 83.3%

Axial Spondyloarthritis



Mean progression nr-axSpA → AS ~5% per year



ASAS Classification Criteria for Peripheral Spondyloarthritis (SpA)

**Arthritis or enthesitis or dactylitis
plus**

≥ 1 SpA feature

- uveitis
- psoriasis
- Crohn's/colitis
- preceding infection
- HLA-B27
- sacroiliitis on imaging

OR

≥ 2 other SpA features

- arthritis
- enthesitis
- dactylitis
- IBP (ever)
- family history for SpA

Peripheral arthritis: usually predominantly lower limbs and/or asymmetric arthritis
Enthesitis: clinically assessed
Dactylitis: clinically assessed

IBP: Inflammatory back pain

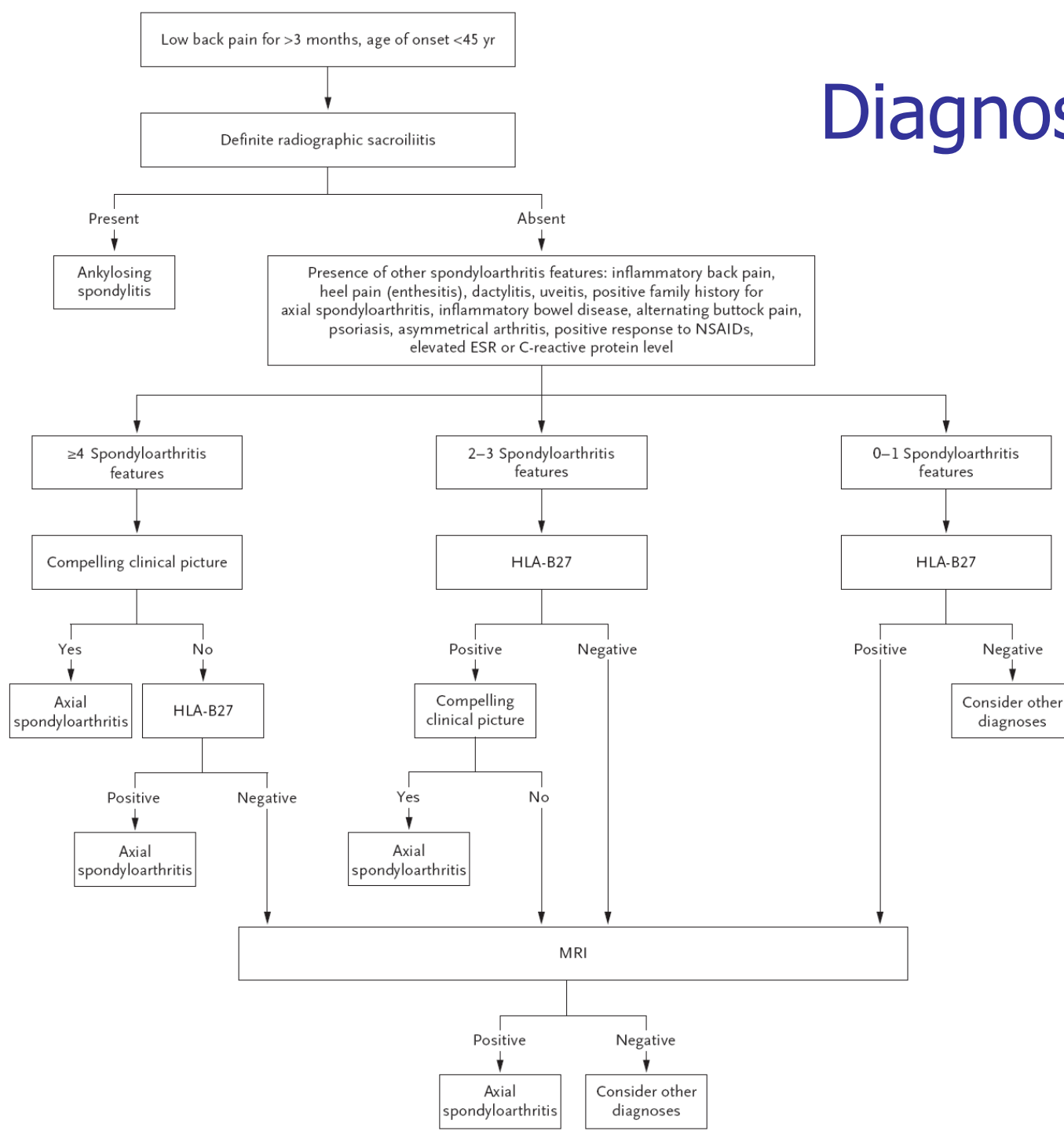
Sensitivity: 77.8%, Specificity: 82.2%; n=266



Investigations



Diagnositic algorithm



Investigations

- **Prise de sang :**
 - **CRP, VS**
 - **HLA-B27**
 - FR et anti-CCP (si présentation périphérique)
- Calprotectine fécale (colite inflammatoire ?)
- **Radiographie du bassin (AP)**
- **IRM du bassin** : T1-STIR + T2 (+/- Gado), coupes sémi-coro
 - (+/- IRM du rachis)
- +/- CT du bassin
- +/- Radiographies – mains / pieds / rachis
- +/- Densitométrie osseuse



Sacroiliitis Grade 0 (Normal)



Sacroiliitis Grade 2 Right, Grade 1 Left



Sacroiliitis Grade 3 Bilaterally



Sacroiliitis Grade 4 Bilaterally

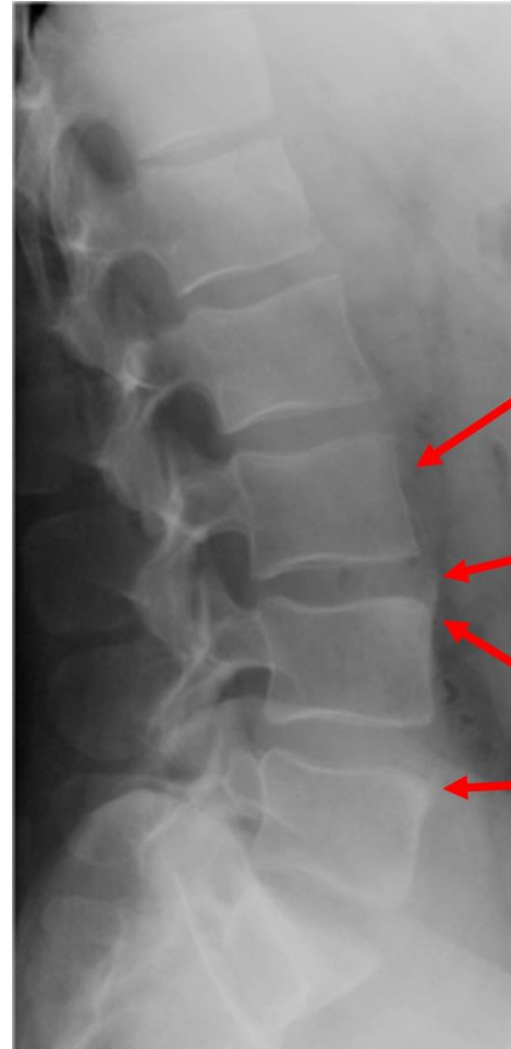


Parfois décrit comme «NORMALE» !



Typical X-ray Changes of the Spine in Ankylosing Spondylitis

male,
37 years old
AS for 5 years



Squaring

Syndesmophyte

Romanus lesion
"shiny corner"

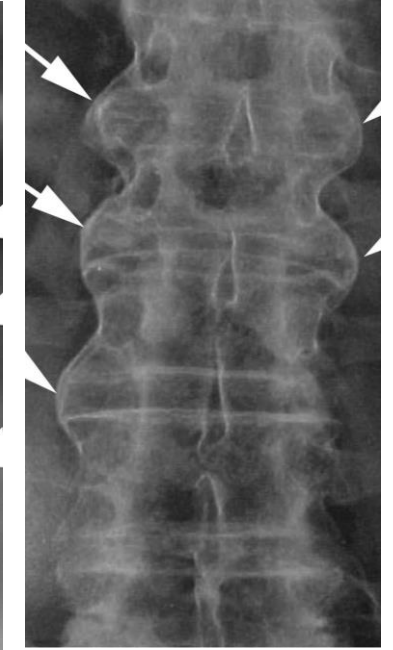
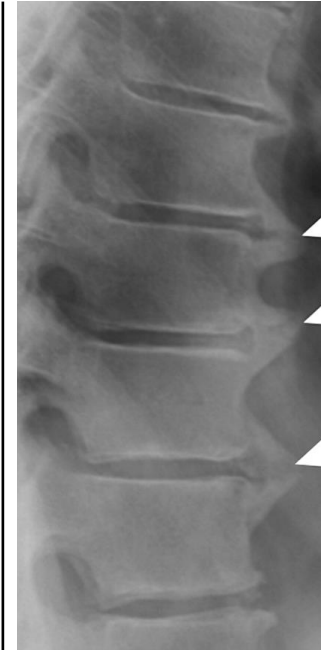
Radiographies du rachis



