

Individualizing Treatment Approaches in SpA Conditions: Best Practices for Selection, Intensification, and Shared Decision-Making

Dos and Don'ts for AxSpA

Dos

- DO assess for "Inflammatory" vs "Mechanical" pain: Prioritize referrals for patients whose stiffness is worse in the morning (lasting >30 minutes) and improves with exercise
- DO include the following information in referrals: Include HLA-B27 results (if done), C-reactive protein (CRP) levels, and any imaging results (X-ray or MRI) of the sacroiliac joints
- DO advise on lifestyle: Recommend smoking cessation, as smoking can worsen disease progression and respiratory function
- DO use valid screening tools: Utilize standardized indices like the ASDAS or BASDAI to track disease activity if already diagnosed

Don'ts

- DON'T wait for X-ray evidence: Radiographic changes (sacroiliitis) often take years to appear. A "normal" X-ray does not rule out non-radiographic axial spondyloarthritis
- DON'T refer based on CRP alone: While elevated CRP supports a referral, a normal CRP level does not exclude SpA, as many patients maintain normal inflammatory markers
- DON'T delay for HLA-B27 results: If clinical suspicion is high (eg, meeting at least one of the ASAS Consensus on Referral Recommendations criteria in a patient with chronic back pain (duration ≥ 3 months) with onset of pain before 45 years of age), referral should proceed regardless of genetic testing status
- DON'T recommend high-impact or twisting movements: Advise patients to avoid movements that twist or strain the back (eg, deep squats, running) during flare-ups

ASAS Consensus on Referral Recommendation

Patients with chronic back pain (duration ≥ 3 months) with back pain onset before 45 years of age should be referred to a rheumatologist if **at least one** of the following parameters is present:

- Inflammatory back pain
- HLA-B27 positivity
- Sacroiliitis on imaging (X-rays or MRI, if available)
- Peripheral manifestations (arthritis, enthesitis and/or dactylitis)
- Extra-articular manifestations (psoriasis, inflammatory bowel disease and/or uveitis)
- Positive family history for spondyloarthritis (ankylosing spondylitis, psoriasis, acute uveitis, reactive arthritis, inflammatory bowel disease)
- Good response to NSAIDs (24-48h after a full dose the pain is not present or is much better)
- Elevated acute phase reactants (CRP/ESR above upper normal limits)

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The PEST* Screening Criteria for PsA

Each 'Yes' answer scores 1 point. A score of ≥ 3 is indicative of PsA.

(Sensitivity = 0.92, specificity = 0.78)

1. Have you ever had a swollen joint (or joints)?
2. Has a doctor ever told you that you have arthritis?
3. Do your fingernails or toenails have holes or pits?
4. Have you had pain in your heel?
5. Have you had a finger or toe that was completely swollen and painful for no obvious reason?

If you score >3 consider referral to a rheumatologist and check CASPAR criteria

*limited to patients with skin psoriasis

Lenman M, Ahraham S. *Br J Gen Pract.* 2014;64:424-425.

CASPAR Criteria for PsA

A patient must have inflammatory articular disease (joint, spine, or enthesal) and ≥ 3 points from the following categories:

Category	Description	Points
Evidence of current psoriasis or personal or family history of psoriasis	<p>Current psoriasis: Psoriatic skin or scalp disease present today as judged by a rheumatologist or dermatologist</p> <p>Personal history: A history of psoriasis that may be obtained from a patient, family physician, dermatologist, rheumatologist, or other qualified healthcare provider</p> <p>Family history: A history of psoriasis in a first- or second-degree relative according to patient report</p>	2 (current) OR 1 (history)
Psoriatic nail dystrophy on current examination	Includes onycholysis, pitting, and hyperkeratosis observed on current physical examination	1
Negative rheumatoid factor	A negative test result for the presence of rheumatoid factor by any method except latex but preferably by enzyme-linked immunosorbent assay or nephelometry, according to the local laboratory reference range	1
Dactylitis (current or on history as recorded by rheumatologist)	Defined as swelling of an entire digit	1
Radiographic evidence of juxtaarticular new bone formation	Appearing as ill-defined ossification near joint margins (but excluding osteophyte formation) on plain radiographs of the hand or foot	1

CASPAR = CIASsification criteria for Psoriatic ARthritis.

Taylor W, et al. *Arthritis Rheum.* 2006;54:2665-2673.