Myanmar Rheumatology Society

Spondyloarthropathy

Myanmar National Guideline

2022

Spondyloarthropathy

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Title	:	Spondyloarthropathy, Myanmar National Guideline
Effective Date	:	August 4, 2022
Version	:	First
Organization	:	Myanmar Rheumatology Society
Purpose	:	To provide a comprehensive guideline for management of Spondyloarthropathy
Intended Users	:	General Practitioners, Internists, Rheumatologists
Target Populations	:	Patients with Spondyloarthropathy
Funding Source	:	Myanmar Rheumatology Society
Update Plan	:	Every Five Years and as needed
Number of Copies	:	1000
Note	:	The following indicate the intended target users

- Rheumatologist
- Internist
- Primary Health Care (GP)

Foreward

I am happy to write a preface for another Myanmar National Guideline, for this time "Spondylo-arthropathy(SpA)". Although SpA is one of the common diseases in Rheumatology disorder, it was almost neglected in Myanmar before, partly because of unavailability of effective treatment option and partly because of the believe of the nature of the disease being not life threatening apart from pain and reduced quality of life. During this century, there are developments of new drugs which can be taken orally as well as biologics in ready filled syringe form in affordable price, and shift of public awareness putting more care on quality of life attracted more patients with inflammatory back pain to Rheumatologists. Although there are explosions of evidences and varieties of biologics, the available investigations and management tools are different in Myanmar from Europe and US. Eastern studies are more relevant to Myanmar in many ways.

The members of the guideline development group had critically appraised many available papers and evidences to get the consensus guidance for Myanmar doctors to help SpA patients most effectively in most understandable format.

I would like to mention the appreciation words for inputs from UM1, UM2, UM Mandalay rheumatologists, internists and not the least, from Physical Medicine & Rehabilitation department.

I believe it will be useful not only for rheumatologists, but also for internal medicine specialists as well as for general practitioners.

Dr. Chit Soe
President
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Contents

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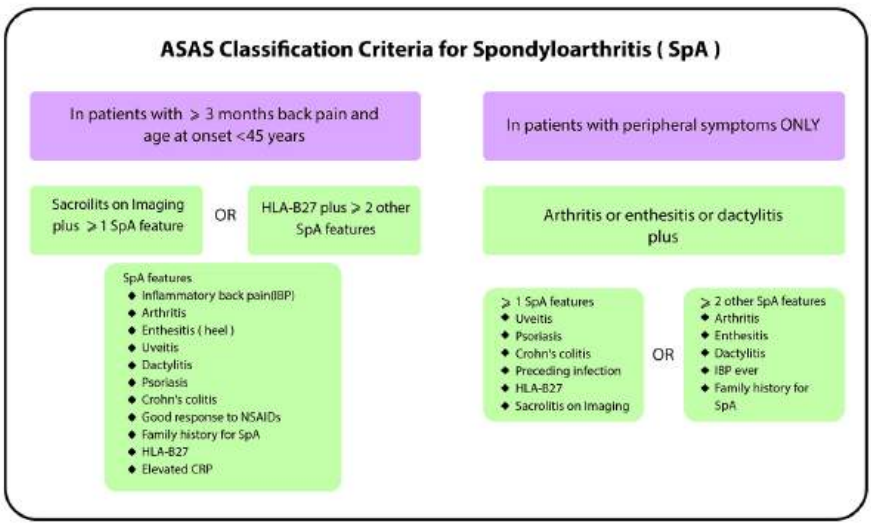
Section 1: Diagnosis of Spondyloarthropathy

1. (A) Criteria for Diagnosis of Spondyloarthropathy

Diagnosis of Spondyloarthropathy will be based on ASAS classification Criteria[1] (Sensitivity 79.5%, Specificity 83.3%, n = 975)



Inflammatory Back Pain (ASAS-iPain)

Insidious onset
Pain at night
Age at onset < 40 years
Improvement with exercise
No improvement with Rest

Good response to NSAIDs

Pain relief within 48 hours after NSAIDs use
& relapse within 48 hours after NSAIDs are stopped