Spondylarthrite
Syndesmophytes



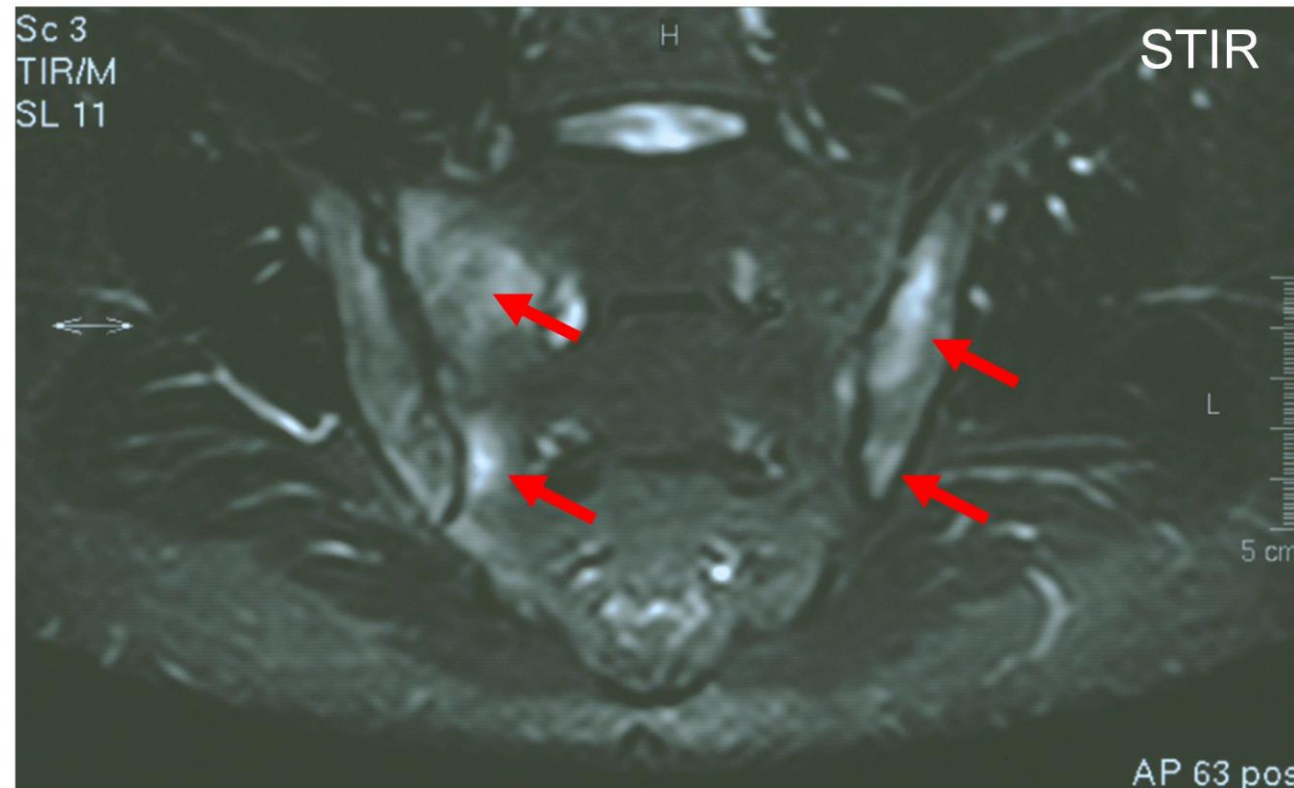
Arthrose
Ostéophytes



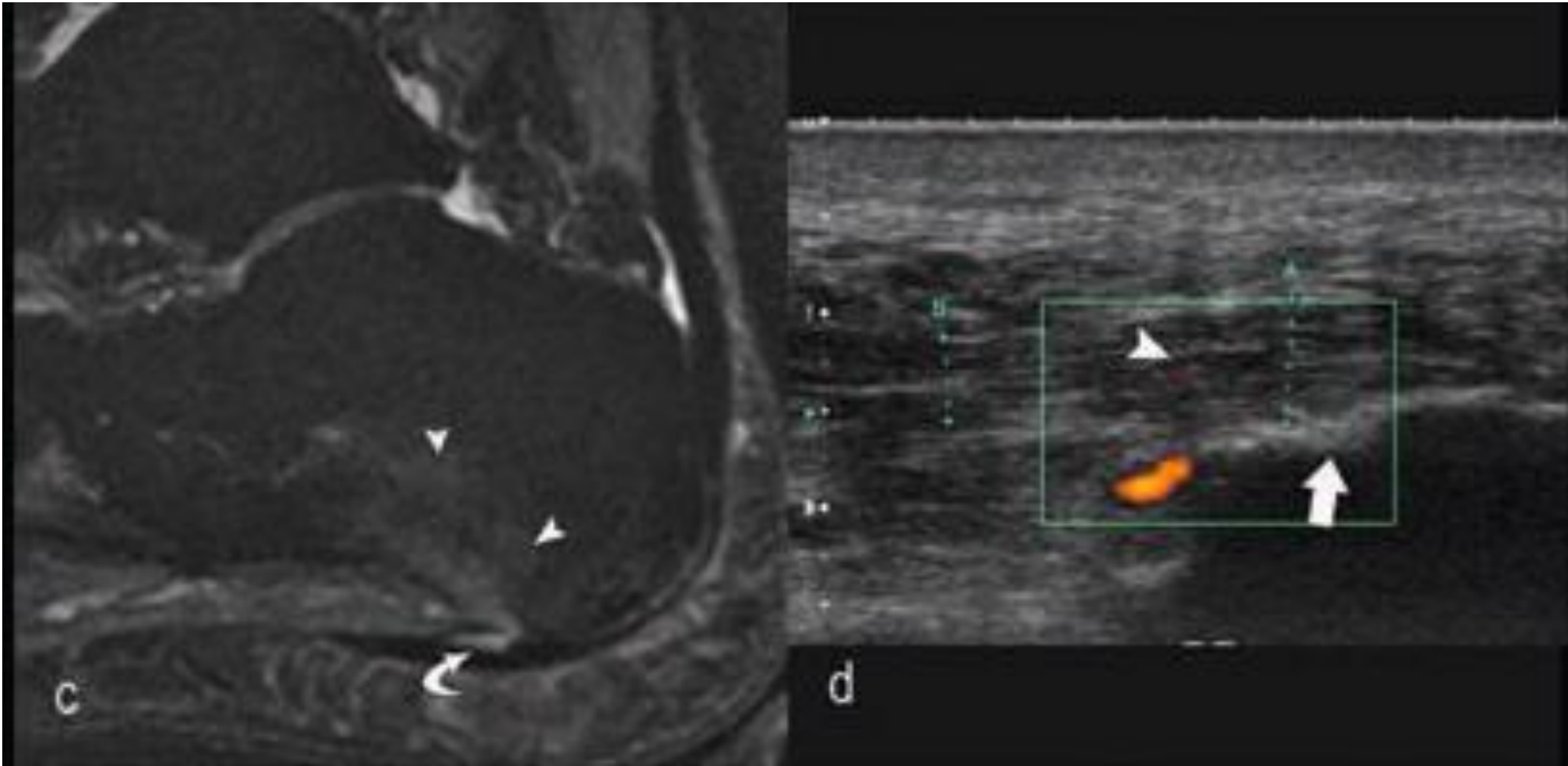
DISH
Para-syndesmophytes
Exubérants
Apparition tardive
D>G
(PsA > axSpA)

