When NICE acknowledges that the purpose of its guideline is not only to provide advice but also to raise awareness, it is evident that understanding about the disorder in question is less than it might be. Which explains why its new guideline on the diagnosis and management of spondyloarthritis includes so much detail about recognition, referral and differential diagnosis. 

Assessment and diagnosis
Spondyloarthritis can manifest as an axial disorder (radiographic, ie ankylosing spondylitis, or nonradiographic), a peripheral disorder (psoriatic arthritis, reactive arthritis, enteropathic spondyloarthritis), or both. Symptoms are diverse and variable but association with uveitis, psoriasis or inflammatory bowel disease (by virtue of positive status for human leukocyte antigen (HLA)-B27), or recent gastrointestinal or genitourinary infection should raise suspicion. Diagnosis entails assessment using validated instruments and appropriate imaging (X-ray and MRI); positive HLA-B27 status increases the likelihood of spondyloarthritis in the presence of typical signs and symptoms. Misdiagnosis as mechanical low back pain or apparently unrelated joint or tendon problems delays treatment.

Referral to a specialist for assessment for axial spondyloarthritis is indicated in patients with low back pain of onset <45 years and more than three months duration, when four or more criteria are present:

- Low back pain with onset before age 35 years
- Symptoms causing waking during the second half of the night
- Buttock pain
- Improvement with movement
- Improvement within 48 hours of taking an NSAID
- First-degree relative with spondyloarthritis
- Current or past arthritis, enthesitis or psoriasis.

If three of these criteria are met, an HLA-B27 test should be performed and, if positive, the patient should be referred. If the criteria are not met but clinical suspicion remains, the patient should be advised...
Axial spondyloarthritis
An NSAID with co-prescribed gastroprotection is the first option for pain relief for axial spondyloarthritis, beginning with the lowest effective dose. If the maximum tolerated dose does not relieve pain after two to four weeks, switching to another NSAID should be considered. If treatment with an NSAID fails, a biological DMARD is the next option. The TNF inhibitors adalimumab, certolizumab pegol, etanercept and golimumab are recommended as first-line options for treating severe active ankylosing spondylitis; the cheapest formulation of the TNF inhibitor infliximab is an alternative. The options for severe nonradiographic axial spondyloarthritis are adalimumab, certolizumab pegol and etanercept.

The response to a biological DMARD should be assessed after 12 weeks; treatment should continue only if there is clear evidence of a response, defined as target reductions in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score and a reduction in the spinal pain visual analogue scale. If treatment with the first TNF inhibitor fails (even after an initial response) or is not tolerated, a switch to another of these TNF inhibitors is recommended or, alternatively, to the interleukin-17A inhibitor secukinumab. The response to this agent should be assessed after 16 weeks.

Peripheral spondyloarthritis
The approach to psoriatic arthritis and other peripheral spondyloarthritides is initially monotherapy with a local corticosteroid injection for nonprogressive monoarthritis. Patients with peripheral polyarthritis, oligoarthritis, or persistent or progressive monoarthritis associated with peripheral spondyloarthritis should be offered a conventional DMARD. If this is not successful after three months, substituting or adding another conventional DMARD should be considered. NSAIDs may be suitable as adjunctive therapy and, if they fail, the next option is an intra-articular, oral or intramuscular steroid.

Several NICE technology appraisals cover treatment options for psoriatic arthritis that meets the criteria for disease activity despite treatment (peripheral arthritis with ≥3 tender joints and ≥3 swollen joints). The oral phosphodiesterase 4 (PDE4) inhibitor apremilast is recommended, as monotherapy or combined with a DMARD, when treatment with two conventional DMARDs has been unsuccessful. Response should be assessed after 16 weeks.

Of the biological DMARDs, adalimumab, etanercept, infliximab and golimumab are recommended for active and progressive psoriatic arthritis meeting the above criteria if the disease has not responded to adequate trials of at least two conventional DMARDs. Response should be assessed after 12 weeks. The interleukin inhibitor ustekinumab is recommended, as monotherapy or combined with methotrexate, only when treatment with TNF inhibitors is contraindicated but would otherwise be considered or the patient has already tried at least one TNF inhibitor. The response should be assessed after 24 weeks.

Nonpharmacological measures
Patients with axial spondyloarthritis should be referred to a specialist physiotherapist for an individualised structured exercise programme that includes stretching; strengthening and postural exercises; deep breathing; spinal extension; a range of motion exercises for the lumbar, thoracic and cervical sections of the spine; and aerobic exercise. Adjunctive hydrotherapy should be considered for pain and to maintain or improve function. Those who have difficulty with everyday activities should be referred to a specialist therapist for assessment for practical aids and this should be repeated periodically to meet changing needs.

When spinal deformity significantly affects quality of life and is progressing despite optimal therapy, the patient should be referred to a complex spinal surgery service for assessment for spinal deformity correction. Suspected spinal fracture is an indication for specialist referral for assessment and, if the fracture is unstable, surgery.

Flares and complications
Flares can be managed by a specialist or, with appropriate support, in primary care. GPs should seek advice when managing patients with recurrent or persistent flares who are taking a biological DMARD, or who have co-morbidities that may impact on their management choices. Uveitis can occur during a flare and warrants same-day referral to an ophthalmologist. Complications may arise from spondyloarthritis or its treatment. Problems with adherence and polypharmacy should be tackled according to NICE guidance on medicines optimisation. Surveillance for adverse effects should be included when monitoring treatment outcomes; patients taking a TNF inhibitor should be warned of the increased risk of skin cancer.
People with axial spondyloarthritis should be advised that they may be prone to fractures and to report falls or physical trauma, especially if musculoskeletal pain is increased. Regular, two-yearly osteoporosis assessment may be considered for people with axial spondyloarthritis; measurement at the hip is more reliable than at the spine.

**Organising care**
The management of spondyloarthritis crosses organisational boundaries, so commissioners need to ensure co-ordination and effective communication between primary and secondary care on prescribing (especially for patients who take a DMARD for another condition) as well as prompt access to specialists. This is something to be provided throughout the course of spondyloarthritis, both vertically within specialties and across the various disciplines involved in managing the many co-morbidities.

**References**

**Declaration of interests**
None to declare.

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