ASAS 2023 Annual Meeting – Report

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The Assessment of Spondyloarthritis International Society (ASAS) is an international society of experts in the field of spondyloarthritis. The mission of ASAS is to support and promote translational and clinical research of spondyloarthritis. The ultimate goal is to improve the wellbeing and outcome of patients with spondyloarthritis.

The means to achieve this goal include:

- Increasing awareness of spondyloarthritis
- Facilitating early diagnosis
- Developing and validating assessment tools
- Evaluating treatment modalities

ASAS members come from 46 countries, 62% work in Europe, 16% in Asia, 14% North America, 5% South America and a small %age in Africa and Oceania.

At the end of 2022, ASAS and ASIF signed a Memorandum of Understanding (MOU) to put our relationship on a more formal footing. This MOU means that both organisations will aim to keep each other informed of key plans agree to identify opportunities for collaboration and will contribute expertise and experience towards mutually agreed objectives.

The Trustees of ASIF were delighted to be invited to send two representatives to attend the ASAS 2023 Annual Meeting which took place in Athens in January. Andri Phoka (pictured left), Secretary, ASIF and Jo Davies (pictured right), Assistant Director, ASIF joined the meeting. We are especially thankful to Xenofon Baraliakos (pictured centre), President of ASAS and to the rest of the Executive Committee for making us so welcome. During the meeting, ASAS educational activities and research projects were presented and discussed. This report covers just a few highlights from the ASAS 2023 Annual Meeting.

ASAS provides a Core Course on Sponydloarthritis – please share details about the upcoming course on 10 and 11 March in Brussels with any Health Professionals you know who might benefit from attending.

The ASAS website offers open access to a slide library. The slides provide a broad overview of the various aspects of spondyloarthritis. It is a very helpful tool that anyone can use. Many slides are available in languages other than English.

The meeting started with an update on ASAS' finished projects – you can find more information about ASAS research projects – completed and ongoing - on the ASAS website

ASAS PerSpA - Peripheral Involvement in SpondyloArthritis

The objective of this cross-sectional study with 24 participating countries was to characterise peripheral musculoskeletal involvement in patients with spondyloarthritis (SpA) including psoriatic arthritis (PsA), across the world.

Conclusion: The results suggest that all peripheral features can be found in all subtypes of SpA, and that differences are quantitative rather than qualitative. In a high proportion of patients, axial and peripheral manifestations coincided. The findings reconfirm SpA clinical subtypes are descendants of the same underlying disease, called SpA.

ASAS Recommendations for requesting and reporting imaging examinations
ASAS' own Michael Mallinson sat on the committee for this project.

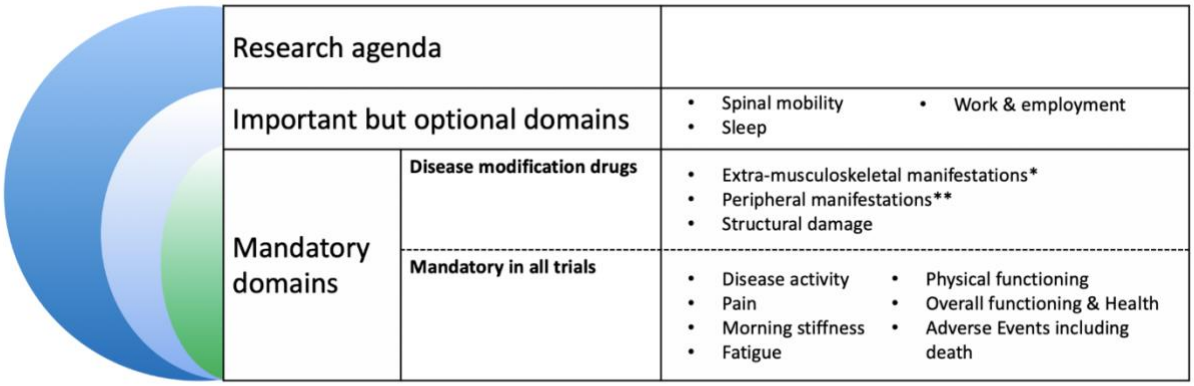
This project developed easy-to-follow guidance for requesting and reporting imaging in axSpA and for standardising communication between rheumatologists and radiologists to improve diagnosis and patient care.