Definition of Positive MRI-SI Joint

- subchondral bone marrow edema
- acute (bilateral) sacroiliitis



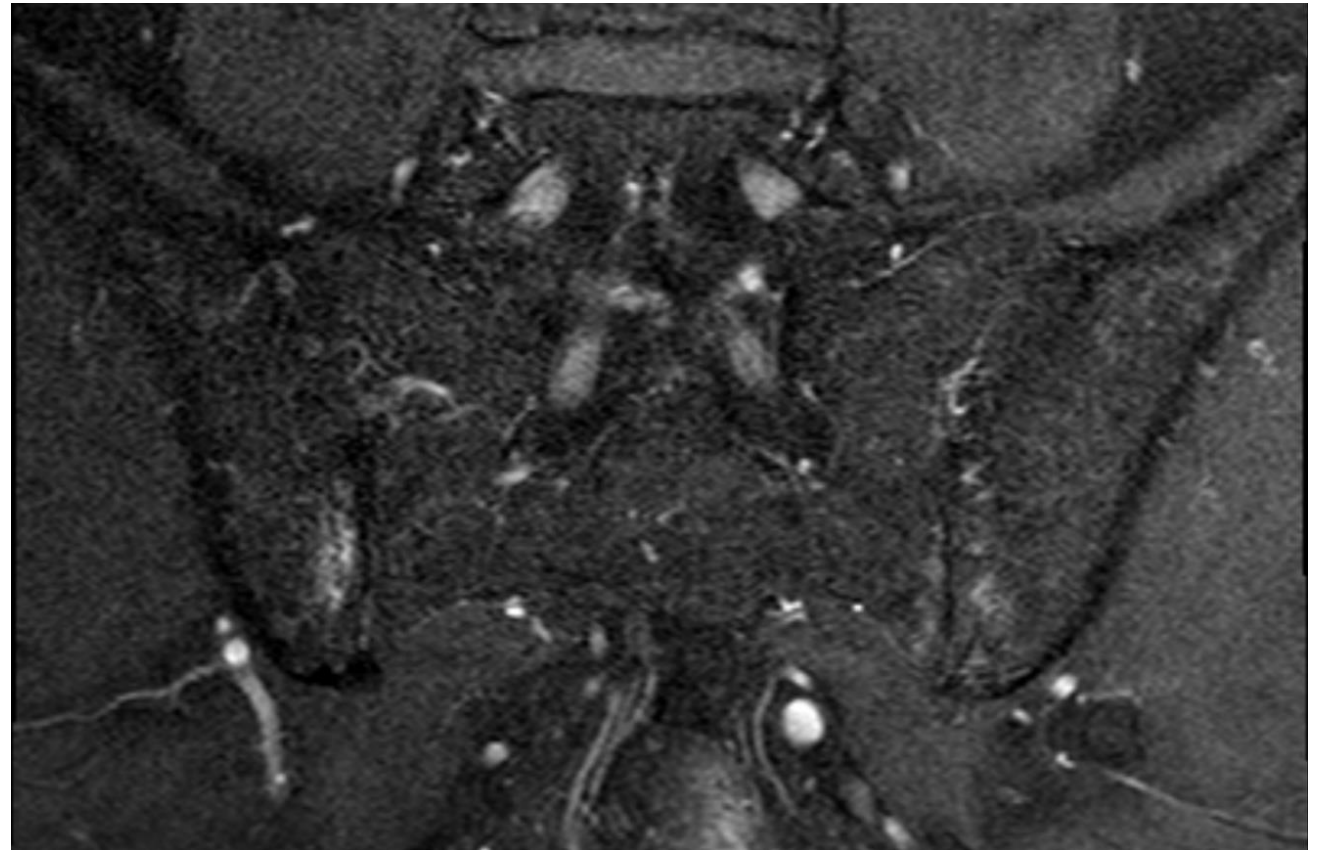
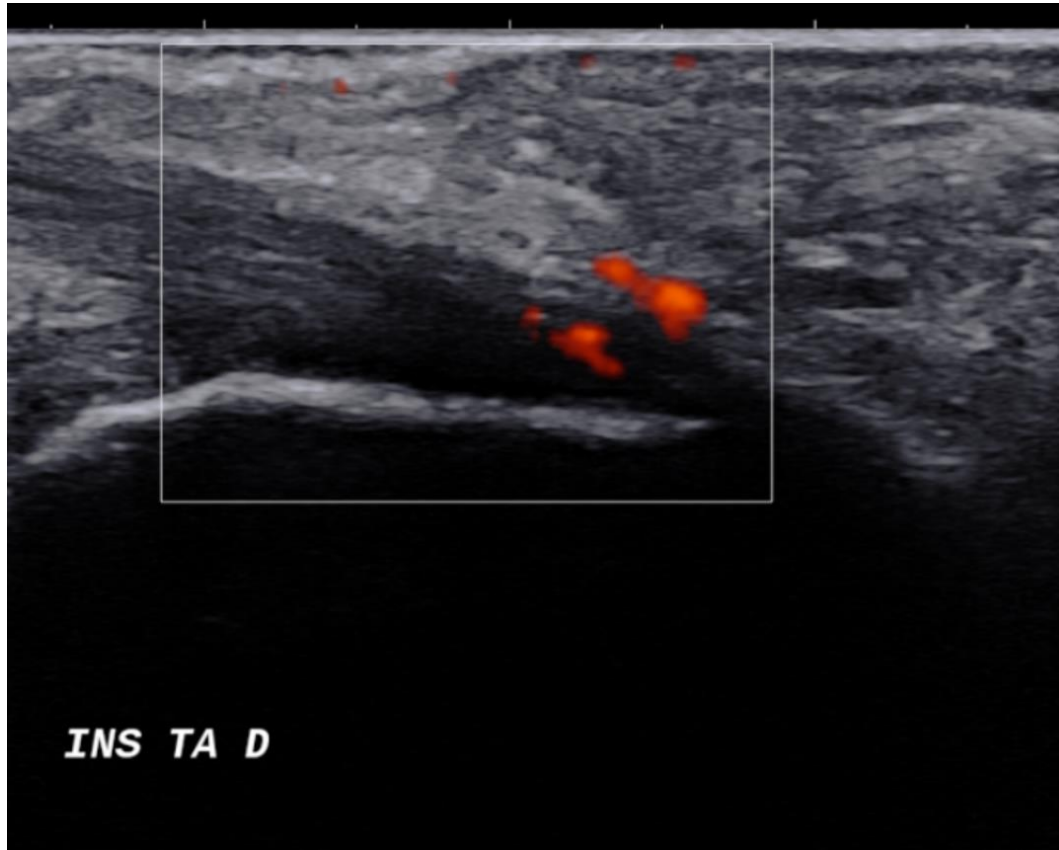
IRM et US-power doppler



STIRw MR sagittal image. Calcaneal inferior bone marrow oedema (arrow head) close to the aponeurosis enthesis, together with thickening and intraaponeurosis high signal area (curved arrow)

PDUS sagittal image. Aponeurosis thickening with loss of fibrillar pattern and Doppler signal (arrow head) are shown associated with bone erosion (arrow)

Homme de 58 ans, pso cutané, PsA ?





Prise en charge



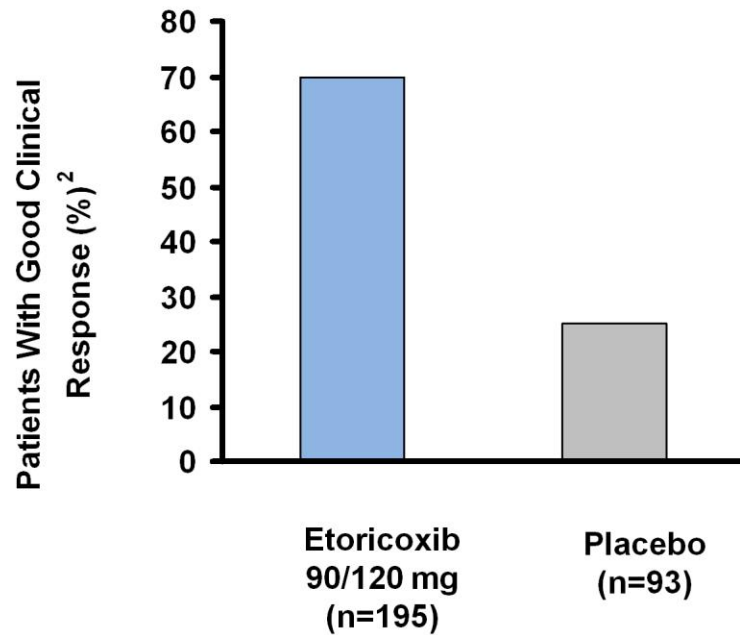
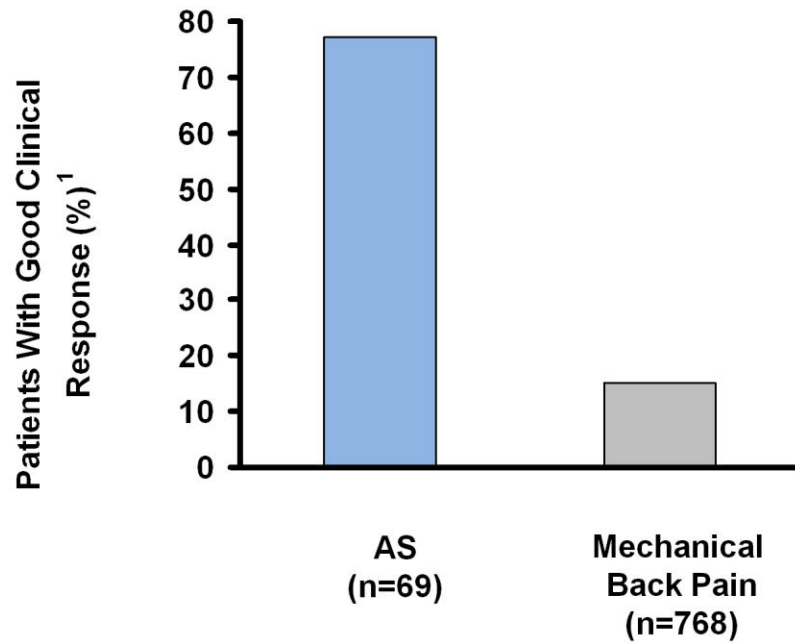
Spondylarthrites – prise en charge

- Multidisciplinaire !
 - Education thérapeutique
 - Dermatologue, rhumatologue, interniste, gastroentérologue, ophtalmologue, ...
 - Physiothérapeute, ergothérapeute, diététicienne
- Atteinte cutanée
- Atteinte articulaire
- Atteinte extra-articulaire
- Gestion des comorbidités (ex cardiovasc)
- Prise en charge des troubles psychiatriques
- Suivie et réévaluation régulière

Spondylarthrites et AINS

- AINS particulièrement efficaces dans la SpA !!!
 - Critère diagnostic
 - Pas ou peu d'effets significatifs sur l'inflammation déterminée par la CRP ou visualisée à l'IRM
 - Possible effet sur la progression radiologique ?

