A worldwide team of spondyloarthritis experts published a new set of criteria for classifying the axial form of the disease, an action expected to dramatically expand the number of patients identified with axial spondyloarthritis and enable physicians to flag affected patients sooner and start them on treatment. A major hope is that earlier treatment, either with NSAIDs or tumor necrosis factor (TNF) inhibitors, will help patients by slowing progression of axial spondyloarthritis (SpA).


The report said the new classification criteria were compared against identification by expert rheumatologists. “If implemented, the new criteria would increase the ‘frequency of diagnosing [axial SpA] by probably threefold, to as high as 1.5% of the adult U.S. population,” said Dr. John D. Reveille, professor of medicine and director of the division of rheumatology and clinical immunogenetics at the University of Texas at Houston. He based his estimate on the application of the new axial SpA criteria to a representative sample of the U.S. population collected in the National Health and Nutrition Examination Survey (NHANES).

“The new criteria will be helpful in identifying more patients with the disease, and also for recognizing the disease very early,” agreed Dr. Muhammad A. Khan, professor of medicine at Case Western Reserve University in Cleveland. “The new criteria are much better than older criteria, which require x-ray evidence of abnormalities in the sacroiliac joints. With the new criteria, you can make the diagnosis [even] when the x-ray is normal, provided you have MRI evidence,” he said in an interview. Dr. Khan was the sole U.S.-based member of ASAS to serve on the expert panel that devised the new classification criteria.

Axial SpA has typically gone undetected until much later in the course of the disease, when it has progressed to ankylosing spondylitis, according to the modified New York criteria.

Classification for Axial Spondyloarthritis

Patients with back pain for at least 3 months and an age of onset younger than 45 years are classified as having spondyloarthritis if they have sacroiliitis on imaging plus at least one spondyloarthritis feature (see below), or if they are HLA B27 positive and have at least two other spondyloarthritis features.

Sacroilitis on imaging is defined as one of the following:

- Active acute inflammation on MRI
- HLA B27 positive
- Elevated C-reactive protein (in the context of chronic back pain)

Spondyloarthritis features include the following:

- Inflammatory back pain
- Arthritis
- Enthesitis
- Uveitis
- Dactylitis
- Psoriasis
- Crohn’s disease/ulcerative colitis
- Good response to NSAIDs
- Family history for spondyloarthritis
- HLA B27 positive


One possible reason why European rheumatologists have been more active in developing the new criteria is that their population contains a higher proportion of people with the HLA B27 genotype, who are most susceptible to developing axial SpA. “The question is, Are the Europeans not only seeing more, but do they see different patients?” Dr. Flynn noted. “I think we’ve got to validate [the new criteria] with U.S. patients too.”

“American rheumatologists are still not as well versed in spondyloarthritis as our European colleagues,” Dr. Khan said. But if the new classification criteria were followed, it would result in better patient care, Dr. Reveille said.

“Treatment today for axial SpA starts with an NSAID, followed by a course with a second NSAID of a different type if the first fails. If both NSAID regimens fail to produce satisfactory results within 3 months, standard standards say the next step is treatment with a TNF inhibitor.”

In the United States, those include adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade), and golimumab (Simponi). Although none has Food and Drug Administration approval for use in axial SpA, all four are approved for treating ankylosing spondylitis.

Ideal treatments for axial SpA don’t include nonbiological disease-modifying drugs, such as methotrexate and sulphasalazine.

No study results have yet documented that early treatment with an NSAID or with a TNF inhibitor slows or stops progression of axial SpA, but specialists are optimistic that such is the case, and that these data will eventually exist.

“We suspect early treatment might have better outcomes; there is the precedent with rheumatoid arthritis,” Dr. Khan said. In addition, even without evidence of slowed progression, early treatment “clearly improves quality of life and function and reduces time lost from work,” Dr. Flynn said.

The importance of early identification and treatment of spondylitis has been recognized by the leadership of the Spondylitis Association of America (SAA). Researchers working with SAA sponsorship developed a screening tool aimed at helping people with chronic back pain self-identify whether they have indications of an inflammatory process that needs medical evaluation.

A report on the development of the SAA screening tool for ankylosing spondylitis is scheduled to appear in the January issue of Arthritis Care and Research, and then the SAA will publicize it as an Internet-based tool, said SAA executive director Laurie Savage.