This was a welcome project that successfully bridges the gap between scientific data and daily clinical practice. There were discussions about how to further disseminate the guidance and ensure its implementation in clinical practice.

ASAS Core Outcome Set
The ASAS-'Outcome Measures in Rheumatology' (ASAS-OMERACT) core outcome set (COS) for ankylosing spondylitis (AS) was developed more than two decades ago. Given the progress made since then, ASAS decided to update the original COS for AS into a COS for axial spondyloarthritis.

The new ASAS-OMERACT core domain set was updated and published. This includes 7 mandatory domains for all studies and 3 additional mandatory domains for studies evaluating DMARDs.

OMERACT Endorsed Core Domain Set for Axial Spondyloarthritis



*Important but optional for trials other than DMARDs (uveitis, IBD, psoriasis)
** Important but optional for trials other than DMARDs (arthritis, enthesitis, dactylitis)

The second phase of the project updated the selection of instruments. The updated core set for axSpA includes seven instruments for the domains that are mandatory for all trials.

The updated ASAS COS for axSpA is a milestone in the field of axSpA. This COS will contribute to ensure that the most relevant aspects of the disease are assessed in all studies and that this is done in a standardised and homogeneous way that will allow comparisons of results across studies. From now on it should be used in all trials evaluating the efficacy and safety of any type of therapy in patients with axSpA.

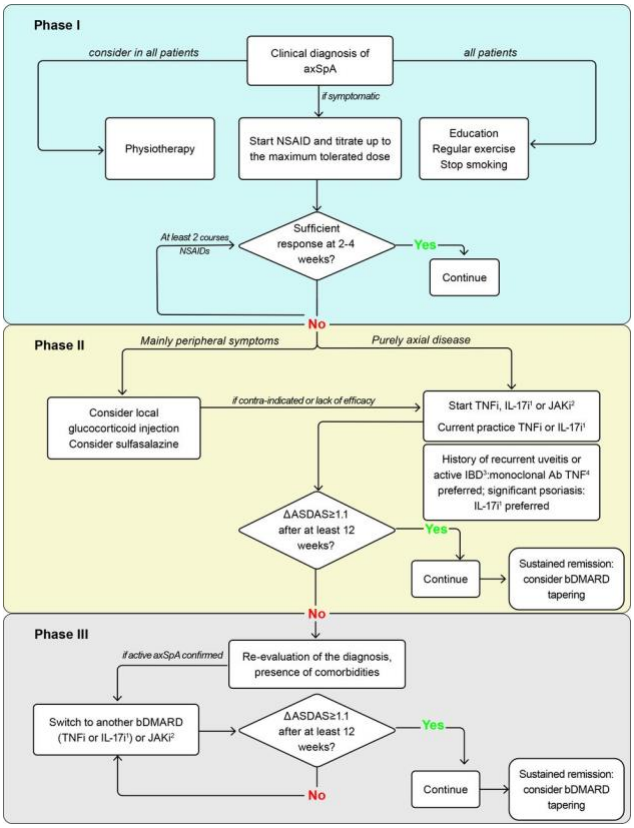
ASAS/EULAR recommendations for the management of axSpA updateASAS and European Alliance of Associations for Rheumatology (EULAR) released in 2022 updated guidance for clinicians for the management of patients with axSpA. The overarching principles remained the same as in the 2016 update. Of the 15 recommendations 8 were unchanged, others were significantly updated or added.

