

key points

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The spondyloarthritis group is divided into two main subgroups: axial spondyloarthritis and peripheral spondyloarthritis. These may exist as separate entities or coexist in the same patient. Axial spondyloarthritis can be further subdivided into non-radiographic axial spondyloarthritis and ankylosing spondylitis (AS). Peripheral spondyloarthritis encompasses psoriatic arthritis, reactive arthritis and enteropathic arthritis. Axial spondyloarthritis tends to occur before the age of 45 years but can occur in older age groups, while peripheral spondyloarthritis tends to affect a wider age group.

The association with the HLA-B27 gene is well established. The vast majority of patients with AS are male, while non-radiographic spondyloarthritis affects both genders equally. Genitourinary and gastrointestinal infections with specific pathogens (*Chlamydia trachomatis* and Shigella, Salmonella and Campylobacter, respectively) are recognised triggers for reactive arthritis. Classically, axial spondyloarthritis presents with insidious onset inflammatory lower back pain, which is typically worse in the morning and after rest, and improves with activity. Peripheral spondyloarthritis can present with peripheral joint pain and/or swelling, swelling of the digits (dactylitis), tendon and enthesal pain that is not secondary to a mechanical cause.

Early referral of patients with suspected spondyloarthritis to specialist care is strongly recommended as this can improve long-term outcomes. In the UK, HLA-B27 is present in up to 90-95% of AS patients and around 50-60% of psoriatic arthritis patients but a negative result does not rule out a spondyloarthritis.

HLA-B27 testing and imaging with plain X-rays are extremely valuable in supporting the diagnosis of spondyloarthritis. NSAIDs (COX-1 and COX-2 inhibitors) are the first-line treatment for axial spondyloarthritis and should be used at the lowest effective dose. The risks and benefits of using NSAIDs should be assessed and gastric protection should be considered. Patients with intolerance or contraindications to NSAIDs, and patients who do not respond to at least two different NSAIDs at the maximum tolerated dose (2-4 weeks each), should be considered for biologic DMARDs. Monitoring of standard and biologic DMARDs requires regular follow-up in a specialist clinic to assess efficacy, and regular blood test monitoring to assess safety.

Flares can be managed with NSAIDs, or oral, intramuscular or intra-articular steroids depending on the nature of the flare. For patients with coexistent psoriasis, there is a small risk of psoriasis exacerbation with oral steroids.