Efficacy of NSAIDs for the Treatment of Patients with Ankylosing Spondylitis



1. Amor B et al. Rev Rheum Engl Ed 1995;62:10-5
2. van der Heijde D et al. Arthritis Rheum 2005;52:1205-15



Spondylarthrites - traitement

■ Atteinte axiale

1. AINS
2. Physiothérapie
3. csDMARDs ?
4. Petites molécules :
 1. Anti-JAK
5. Biologics :
 1. Anti-TNFs
 2. Anti-IL17

■ Atteintes périphériques

1. Antalgiques, AINS, (Pred)
2. csDMARDs :
 1. Salazopyrine
 2. Méthotrexate
 3. Leflunomide
3. Petites molécules :
 1. Anti-PDE4
 2. Anti-JAK
4. Biologics :
 1. Anti-TNFs
 2. Anti-IL17
 3. Anti-IL12/23

Spondylarthrites - traitement

Anti-inflammatoires

Traitements de fond
(DMARD) (PO, SC)

Methotrexate (PO, SC)

Leflunomide (Arava) (PO)

Sulfasalazine (Salazopyrine) (PO)

Hydroxychloroquine (Plaquenil) (PO)

Anti-PDE4
(PO)

Apremilast (Otezla)

Anti-JAK (PO)

Tofacitinib (Xeljanz)

Baricitinib (Olumiant)

Upadacitinib (Rinvoq)

Anti-TNF (SC, IV)

Infliximab (Remicade, Inflectra*) (IV)

Etanercept (Enbrel, Erelzi*, Benepali*) (SC)

Adalimumab (Humira, Hyrimoz*, Amgevita*) (SC)

Golimumab (Simponi) (SC)

Certolizumab (Cimzia) (SC)

Anti-IL-17A
(SC)

Secukinumab (Cosentyx)

Ixekizumab (Taltz)

Anti-IL12/IL23
(SC)

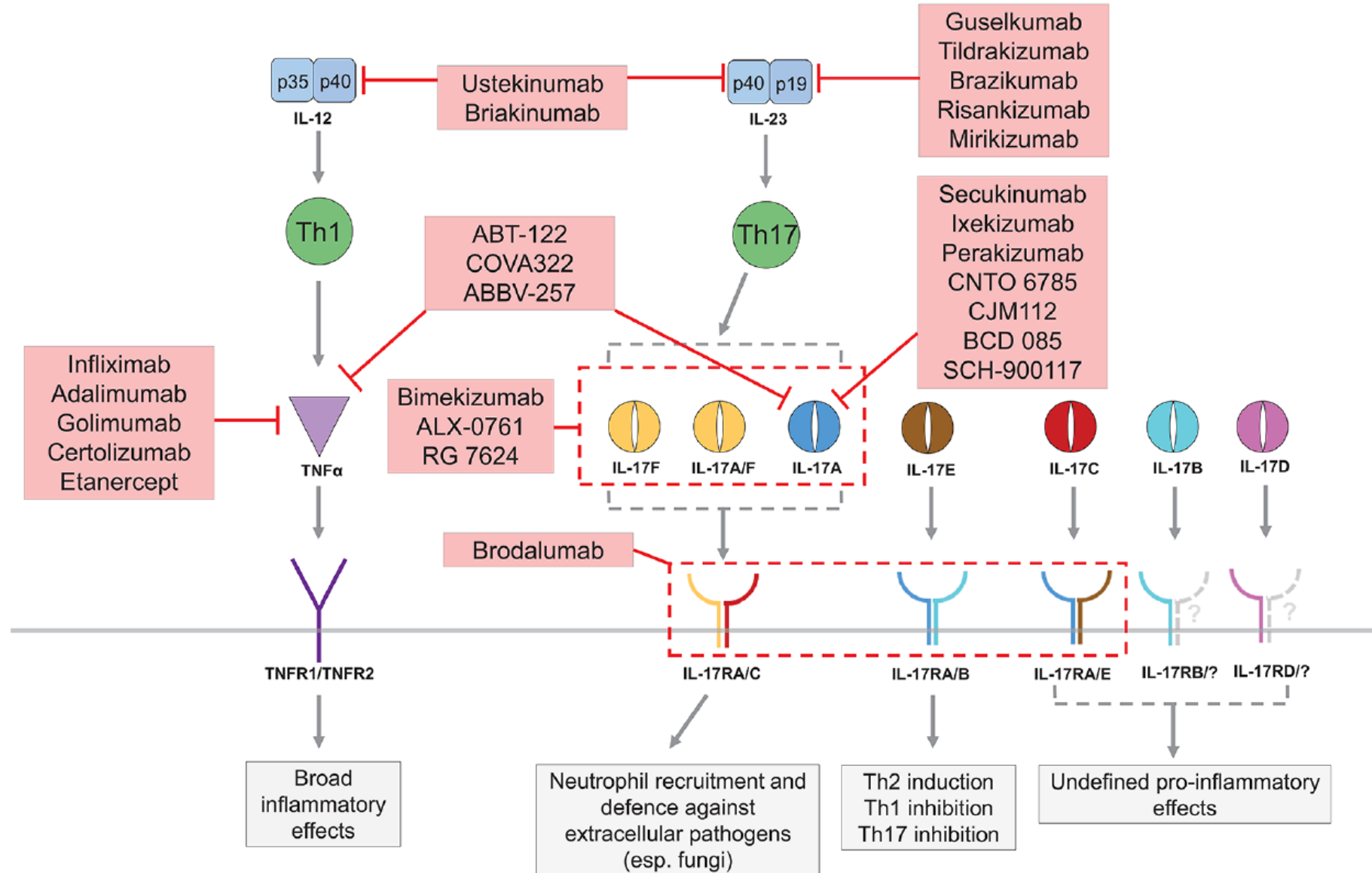
Ustekinumab (Stelara)

Anti-IL23
(SC)

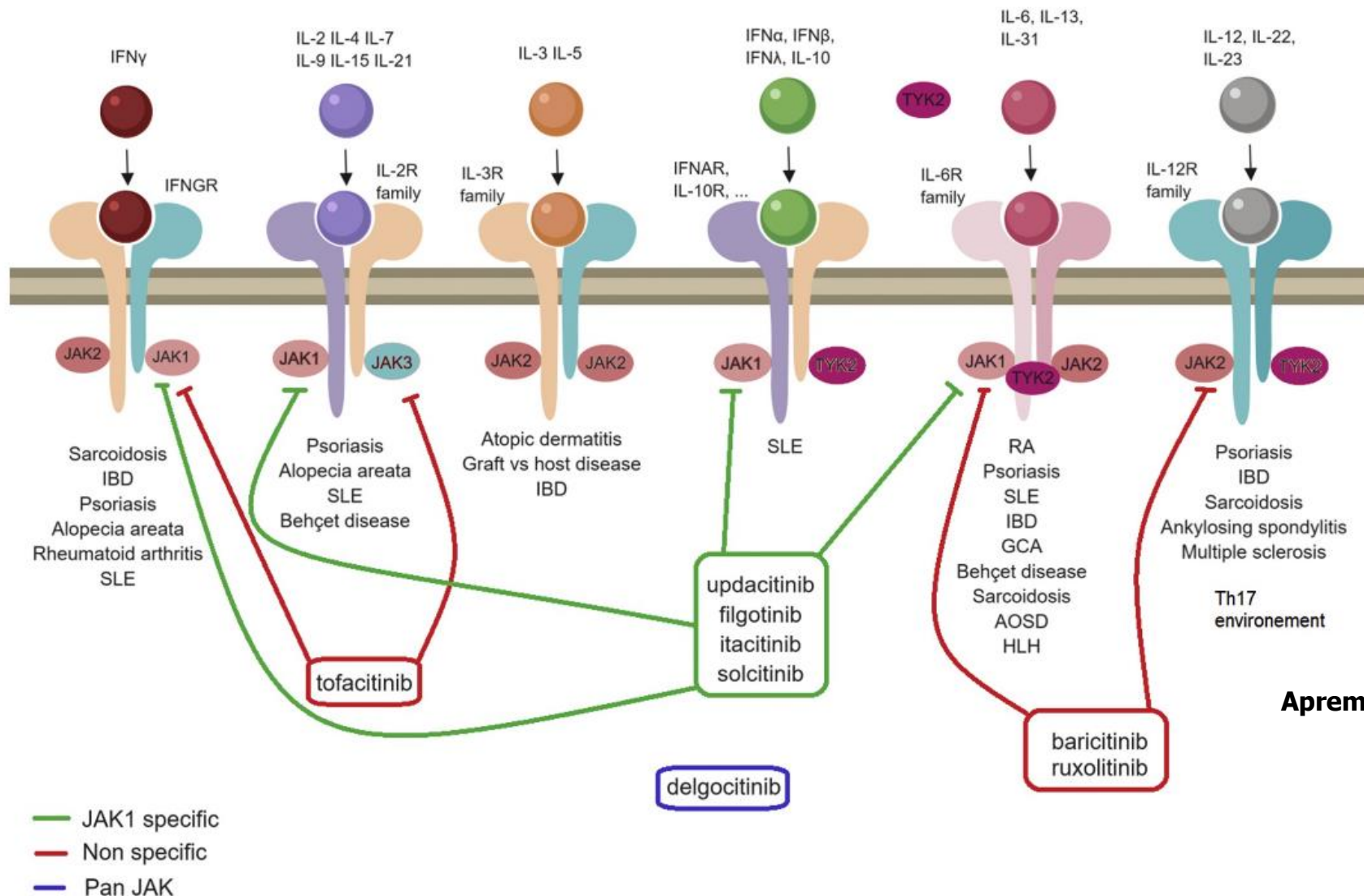
Guselkumab (Tremfya)