Table: ASAS-EULAR recommendations for the management of axial spondyloarthritis, 2022 update

	OVERARCHING PRINCIPLES
A	Axial Spondyloarthritis (axSpA) is a potentially severe disease with diverse manifestations, usually requiring multidisciplinary management coordinated by the rheumatologist.
B	The primary goal of treating the patient with axSpA is to maximize health related quality of life through control of symptoms and inflammation, prevention of progressive structural damage, preservation/normalisation of function and social participation.
C	The optimal management of patients with axSpA requires a combination of non-pharmacological and pharmacological treatment modalities.
D	Treatment of axSpA should aim at the best care and must be based on a shared decision between the patient and the rheumatologist.
E	axSpA incurs high individual, medical and societal costs, all of which should be considered in its management by the treating rheumatologist.
	RECOMMENDATIONS
1	The treatment of patients with axSpA should be individualised according to the current signs and symptoms of the disease (axial, peripheral, extra-musculoskeletal manifestations) and the patient characteristics including comorbidities and psychosocial factors.
2	Disease monitoring of patients with axSpA should include patient reported outcomes, clinical findings, laboratory tests and imaging, all with the appropriate instruments and relevant to the clinical presentation. The frequency of monitoring should be decided on an individual basis depending on symptoms, severity, and treatment.
3	Treatment should be guided according to a predefined treatment target.
4	Patients should be educated about axSpA and encouraged to exercise on a regular basis and stop smoking; physiotherapy should be considered.
5	Patients suffering from pain and stiffness should use an NSAID as first line drug treatment up to the maximum dose, taking risks and benefits into account. For patients who respond well to NSAIDs continuous use is preferred if needed to control symptoms.
6	Analgesics, such as paracetamol and opioid-(like) drugs, might be considered for residual pain after previously recommended treatments have failed, are contraindicated, and/or poorly tolerated.
7	Glucocorticoid injections directed to the local site of musculoskeletal inflammation may be considered. Patients with axial disease should not receive long-term treatment with systemic glucocorticoids.
8	Patients with purely axial disease should normally not be treated with csDMARDs; Sulfasalazine may be considered in patients with peripheral arthritis.
9	TNFi, IL-17i* or JAKi^ should be considered in patients with persistently high disease activity despite conventional treatments (Figure 1); current practice is to start a TNFi or IL-17i*.
10	If there is a history of recurrent uveitis or active IBD, preference should be given to a monoclonal antibody against TNFα**. In patients with significant psoriasis, an IL-17i* may be preferred.
11	Absence of response to treatment should trigger re-evaluation of the diagnosis and consideration of the presence of comorbidities
12	Following a first b/tsDMARD failure, switching to another bDMARD (TNFi or IL-17i*) or a JAKi^ should be considered.
13	If a patient is in sustained remission, tapering of a bDMARD can be considered.
14	Total hip arthroplasty should be considered in patients with refractory pain or disability and radiographic evidence of structural damage, independent of age; spinal corrective osteotomy in specialised centres may be considered in patients with severe disabling deformity.
15	If a significant change in the course of the disease occurs, causes other than inflammation, such as a spinal fracture, should be considered and appropriate evaluation, including imaging, should be performed.

*IL-17i: refers only to IL-17A-inhibitors; ^special caution in patients with CV risk factors and patients >65 years **This includes a pegylated Fab' fragment

A new treatment algorithm – of the patient journey – was formulated (Figure 1 and table 1 from the ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. Reprinted from the Annals of Rheumatic Diseases with kind permission from BMJ publishing group ltd):



Algorithm based on the ASAS-EULAR recommendations for the management of axial spondyloarthritis (axSpA). Ab, antibody; ASAS, Assessment of SpondyloArthritis international Society; ASDAS, Ankylosing Spondylitis Disease Activity Score; bDMARD, biological disease-modifying antirheumatic drug; IBD, inflammatory bowel disease; IL-17i, interleukin-17 inhibitors; JAKi, Janus kinase inhibitors; NSAID, non-steroidal anti-inflammatory drug; TNFi, tumour necrosis factor inhibitors.