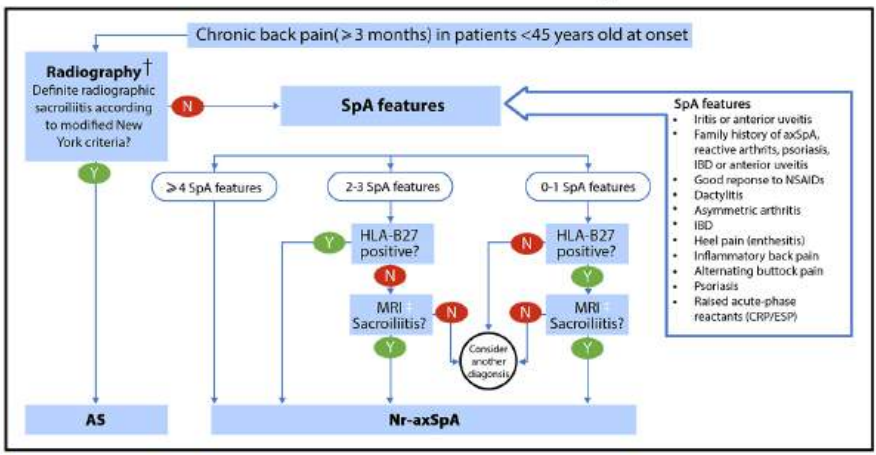
Diagnosis will be

- Axial SpA — purely Inflammatory Back Pain (IBP)
- Peripheral SpA (Arthritis / Psoriasis / Inflammatory bowel disease (IBD) / Uveitis / Enthesitis) with axial or without axial

1. (B) How to approach the patient with Low back Pain?

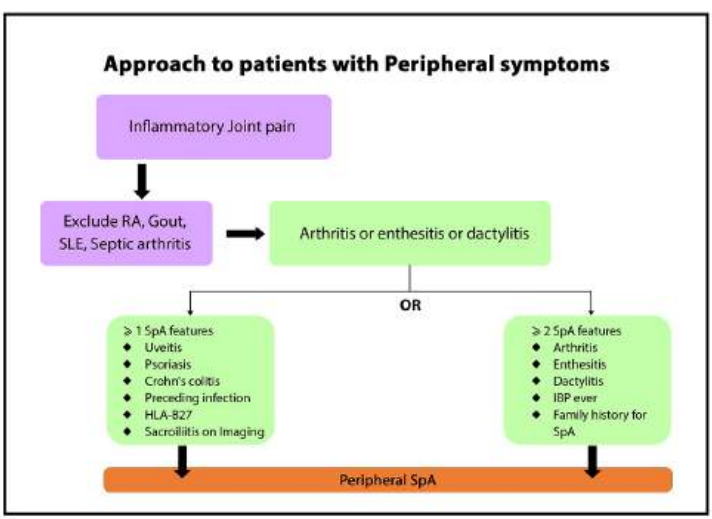
Patients presenting with low back pain should be approached according to ASAS modification of the Berlins algorithm

ASAS modification of the Berlins algorithm



(B) How to approach the patient with peripheral joint pain?

For those presenting with peripheral joint pain, the approach should be as follows:



1.(C) Imaging in Spondyloarthropathy :

There will be two options for Imaging assessment in SpA

1. Conventional Radiography
2. MRI
   (a) Only two sequences are necessary:
   (b) T1-weighted, plus either short tau inversion recovery (STIR) sequences or
   (c) T2-weighted sequences with fat suppression.
   (d) Contrast enhancement is not necessary, unless the findings without contrast are uncertain and a high suspicion of axSpA remains.
   (e) Oblique axial images, semicoronal (coronal oblique) MRI images of the SI joints should be obtained

Positive MRI finding means "A positive MRI, which should show at least two bone marrow edema lesions on the same slice, or one lesion in the same quadrant on at least two consecutive slices."

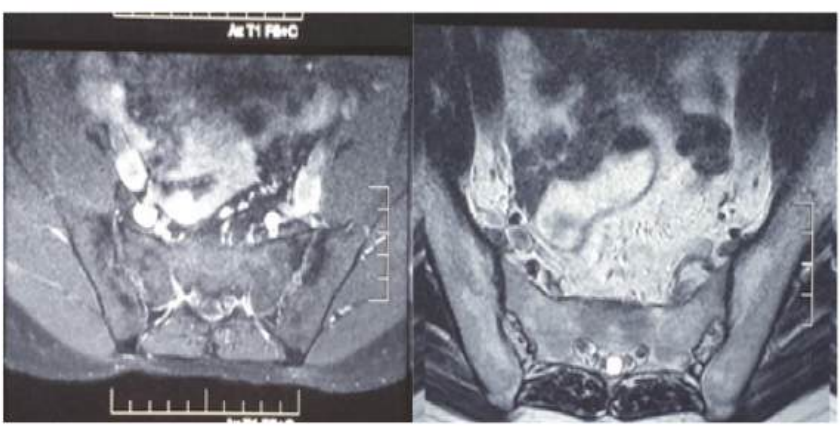


Figure: Bilateral Sacroiliitis (with verbal consent from patient)