Risankizumab (Skyrizi)

Spondylarthritides – traitements « biologiques »



Spondylarthrites – traitements « oraux »



Apremilast (Otezla®) - PDE4i

Maladie:

- Axiale
- Périphérique
- Dactylites
- Enthésites

Antécédents :

- Candidose
- Herpes
- Thrombose

Recommandations locales

Traitements antérieurs :

- échec (primaire vs. secondaire)
- effets secondaires

Manifestations extra-articulaires:

- Uvéite
- MICI
- Psoriasis

Comorbidités (ex. obésité, SEP, NASH)

Niveau d'activité de la maladie

Préférences du patient / médecin

CHOIX DU TRAITEMENT

Caractéristiques du patient:

- âge
- sexe
- poids
- risque infectieux
- souhaite de grossesse

Caractéristiques du médicament:

- Mode d'action
- Voie d'administration
- Profil des effet secondaires
- Demi-vie/fréquence
- Prix (biosimilaires)

Prise en charge des uvéites non infectieuses liées à une maladie systémique: guide pour les praticiens

Dr MICHAEL NISSEN^a et Pr YAN GUEX-CROSIER^{b,c}

Rev Med Suisse 2020; 16: 2059-73



TABLEAU 2 Caractéristiques des uvéites selon le type de spondylarthrite

Nr-axSpA: SpA axiale non radiographique; MICI: maladies inflammatoires chroniques de l'intestin; PsA: arthrite psoriasique; RCUH: rectocolite ulcéro-hémorragique; >>: beaucoup plus fréquente que.

Maladie	Âge de début	Ratio H/F	HLA-B27	Prévalence de l'uvéite	Caractéristiques de l'uvéite
SpA axiale	30-35 ans	2/1	90%	20-40%	Uvéite antérieure, unilatérale, récidivante (atteinte postérieure dans 10%). Début aigu
Nr-axSpA	30-35 ans	1/1	60-80%	10-20%	Uvéite antérieure, unilatérale, récidivante. Début aigu
SpA réactionnelle	30-35 ans	4/1	30-75%	5-10%	Uvéite antérieure, intermédiaire ou postérieure, bilatérale et chronique. Début aigu. Conjonctivite, sclérite ou kératite souvent associée
PsA	40-50 ans	1/2	40-50%	5-25%	Uvéite antérieure, intermédiaire et surtout postérieure (donc plus sévère), bilatérale et chronique. Début insidieux
MICI	35-40 ans	1/4	30-75%	5-40%	Uvéite postérieure, bilatérale et chronique. Début insidieux. Crohn >> RCUH = 4 :1. Sclérite souvent associée
SpA juvénile	2-6 ans	1/4	20%	20%	Uvéite antérieure (mais 20% intermédiaire ou postérieure) et bilatérale

(Adapté des réfs. 17,21,22,35,73).



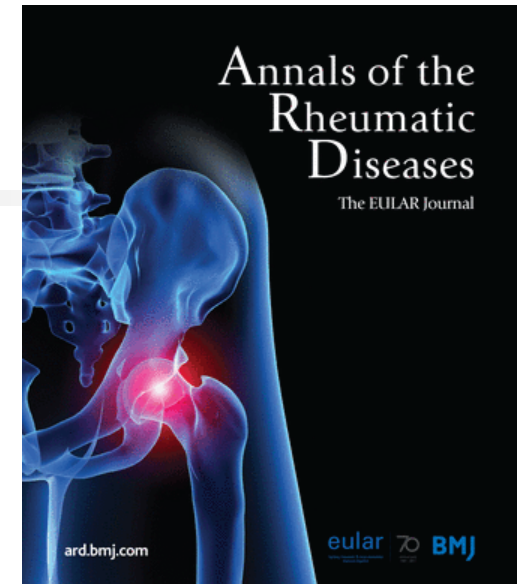
		csDMARD	Anti-PDE4	JAKi	TNFi	Anti-IL-17	Anti-IL-12/23	Anti-IL-23
Administration		MTX, LEF, SSZ	Aprémilast	TOFA, UPA, BARI, Deucravacitinib	ADA, IFX, ETN, CER, GOL	SECU, IXE	UST	GUS, RZB
	Voie	orale/SC	orale	orale	SC / IV	SC	SC	SC
	Fréquence	Quotidienne ou hebdomadaire	2×/jour	1-2×/jour	Hebdomadaire à tous les 2 mois	Toutes les 2-4 semaines	Tous les 3 mois	Tous les 2-3 mois
Efficacité	Articulaire	✓✓	✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓
	Cutanée	✓✓ MTX ✓ LEF	✓✓	✓✓✓	✓✓✓	✓✓✓✓	✓✓✓(✓)	✓✓✓✓(✓)
	Enthésites	(✓)	✓	✓✓	✓✓	✓✓(✓)	✓✓	✓✓
	Dactylites	✓	✓	✓✓	✓✓	✓✓	✓✓	✓✓
	Colites (MICI)	✓	(✓)	✓ (TOFA RCUH)	✓✓ (sauf ETN)	×	✓✓	? ✓
	Uvéïtes	✓ (MTX)	?	?	✓✓ (IFX, ADA)	✓	?	?
Amélioration de la progression radiologique	Axiale	×	(✓)	✓(✓)	✓✓	✓✓	×	?
	Axiale	×	?	?	✓	✓	×	?
	Périphérique	× (MTX, SSZ)	?	✓ (ADA)	✓	✓	✓	(✓)
Autre	↑ Fonction (HAQ)	✓ (MTX)	✓	✓✓	✓✓	✓✓	✓✓	✓✓
	Effets secondaires	✓✓	✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓
	Coût^a (CHF/année)	1000-2,000	12,000	16-25,000	10-25,000	9-18,000	15,000	15,000
	Remarques	Précaution avec le MTX en cas de stéatose hépatique.	Prise avec le MTX si C/I aux AINS.	Éviter si TVP, EP, cancer, herpès, hyperlipidémie, > 65 ans, ou tabagisme.	Éviter en cas de SEP ou d'ICC sévère. CER si Crohn ou grossesse. GOL si RCUH.	Risque de candidose. Éviter si colite.	Moins efficace pour l'arthrite périphérique.	Meilleur pour les articulations que l'anti-IL-12/23. Pas de risque de candidose.

Importance d'un traitement précoce !