Nomenclature

There were lengthy discussions about what we call our disease. We all know there are many different names and a lot of confusion, certainly among patients. Do we have axial spondyloarthritis, axSpA, Ankylosing Spondylitis, r- or nr-axSpA, Morbus Bechterew – and on it goes?

Axial Spondyloarthritis includes the sub-types of the condition - nr-axial spondyloarthritis (nr-axSpA) and r-axial spondyloarthritis (r-axSpA) otherwise

known as Ankylosing Spondylitis (AS). A few years ago, ASAS proposed to use the terms radiographic axSpA and ankylosing spondylitis as interchangeable terms. It seems that this is still leading to confusion as many recent clinical trials continue to use the term AS (ankylosing spondylitis) instead of r-axSpA and people erroneously are interpreting this is a different disease from nr-axSpA.

Andri asked the assembled meeting to take a lead and stop the confusion; she said that it is clear from some of the messages received from patients that they are not sure what they have because it has so many different names.

On-going ASAS Research Projects

There was an update on the on-going projects including:

SPEAR – ASAS Spondyloarthritis Early definition
To develop a consensual definition for the terms early axSpA and early pSpA in a research setting. The terms early axial spondyloarthritis and early peripheral spondyloarthritis are routinely used in research. This project aims to establish a standardised definition of those terms to be used in studies.

ASAS D2T SpA – ASAS definition of difficult-to-treat axial spondyloarthritis
In 2021 EULAR had developed points to consider (PtCs) for the management of difficult-to-treat rheumatoid arthritis (D2T RA). A useful tool for clinicians to refer to when considering treatment options.

Despite the availability of several potent anti-inflammatory treatment options, many axSpA patients remain non-responsive to treatment. This project aims to develop a consensus definition of what is meant by difficult to treat axSpA.

AXIS - Axial Involvement in Psoriatic Arthritis
Involvement of the axial skeleton (sacroiliac joints and spine) is a relatively frequent manifestation associated with psoriatic skin disease, mostly along with involvement of peripheral musculoskeletal structures (peripheral arthritis, enthesitis, dactylitis), which are referred to as psoriatic arthritis (PsA). Data suggest that up to 30% of patients with psoriasis have PsA. Depending on the definition used, the prevalence of axial involvement varies from 25% to 70% of patients with PsA. However, there are currently no widely accepted criteria for axial involvement in PsA. The overarching aim of the AXIS study is to systematically evaluate clinical and imaging manifestations indicative of axial involvement in patients with PsA and to develop classification criteria and unified nomenclature for axial involvement in PsA.

CLASSIC - ASAS Classification of Axial SpondyloarthritiS Inception Cohort

ASAS has developed classification criteria for axial spondyloarthritis that allow the inclusion of patients with an early form of disease that is not yet clearly visible on plain radiography. The external standard for evaluation of these criteria was the rheumatologist expert opinion of the SpA diagnosis after incorporating laboratory and imaging data with clinical evaluation. Since their introduction, some have raised concerns regarding the ASAS classification criteria as substantial differences in the prevalence estimates of axSpA have been found. A joint meeting of the ASAS and the SpA Research and Treatment Network (SPARTAN) executive boards has recommended that the ASAS classification criteria undergo further validation in a prospective cohort in North America (Canada, Mexico, and United States) under supervision of SPARTAN and in a prospective cohort in Europe and other parts of the world of patients under supervision of ASAS presenting with undiagnosed active chronic back pain to rheumatologists. The aim is to validate the performance of the current ASAS classification criteria in a prospective combined cohort of patients presenting to a rheumatologist in North America, Europe and other parts of the world with undiagnosed current back pain of ≥3 months duration with onset ≤years of age. If a specificity of ≥90% and a sensitivity of ≥75% of the original ASAS criteria will be found in the study, the ASAS criteria will be considered validated and no further analyses will be done. Only if the primary objective is not met, refinements of the criteria will be made and tested.

You can find out more about ASAS research projects on the ASAS website.