Section 2: Referral and Shared Care in Spondyloarthropathy

A.Shared care in Spondyloarthropathy (Primary Health Care Level)

1. ***When to suspect SpA***

   Patients with Inflammatory LBP or oligo or polyarthritis not fulfilling criteria for RA or enthesitis or dactylitis persisting > 1month

2. ***What to do when spondyloarthropathy is suspected***

   The general practitioner should refer the patients to **Internists** or **Rheumatologists** if suspect a case of spondyloarthropathy to confirm diagnosis by Imaging and Laboratory tests or any cases with definite spondyloarthropathy to evaluate the extent of musculoskeletal and extra-musculoskeletal involvement such as interstitial lung disease (ILD), uveitis, psoriasis and inflammatory bowel diseases.

3. ***Monitoring and Indications for refer back to Rheumatologist***

   Monitoring should be done with CP, ESR, ALT, Creatinine at least every 3 to 6 months and as symptoms suggested at follow-up (see the details in the Section 4; monitoring)

   Refer back to Rheumatologist if

   (1) when there is the complication of treatment with NSAIDs or csDMARDs or bDMARDs or tsDMARDs
   (2) when the patient has family planning or becomes pregnant
   (3) when there is suspect of progression of existing extra-musculoskeletal manifestations or new involvement.

4. ***Continued care at primary health care level for the minor infections such as acute gastroenteritis without features of sepsis, upper respiratory tract infection, lower urinary tract infection or minor skin infections such as herpes simplex or fungal infection.***

B. The internists should refer the patients with spondyloarthropathy to Rheumatologist if

1. when the first diagnosis of spondyloarthropathy is being made
2. when the patient with spondyloarthropathy has been detected for extra-musculoskeletal involvement (ILD, uveitis or IBD)
3. when there is the complication of treatment with DMARDs
4. when the patient is pregnant

C. The rheumatologist should refer the patients with psoriatic arthritis to **Dermatologists** if the patients has extensive skin involvement(role of PUVA/UVB?)

Section 3: Initial Assessment in Spondyloarthropathy

Every patients suspected of Spondyloarthropathy must be referred to Rheumatologists or Internists and assessed with thorough history and physical examination with confirmatory investigations including MRI or HLA-B27.

Baseline investigations before immunosuppressants:

CP,ESR, Creatinine, ALT, RBS, CXR, ECG

Confirmatory Investigations:

conventional Radiography or MRI or HLA-B27

Assessment in confirmed SpA includes the following components[4] :

1. Function : BASFI (Bath Ankylosing Spondylitis Functional Index)
2. Pain : Numerical Rating Scale (NRS), Visual Analog Scale (VAS) (last week/spine/at night due to AS)
3. Spinal mobility:
    - Chest expansion
    - Modified Schober
    - Occiput to wall
    - Cervical rotation
    - Lateral spinal flexion or BASMI (Bath Ankylosing Spondylitis Metrology Index)
4. Patient global : NRS/VAS (global disease activity last week)
5. Stiffness : NRS/VAS (duration of morning stiffness/spine/last week)
6. Fatigue : Fatigue question BASDAI (Bath Ankylosing Spondylitis Disease Activity Index)

For activity and guide to start or taper DMARDs, ASDAS is needed to calculate with the formula described below.

- ASDAS CRP: 0.1216 total back pain+0.1106 patient global+0.0736 peripheral pain/swelling+0.0586 duration of morning stiffness+ 0.5796Ln(CRP+1).
- ASDAS ESR: 0.1136 patient global+ +0.0866 peripheral pain/swelling+0.0696 duration of morning stiffness+0.0796 total back pain.

◆ ASDAS CRP is preferred, but the ASDAS ESR can be used in case CRP data are not available. CRP in mg/litre; all patient assessments on a 10 cm scale.