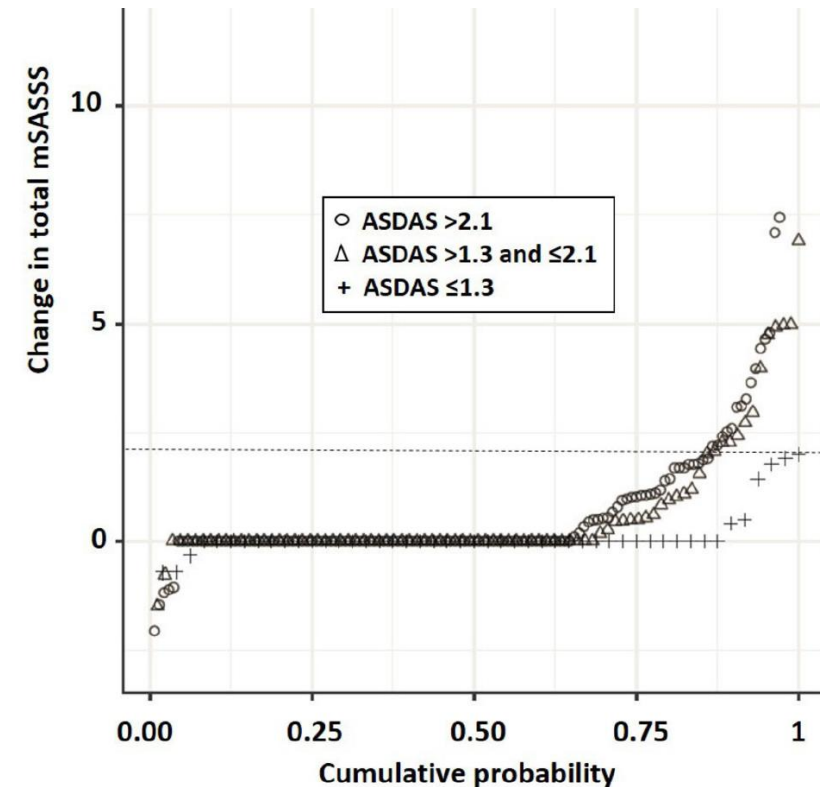
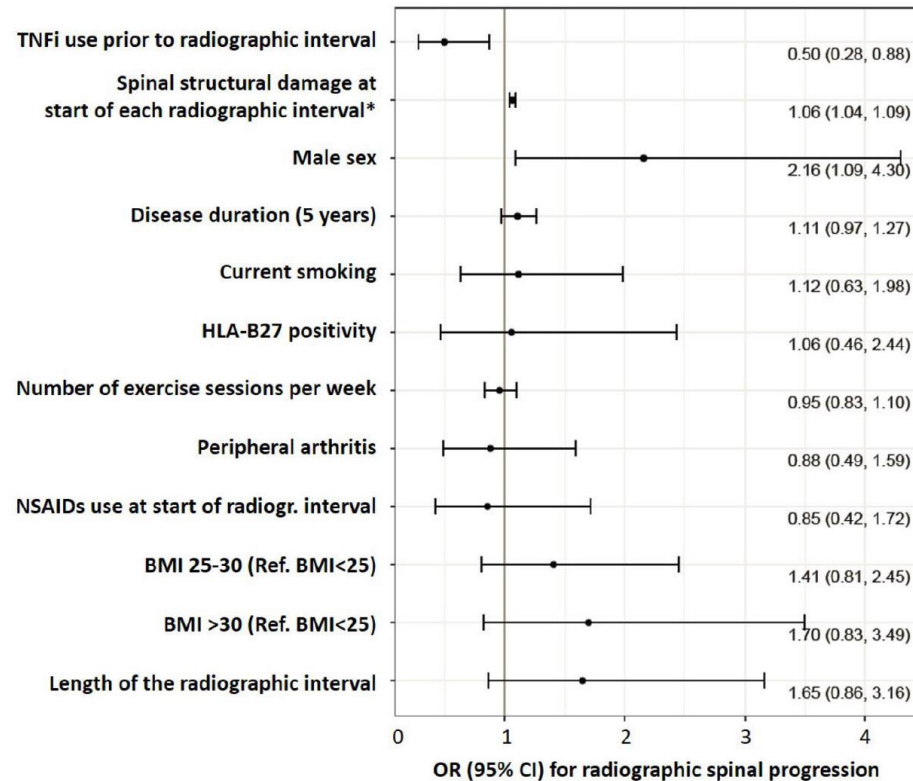
EXTENDED REPORT

TNF blockers inhibit spinal radiographic progression in ankylosing spondylitis by reducing disease activity: results from the Swiss Clinical Quality Management cohort

Christoph Molnar,¹ Almut Scherer,¹ Xenofon Baraliakos,² Manouk de Hooge,³ Raphael Micheroli,⁴ Pascale Exer,⁵ Rudolf O Kissling,⁶ Giorgio Tamborrini,⁷ Lukas M Wildi,⁴ Michael J Nissen,⁸ Pascal Zufferey,⁹ Jürg Bernhard,¹⁰ Ulrich Weber,^{11,12} Robert B M Landewé,^{13,14} Désirée van der Heijde,³ Adrian Ciurea,⁴ on behalf of the Rheumatologists of the Swiss Clinical Quality Management Program



A. progression ≥ 2 mSASSS units per 2 years

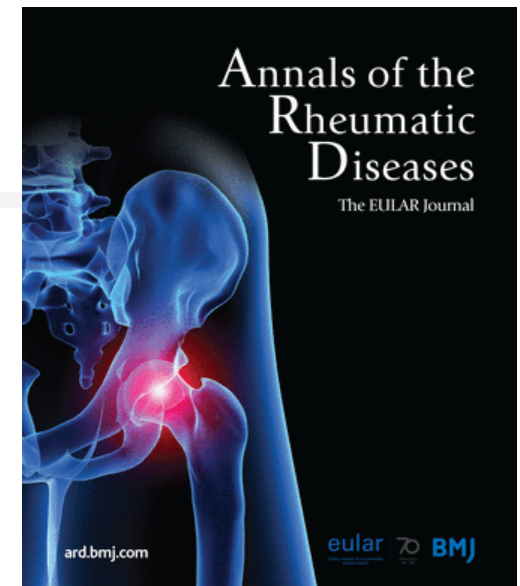




Suivi et évaluation de l'activité de la SpA

ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update

Sofia Ramiro ,^{1,2} Elena Nikiphorou ,^{1,3} Alexandre Sepriano ,^{1,4}
Augusta Ortolan ,⁵ Casper Webers ,⁶ Xenofon Baraliakos,⁷
Robert B M Landewé ,^{8,9} Filip E Van den Bosch ,^{10,11} Boryana Boteva,¹²
Ann Bremander,^{13,14} Philippe Carron ,^{10,11} Adrian Ciurea ,¹⁵
Floris A van Gaalen ,¹ Pál Géher,¹⁶ Lianne Gensler,¹⁷ Josef Hermann,¹⁸
Manouk de Hooge ,¹⁰ Marketa Husakova,¹⁹ Uta Kiltz ,⁷
Clementina López-Medina ,^{20,21} Pedro M Machado ,^{22,23,24}
Helena Marzo-Ortega,²⁵ Anna Molto ,²⁶ Victoria Navarro-Compán ,²⁷
Michael J Nissen ,²⁸ Fernando M Pimentel-Santos,⁴ Denis Poddubnyy ,²⁹
Fabian Proft ,²⁹ Martin Rudwaleit ,³⁰ Mark Telkman,³¹
Sizheng Steven Zhao ,³² Nelly Ziade ,^{33,34} Désirée van der Heijde ,¹



ASAS-EULAR Recommendations for the treatment of patients with axSpA with b/tsDMARDs

Rheumatologist's diagnosis of axial SpA

and

Elevated CRP or positive MRI-SIJ or Radiographic sacroiliitis*

and

Failure of standard treatment

All patients

At least 2 NSAIDs over 4 weeks (in total)

Patients with predominant peripheral manifestations

One local steroid injection if appropriate
Normally a therapeutic trial of sulfasalazine

