# Gains Seen in Ankylosing Spondylitis; Dx Lags

BY BRUCE K. DIXON
*Chicago Bureau*

CHICAGO — Early treatment of ankylosing spondylitis may or may not prevent structural damage but it certainly improves quality of life and the ability to function, Dr. John Davis told a symposium of the American College of Rheumatology.

Dr. Davis pointed to four reasons for why ankylosing spondylitis (AS) is typically diagnosed about 8 years after disease onset: low awareness of the spondyloarthritis among nonrheumatologists; the erroneous belief among rheumatologists that AS is a "man's disease"; the difficulty in differentiating between mechanical and inflammatory back pain; and reliance on radiologic sacroiliitis, which is a late feature of AS.

Dr. Davis, who directs the Clinical Trials Center at the University of California, San Francisco, noted that the Spondylitis Association of America guidelines call for a thorough physical exam including x-rays, individual medical history, and any family history of AS, as well as blood work that includes a test for HLA-B27 antigen. Important signs of AS include pain that has persisted longer than 3 months, back pain, and stiffness that worsen with immobility but ease with physical activity, and a positive response to NSAIDs.

Research efforts are now focusing on three TNF inhibitors. Phase III trials of three biologics showed good responses that were maintained at over 2 years (etanercept and infliximab) and 24 weeks (adalimumab). All three drugs significantly outperformed placebo in phase III studies using the Assessment in AS (ASAS) International Working Group criteria and the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI). The BASDAI form contains six visual analog scales ("none" to "very severe") on fatigue, neck, back or hip pain, joint pain and swelling, tender areas, and morning stiffness. "If you use the BASDAI as an outcome measure you should expect about a 50% improvement in the BASDAI 50 in all the anti-TNF studies," Dr. Davis explained, adding that physicians can print out the one-page form and have patients fill it out in their offices. The form is available at www.spondylitis.org/physician_resources/cme/basdai.pdf.

**Those with axial involvement should skip DMARDs and go directly to a biologic agent.**

**DR. DAVIS**

In studies using the ASAS 5/6 Improvement Criteria, patient responses to tumor necrosis factor (TNF) inhibition approached 50%. Under this protocol, said Dr. Davis, patients had to have an improvement of at least 20% in four of five domains, including patient global, pain, function, inflammation, C-reactive protein, and/or spinal mobility. "Also, total spinal fusion is not a contraindication for using anti-TNF agents, as about 10% of patients who enrolled in the adalimumab study could have had total spinal fusion yet they responded to that drug," he said, stressing that because anti-TNF therapy is lifelong, patients need to understand its risks and benefits.

International guidelines for treating patients with AS have been modified by the Spondyloarthritis Research and Treatment Network (SPARTAN) and are now in print (J. Rheumatol. 2006;33:978-82). "You can use the modified New York criteria or other evidence of spondyloarthropathy including inflammatory back pain, elevated acute phase reactants, rapid radiographic progression, spinal inflammation on imaging—including MRI—or, interestingly, ultrasound," Dr. Davis explained, noting that French researchers found ultrasound to be especially useful in assessing enthesopathies.

"Your patient should have a BASDAI score of at least 4, and you as a physician should assign a moderate disease activity score on either a visual analog scale or the Likert scale. In general, there are three clinical presentations you need to keep in mind … the axial, peripheral arthritis excluding the hip, and the entheses. Pick out the predominant feature that you're going to treat and follow. All the manifestations should be treated with at least two courses of an NSAID, and those with significant

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# AS Effects on Shoulder Often Are Overlooked

BY NANCY WALSH
*New York Bureau*

GLASGOW, SCOTLAND — Shoulder involvement is often overlooked in ankylosing spondylitis, despite patients' reports that upper body pain interferes with their daily activities, Dr. Charlotte E. Page reported in a poster session at the annual meeting of the British Society for Rheumatology.

Among a group of 31 ankylosing spondylitis (AS) patients attending a 2-week physiotherapy program who responded to questionnaires about their symptoms, 12 reported current shoulder pain, while 10 patients reported experiencing shoulder pain in the past, reported Dr. Page of the rheumatology department of University Hospital of Wales, Cardiff. The patients, aged 17-62 years, had a mean AS duration of 19 years.

Among patients with current shoulder pain, four reported bilateral symptoms, and nine indicated that their daily activities were affected. Among those with previous pain, three study patients reported that their shoulder involvement continued to interfere with their daily activities, noted Dr. Page.

The reported prevalence of shoulder pain among the general population is approximately 12%, and estimates among those with AS range from 7% to 33%, she noted. "Our prevalence of 39% is slightly higher, probably reflecting the type of patients who attend intensive physiotherapy programs."

Only 10 of the 22 patients who had either current or past shoulder pain had undergone one or more radiologic investigations. Eight had been evaluated with plain radiographs, three with ultrasound, and three with MRI arthrograms.

Among the eight patients who had received one or more corticosteroid injections to the shoulder region, five reported still having shoulder pain and six reported still experiencing symptoms that interfered with daily activities. Among the seven who had received physiotherapy directed at their shoulder symptoms, five continued to experience pain.

Specific physiotherapy and corticosteroid injections had therefore been given to only 32% and 36% of patients, respectively, and had not alleviated the symptoms in the majority, she noted.

Moreover, a total of 26 patients reported peripheral joint involvement other than the shoulder. Despite this, only six patients received disease-modifying antirheumatic drugs or anti–tumor necrosis factor–α therapy, which suggests an underappreciation of the extent of AS patients' peripheral joint pain, according to Dr. Page.

Much of the shoulder involvement was rotator cuff tendonitis, which can be imaged and treated, Dr. Page said in an interview. Patients should be asked specifically about this, she said.

"We all know about their hip pain but we seem to forget about the top half" of the body, she said. ■

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arthritis or refractory enthesopathies should have failed either methotrexate or sulfasalazine at maximally tolerated doses for at least 3 months. For those with axial involvement, there's no requirement for nonbiologic disease-modifying antirheumatic drugs (DMARDs) and they should go directly to a biologic agent," Dr. Davis said, adding that methotrexate and leflunomide have shown little evidence of efficacy in AS, while sulfasalizine has been shown to have effects mostly on peripheral manifestations. "Thalidomide and pamidronate interestingly have weak anti-TNF activity and have shown some clinical efficacy in small trials."

Muscle relaxants can help, particularly when the patient is starting physical therapy. Corticosteroids injected into the sacroiliac joints alleviate refractory pain and topical corticosteroids are effective in treating acute anterior uveitis, Dr. Davis said.

After placing a patient on TNF blockade, expect a response (based on clinical trials and clinical experience) within 12 weeks. "And you want a change in your BASDAI score of at least 50% or two units, and a change in your physician global score of at least one." Etanercept and infliximab have FDA approval, while approval of adalimumab is pending. Patients taking these medications should be screened for tuberculosis and consideration should be given to testing for hepatitis, especially in those from endemic areas, Dr. Davis said. ■