◆ ASDAS calculator can be downloaded from Apple store or Google play or ASDAS can be calculated online (asas-group.org – ASDAS calculator)

The followings are included in the assessment:

Back Pain (BASDAI Question 2) [0-10]

Peripheral Pain/Swelling (BASDAI Question 3) [0-10]

Duration Morning Stiffness (BASDAI Question 6) [0-10]

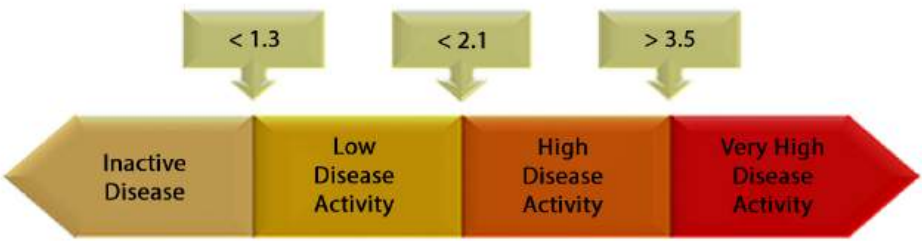
Patient Global [0-10]

CRP (mg/l mg/dl) or ESR(mm/hr)

ASDAS-CRP or ASDAS-ESR

A CRP value <2mg/l (0.2 mg/dl) is not allowed. If CRP is below the limit of detection or is <2 mg/l (<0.2 mg/dl), the fixed value of 2 mg/l (0.2 mg/dl) will be entered.

ASDAS disease activity states



ASDAS improvement criteria

⩾ 1.1 - clinically important improvement

⩾ 2 - major improvement

Section 4: Monitoring of the patients with Spondyloarthropathy

Monitoring at regular interval at primary health care level monthly or 3 monthly for stable patients on oral medication and at Specialist centre for at least once a year

A. Monitoring at primary health care level or specialist centre

- Disease activity assessment by ASDAS and extra-musculoskeletal manifestations at every visit
- CBC, RBS, Liver enzymes, Creatinine, urea and electrolytes, urine RE, cholestrol, CK (if myopathy present)
- Eye examination: for uveitis or cataract due to long-term steroid use
- Pregnancy screening in reproductive age females

B. Monitoring at Specialist Centre (preferably rheumatologists or internists if not available)

- Functional Assessment by BASFI, Pain score by NRC, Activity assessment by ASDAS and spinal mobility by BASMI (Internists and Rheumatologists)[4]
- BMD testing for age over 50 or risk of Osteoporosis (OP)
- CVD risk stratifications

Section 5: Management of Spondyloarthropathy

There will be musculoskeletal and extra-musculoskeletal manifestations such as uveitis, psoriasis and IBD in SpA and management need to consider the extra-musculoskeletal manifestations to guide the therapeutic decisions.

For details on NSAIDs, Steroid, csDMARDS and bDMARDS, refer to RA Guideline, MRS 2020 update.

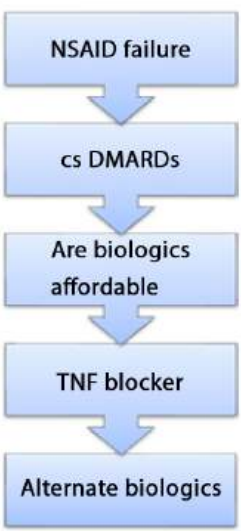
Treat-To-Target in SpA

- ASDAS score as disease activity assessment
- Improvement in ASDAS score at least 1.1 for continuation or tapering or discontinuation of Treatment
- Assessment Interval - 3 to 6 months

Recommendation for NSAIDs

NSAIDs recommended for continuous use rather than as required.
** choice of NSAIDs depends on presence of comorbidies such as GI, Renal and CVD and monitoring of side effects is recommended.

Indications for csDMARDs



Sulfasalazine is effective in axial AS exp. in younger patients (<25 years), disease duration < 4 years at the time of initiation of treatment and high disease activity (BASDAI > 7, CRP > 50 mg/L).

Methotrexate should be used in ax SpA with Peripheral involvement

Leflunomide should not be used in ax SpA

Combination of Sulphasalazine and Methotrexate should be considered in Ax-SpA with peripheral involvement

Proposed Strategies for Axial SpA

- Recommend bDMARDs
- Choice of csDMARDs depends on adverse events, affordability of bDMARDs and contraindications

Proposed strategies for peripheral SpA

- Choice of csDMARDs depends on adverse events, affordability of bDMARDs and contraindications

Indications for bDMARDs[2]

bDMARDs or tsDMARDs will be considered in patients with diagnosis of axial SpA by Rheumatologists

+ Elevated CRP or positive MRI-SIJ or Radiographic sacroiliitis
+ Failure of Standard Treatment
+ High ASDAS >=2.1
+ Positive rheumatologist's opinion