and

High disease activity: ASDAS \geq 2.1

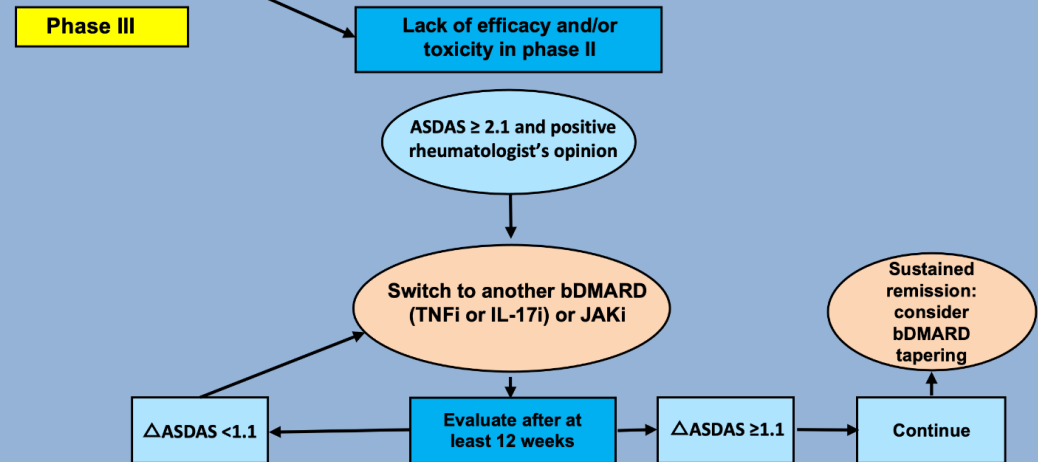
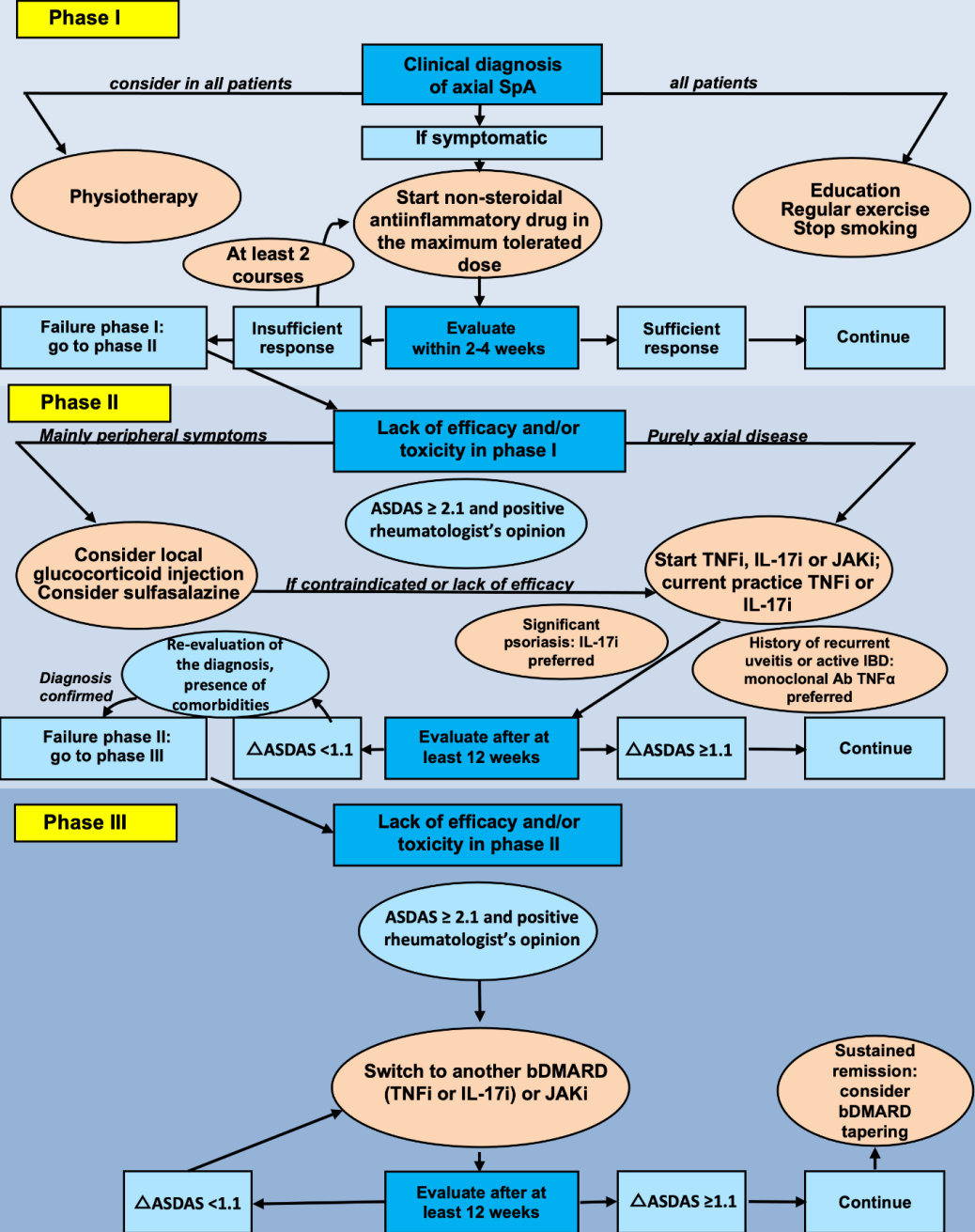
and

Positive rheumatologist's opinion

or ~~BASDAI~~ \geq 4

* Radiographic sacroiliitis is currently mandatory for infliximab and JAKi

ASAS-EULAR RECOMMENDATIONS FOR THE MANAGEMENT OF AXIAL SPONDYLOARTHRITIS (2022 UPDATE)



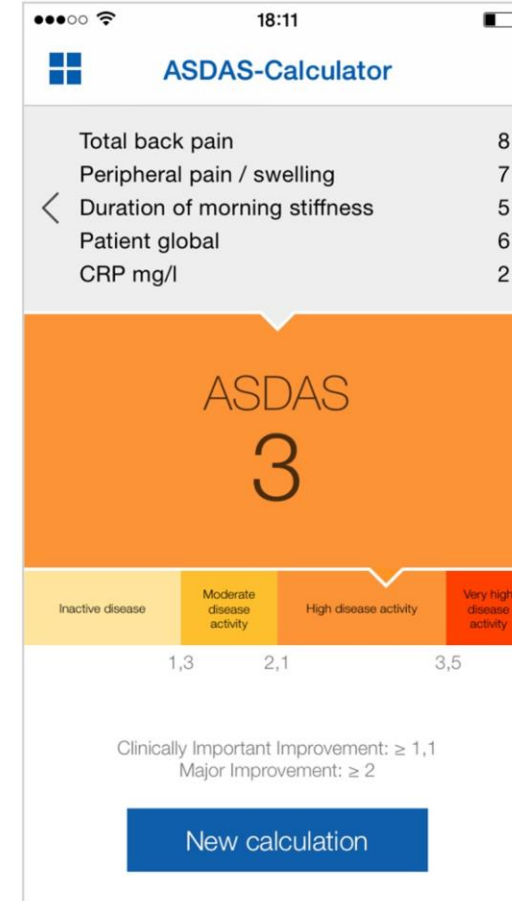
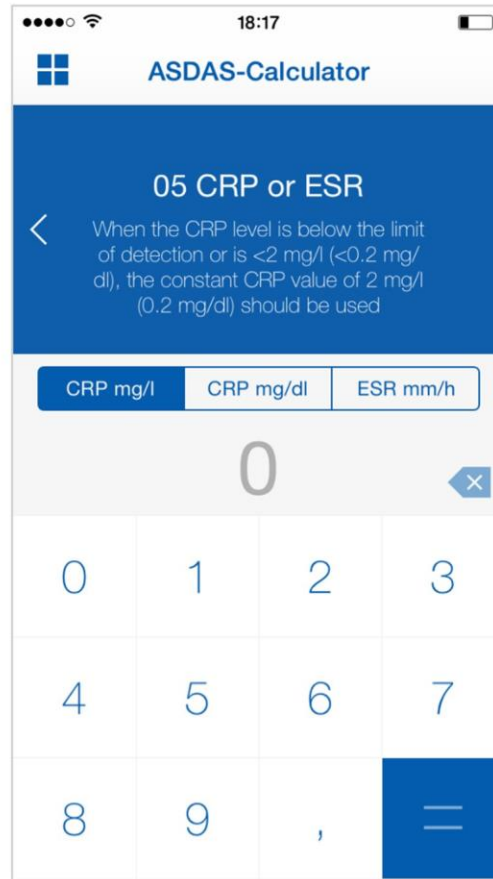
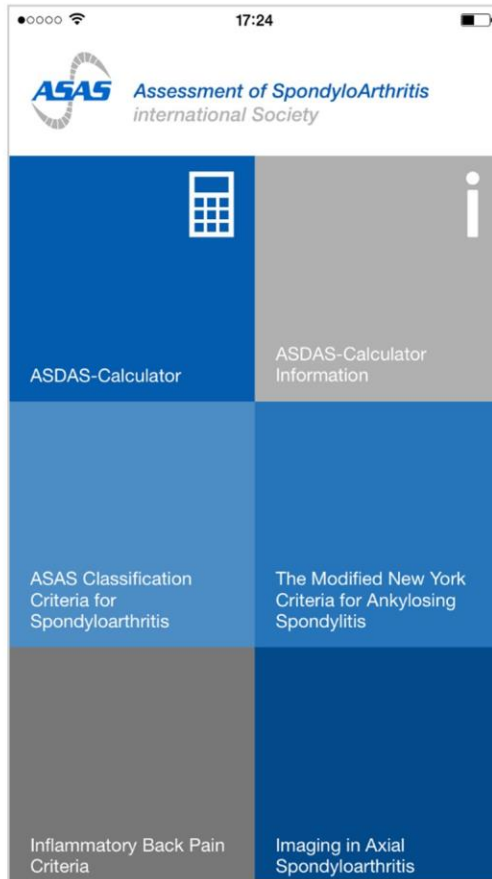


Ankylosing Spondylitis Disease Activity Score (ASDAS)

Parameters used for the calculation of the ASDAS

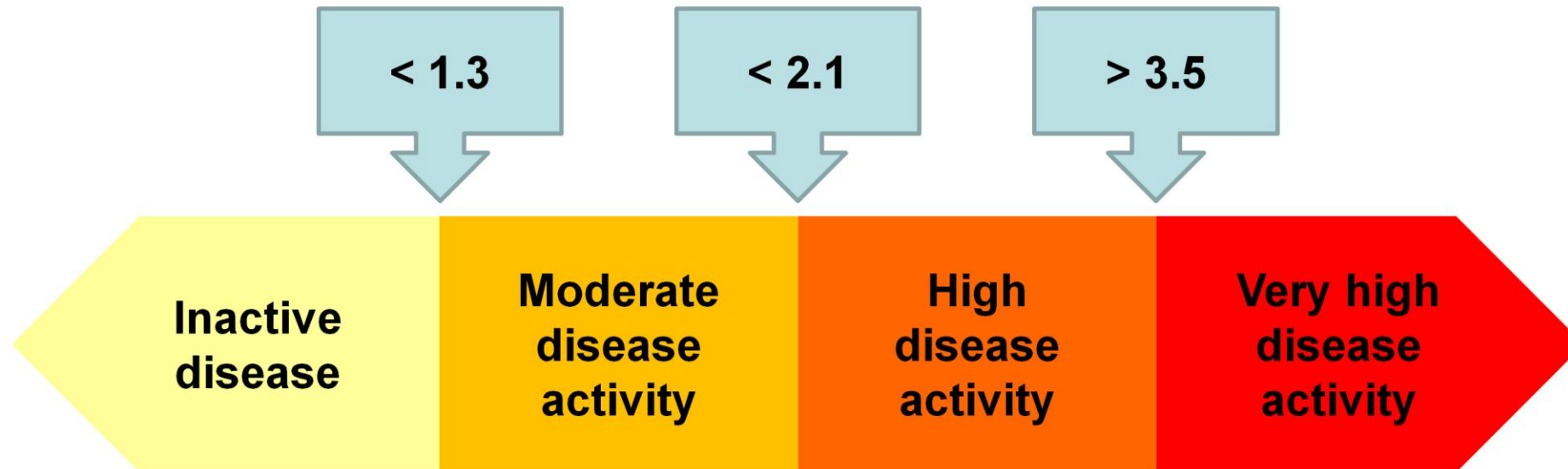
1. Total back pain (BASDAI question 2)
2. Duration of morning stiffness (BASDAI question 6)
3. Patient global assessment of disease activity
4. Peripheral pain/swelling (BASDAI question 3)
5. C-reactive protein (CRP) in mg/l [or erythrocyte sedimentation rate (ESR)]

