Criteria May Help Identify Spondyloarthritis Earlier

BY MITCHEL L. ZOLER

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 nonsteroidal anti-inflammatory drugs (NSAIDs) or tumor necrosis factor (TNF) inhibitors, will help patients by slowing progression of axial spondyloarthritis (SpA). But this anticipated benefit has yet to be supported by study results.

The landmark step in formalizing the early identification of axial SpA was taken by a primarily Eurocentric organization, the Assessment of Spondyloarthritis International Society (ASAS). With the new ASAS classification criteria now published (Ann. Rheum. Dis. 2009;68:770-6; 778-83), it remains unclear whether most U.S. primary care physicians will buy into the criteria and apply them.

The report, published in June, showed that the new classification criteria (see box) identified people with axial SpA with a sensitivity of 83% and a specificity of 84% when tested on 649 patients. 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.

"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 old criteria 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 with its characteristic spinal-bone changes that are visible on plain x-ray films.

"The old classification criteria required patients to have x-ray changes of sacroiliitis, which take 6-10 years to develop after patients have other symptoms," said Dr. Atul Deodhar, medical director of the rheumatology clinics at the Oregon Health and Science University in Portland. "We definitely need new criteria; we can't call it ankylosing spondylitis if the patient doesn't have x-ray changes," he said in an interview. "We think that some—but not all—patients with axial spondyloarthritis will progress to ankylosing spondylitis."

Identification of inflammation in axial joints using MRI is a key element in the new axial SpA classification. Axial joint inflammation is often hard to diagnose without MRI because the affected joints are in locations that are impossible to palpate, Dr. Deodhar said.

He stressed that the appearance of axial joint inflammation on MRI is not enough to make the diagnosis, as this can occur in people without axial SpA. Other key factors include age younger than 45 years, slow onset of symptoms, reduced spine mobility, stiffness and pain that worsens with rest but improves with exercise (unlike mechanical back pain that improves with rest and worsens with exercise), and exacerbation of pain and stiffness while sleeping.

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. But even without evidence of slowed progression, early treatment "clearly improves quality of life and function and reduces time lost from work," Dr. Flynn said. ■

Features of Axial Spondyloarthritis

Patients with back pain for at least 3 months and with onset younger than 45 years are classified as having spondyloarthritis if they have sacroiliitis on imaging plus at least one spondyloarthritis feature, including:

- ► Inflammatory back pain
- ► Arthritis
- ► Enthesitis
- ► Uveitis
- ► Dactylitis
- ► Psoriasis
- ► Crohn's disease/ulcerative colitis
- ► Good response to NSAIDs
- ► Family history of spondyloarthritis
- ► HLA B27 positive
- ► Elevated C-reactive protein

Source: Ann. Rheum. Dis. 2009; 68:777-83

CLINICAL GUIDELINES FOR FAMILY PHYSICIANS

Opioids in Chronic Noncancer Pain

BY NEIL SKOLNIK, M.D., AND GINA MENICHELLO, D.O.

Chronic noncancer pain (CNCP) is a leading cause of disability and discomfort for patients in the United States. Health care expenses for chronic back pain alone were roughly $90 billion in 2005. Opioids have long been an accepted treatment for the pain associated with cancer or the end of life, and the past few decades have seen an increase in the use of opioids for chronic noncancer pain as well, although opioids in this setting remain controversial. The American Academy of Pain Medicine and American Pain Society recently gathered a multidisciplinary expert panel to formulate evidence-based guidelines on chronic opioid therapy (COT) for adults with CNCP (J. Pain 2009;10:113-30). Here is a quick look at their recommendations:

Guidelines are most useful when they are available at the point of care. A free and concise handheld computer version of this guideline is available for download at www.redi-reference.com.

Initiating Therapy

One of the most important aspects of initiating COT is proper patient selection. A thorough history and physical examination—as well as appropriate diagnostic tests to evaluate the patient's pain—should be completed. Clinicians should consider if the underlying condition causing pain can be treated with nonopioid therapy before deciding to start COT. Randomized trials demonstrating the benefit of COT are seen with patients who have moderate to severe pain that is unrelieved by nonopioid therapy. COT is effective for both neuropathic and nonneuropathic pain, and can be considered if the patient's functioning or quality of life is significantly affected and if benefits of therapy outweigh potential risks. It is important for patients to have reasonable expectations upon starting COT. Total pain relief is rare, and most patients' pain improves 2-3 points on a 0- to 10-point scale.

One of the most significant risks associated with opioid therapy is drug abuse or misuse. The strongest predictor of drug abuse or misuse in COT is a personal or family history of drug or alcohol abuse.

After receiving informed consent regarding the risks and benefits of COT, a written management plan should be considered. This plan can include the goals of therapy, random urine drug screens, instructions for dispensing medications, follow-up timeline, consequences for misuse of medications, and clarification that opioids should be obtained from only one prescriber.

There is no evidence that any one opioid is better for initiating therapy. It may be safer to begin with short-acting opioids for initial therapy because they have a shorter half-life and possibly less risk of accidental overdose; however, there is insufficient evidence to recommend short-acting vs. long-acting opioids. The suggested benefits of long-acting opioids include more consistent control of pain, improved compliance, and lower risk of addiction or abuse. For breakthrough pain, short-acting or rapid-onset opioids used as needed may be effective. There is limited evidence at this time to recommend any specific opioid in this setting.

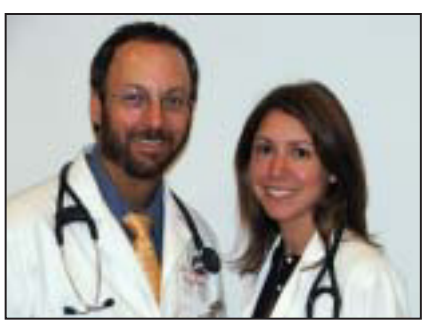
Methadone use has increased over the last decade, but clinicians need to be aware that it has complicated pharmacokinetics and should be used by clinicians familiar with its use and risks.

Monitoring Therapy

Patients on COT should be monitored periodically to assess level of function, pain severity, adverse events, compliance with drug regimens, and degree of progress to goals of therapy. Clinicians can obtain periodic urine drug screens in patients who are at high risk for drug abuse or misuse, and may consider such screening in low-risk patients. Patients with repeated dose titrations should be reassessed, especially for adverse effects and drug misuse. Opioid rotation may be considered for patients with intolerable adverse effects or those with inadequate pain control despite continued dose titration.

Patients involved in aberrant drug-related behaviors should be weaned off COT. Therapy should also be tapered for patients who are experiencing intolerable adverse effects or who are not progressing to goals of therapy. Slower rates of weaning (for example, a 10% dose reduction per week) may help decrease symptoms of withdrawal.

When prescribing COT, clinicians should consider incorporating psychotherapeutic interventions for the treatment of CNCP.



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