Failure of Standard Treatment in Axial SpA means failure of the followings;

(A) All patients – at least 2 NSAIDs over 4 weeks in total

(B) Patients with predominant peripheral manifestations: one local steroid injection if appropriate or normally therapeutic trial of sulfasalazine

bDMARDS and tsDMARDs for Axial SpA

bDMARDs : Adalimumab (Exemptia), Etanercept (Etveza)
tsDMARDs: Tofacitinib, Baricitinib(off-label)

Dosage of tsDMARD (JAKi)

Oral Tofacitinib 5 mg BD (avoid in patients with thromboembolic risks)
Oral Baricitinib 2 mg – 4 mg OD (cautions: patients with CVD)

Dosage of bDMARDs including biosimilar TNFi:

Etanercept – subcutaneous 50 mg/week
Adalimumab – subcutaneous 40 mg every other week

Dietary recommendations

- Food to avoid : Excess red meat, processed foods, excess sugar, salt, fried foods, artificial color, flavors and additives
- Avoid smoking
- recommend for supplements of VitD, Omega3 and probiotic

Section 6. Minimal Care in Spondyloarthropathy

Minimal Care in SpA includes

1. Management of Arthritis: Treat-to-Target (NSAID, Steroid, DMARD) and physiotherpy
2. Management of Eye, lung, Extra-musculoskeletal manifestations
3. Management of Complications: GI, Osteoporosis
4. Prevention CVD & Infections: CVD risk stratification, Immunization
5. Social & family planning, Lactation: counselling with partner

6. (a) Bone protection[3]

All adults taking Prednisone at a dose of 2.5 mg/day for 3 months

- Optimize calcium intake (1,000–1,200 mg/day) and vitamin D intake (600–800 IU/day) and
- Lifestyle modifications
  - balanced diet,
  - maintaining weight in the recommended range,
  - smoking cessation,
  - regular weight-bearing or resistance training exercise,
  - limiting alcohol intake to 1–2 units of alcoholic beverages/day

In Adults age $\geqslant$ 40 years at moderate to high risk of major fracture,

- An oral bisphosphonate is prefered to IV bisphosphonates, teriparatide, denosumab, or raloxifene

6. (b) Nutrition

- Advice on optimal nutritional intake and explain the impact from taboo
- Balanced diet with carbohydrate, protein, fat and trace elements as well as vitamins

6. (c) CVD risk stratification and prevention

- High CVD risk in SpA patients especially in axial SpA
- regularly screen, monitor and address CVD risks in SpA patients within 6 months of diagnosis and depending on individual risk factors especially to those taking tsDMARDs
- Healthy lifestyle to reduce CVD risks

6. (d) Vaccination and infection screening

Infections

- Higher risk of infections in SpA
- depending on Individual risk of infections and severity of infections
- Vaccination for SpA
  - HBV: double dose of HBV i.e, 2 vials at 0,1,2 or 0,1,6 regime. Booster dose in those already vaccinated
  - Flu vaccine yearly
  - Covid vaccine according to national program.
  - Pneumococcal vaccine every 5 years if available
  - Avoid live vaccines

Have low threshold for infection screening especially Koch's lung which can reactivate re-infected or co-existing in patients with chronic lung disease such as ILD.

6. (e) Family planning and lactation (6)

Family planning

- Pregnancy _ no contraindication
- Oligospermia in male patients on SSZ
- Every patients of reproductive age should be counselled for family planning and pregnancy before starting treatment
- Their partners also need to be counselled.

Recommend against pregnancy while the disease is active

*****Refer to OGs before planned pregnancy and during pregnancy for proper AN care.**

Use of Drugs during Pregnancy

Minimal : SSZ
Selective use: TNFi, NSAIDs
Moderate to high risk : Lef, MTX
Limited information: IL-17, tsDMARDs

Postpone pregancy (use the contraceptive) till

- 2 years after leflunomide
- 6 months after the last dose of methotrexate

Pregnant while on DMARDs

Elimination procedure for leflunomide:

- PO Cholestyramine 8 grams TDS for 11 days

During lactation,

- the following drugs should be continued : HCQ, CQ, SSZ, AZA, Ciclosporin, TAC, Colchicine, prednisolone, Immunoglobin, non-selective COX inhibitors and celecoxib
- the following drugs should be avoided: methotrexate, leflunomide, tofacitinib, COX II inhibitors apart from celecoxib
- Biologics: infliximab, adalimumab, etanercept and certolizumab can be continued due to low transfer to breast milk

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