ASAS App with ASDAS Calculator for Smartphones and Tablets



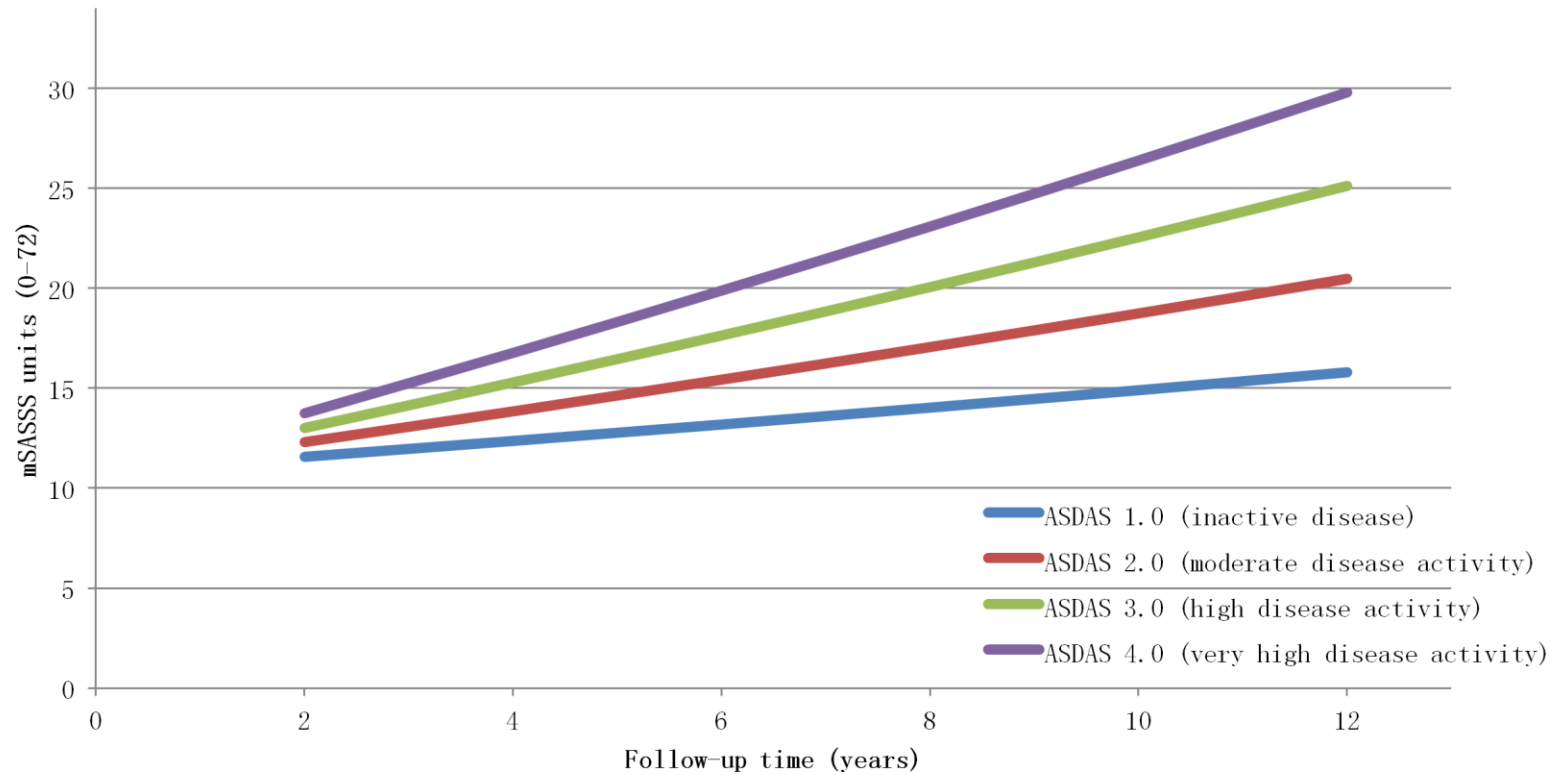


ASDAS Cut-Offs for Status Scores



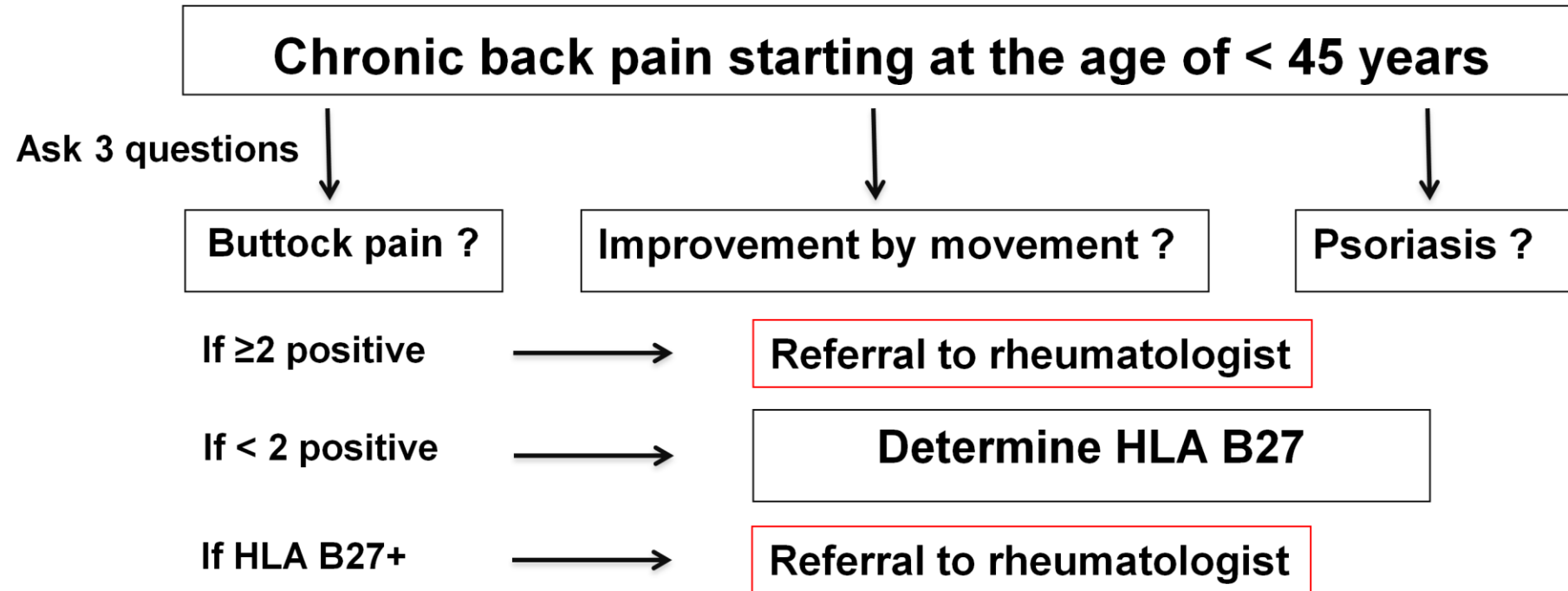
Longitudinal Relationship between Disease Activity and Radiographic Damage

Longitudinal relationship between ASDAS and mSASSS



A Possible 2-Step Referral Strategy

Primary care setting



Re-analysis and modelling of the study data
based on inclusion of HLA-B27

Sensitivity 80.4%
Specificity 75.4%

Conclusions

- Il faut y penser !
- Fréquente (1-2% de la population)
- Diagnostic :
 - Clinique (<45 ans, >3 mois douleurs «inflammatoires»)
 - HLA B27+
 - IRM du bassin+ (! probabilité pré-test et faux positifs)
- Traitement :
 - «Précoce» pour ralentir la progression de la maladie
 - Choix du médicament selon l'atteinte : axiale, périphérique, manifestations extra-articulaires, etc.
 - Utilisation de l'ASDAS et modification du traitement si besoin