ACR Convergence 2022

12S142. Abstracts: Spondyloarthritis Including PsA – Treatment I: Axial Spondyloarthritis (0542–0547)

0542. ASAS-EULAR Recommendations for the Management of Axial Spondyloarthritis: 2022 update.

Presented by Dr. Sofia Ramiro, Leiden University Medical Centre.

We have previously reported on the updated ASAS-EULAR recommendations, but Sofia's presentation explained the rationale, methodology, and thinking behind the updates, so we are reporting on them again.

The last update to the ASAS-EULAR recommendations was in 2016. Since then, there have been new insights into the disease and its treatment, and a new drug class has become available. The update was the work of a task force of 33 members from 16 countries. The task force used the 2014 EULAR Standardised Operating Procedures and conducted two systematic literature reviews, one on the safety and efficacy of non-pharmacological and non-biological interventions and the other on the efficacy and safety of biological DMARDs. The task force met to discuss the systematic literature reviews, the overarching principles, updates to the recommendations if warranted by the evidence and to achieve a consensus by rounds of voting.

The Overarching Principles are described below:

ASAS/EULAR Recommendations for the Management of Axial Spondyloarthritis: Overarching Principles

1. axSpA is a potentially severe disease with diverse manifestations, usually requiring multidisciplinary treatment coordinated by the rheumatologist.
2. The primary goal of treating the patient with axSpA is to maximise health-related quality of life through control of symptoms and inflammation, prevention of progressive structural damage, preservation/normalisation of function and social participation.
3. The optimal treatment of patients with axSpA requires a combination of non-pharmacological and pharmacological treatment modalities.
4. Treatment of axSpA should aim at the best care and must be based on a shared decision between the patient and the rheumatologist.
5. axSpA incurs high individual and societal costs, all of which should be considered in its management by the treating rheumatologist.

van der Heijde D et al. Ann Rheum Dis. 2017;76:978-991 (with permission)

There are 15 recommendations, eight of which (nos. 2,3,6,7,8,13, 14, 15) are unchanged. Three (nos.1,4,5) have minor edits, mainly to nomenclature. Two have been significantly updated (nos. 9,12), and two (nos. 10, 11) are newly formulated.

Sofia noted that this is the first time that the recommendations have been based on ASDAS because it has been seen that ASDAS outperforms other measurements, specifically BASDAI. In going through the three Phases of recommendations, in Phase I, immediately after diagnosis, all patients should be advised to educate themselves about the disease, to exercise, and to stop smoking, if applicable. Additionally, physiotherapy should be considered for all patients.

The first pharmacological treatment is NSAIDs, which is to continue for those patients who have a sufficiently positive response to them. These patients may eventually be prescribed NSAIDs on demand. For patients who do not respond to a course of NSAIDs over 2-4 weeks, another NSAID should be tried. If they fail to respond adequately to the second NSAID, Phase II addresses starting on biologic or targeted synthetic DMARDs.

Recommendations 9 and 10 cover starting on biologics. The conditions to do so are that the patient has a rheumatologist's diagnosis of axSpA, and that they have an elevated CRP or a positive MRI-SIJ or radiographic sacroiliitis, and a failure of

standard treatment (at least two NSAIDs and for patients with predominantly peripheral manifestations, local steroid injections and/or a therapeutic trial of sulfasalazine). Patients should also have high disease activity of at least ASDAS 2.1 or more, plus a positive rheumatologist's opinion on starting biologics.

Recommendations 9 and 10 say that TNFi, IL-17i, or JAKi should be considered for patients meeting the above conditions, noting that the current practice is to start on TNFi or IL-17i (specifically IL-17A-inhibitors). How to choose between the two? New Recommendation 10 says preference is given to TNFi where the patient has extra-musculoskeletal manifestations (for example, uveitis or IBD) and to IL-17i if the patient has significant psoriasis.

JAKi should be given with caution because of the EMA and FDA warnings about administering them to certain patients. The EMA warning dated 26 October, 2022 is as follows:

EMA recommends measures to minimise risk of serious side effects with Janus kinase inhibitors for chronic inflammatory disorders.

EMA's safety committee (PRAC) has recommended measures to minimise the risk of serious side effects associated with Janus kinase (JAK) inhibitors. These side effects include cardiovascular conditions, blood clots, cancer and serious infections.

The Committee recommended that these medicines should be used in the following patients only if no suitable treatment alternatives are available: those aged 65 years or above, those at increased risk of major cardiovascular problems (such as heart attack or stroke), those who smoke or have done so for a long time in the past and those at increased risk of cancer.

The Committee also recommended using JAK inhibitors with caution in patients with risk factors for blood clots in the lungs and in deep veins (venous thromboembolism, VTE) other than those listed above. Further, the doses should be reduced in some patient groups who may be at risk of VTE, cancer or major cardiovascular problems.

The next Phase of the recommendations deals with the continuation of b/tsDMARDs. If, after 12 weeks of treatment, there is an improvement in ASDAS of 1.1 or more, and the rheumatologist's opinion is to continue, therapy can continue. New Recommendation 11, which is driven by evidence from daily clinical practice, says that the absence of a response to b/tsDMARD treatment should prompt a re-evaluation of the diagnosis and consideration of the presence of comorbidities. Recommendation 12 says that if active axSpA is confirmed following a first b/tsDMARDs failure, the patient should be switched to another bDMARD or a JAKi.

ASAS slides relevant to the updated Recommendations can be seen and downloaded from the ASAS Educational Slides library: https://sl.asas-group.org/?_sf_s=ASAS%20EULAR%20recommendations&_sft_category=treatment