In a prospective cohort with a high pre-test probability of axSpA certain clinical SpA features were not helpful in discriminating a diagnosis of SpA from not-SpA. Deletion of these features from the list of SpA features used in the ASAS classification criteria enhanced the performance of the criteria, especially in female patients and those with early disease.

References:

Objectives: Walter P. Maksymowych Grant/research support from: AbbVie, Novartis, and UCB, Consultant of: AbbVie, Boehringer Ingelheim, Celgene, Eli Lilly, Galapagos, Janssen, Novartis, and UCB, Employee of: Chief Medical Officer of CARE Arthritis Limited, Speaking bureau: AbbVie, Janssen, Novartis, and UCB, Raj Carmona: None declared, Jon Chan: None declared, James Yeung: None declared, Sibel Aydin: None declared, Liam Martin: None declared, Ariel Masetto: None declared, Olga Ziouzina: None declared, Stephanie Keeling: None declared, Sherry Rohekar: None declared, Rana Dadashova: None declared, Joel Pasche: None declared, Amanda Carapellucci: None declared, Robert G Lambert: None declared.

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Axial spondyloarthritis. Misclassification may be associated with this delay, as treatment responses in patients with SpA, including psoriatic arthritis (PsA) and nail psoriasis. Increased physician awareness of the potential overlap and distinctions between SpA and RA, especially seronegative RA, may present with similar manifestations in SpA vs. RA, overlap was present suggesting that misclassification could occur. Differences in the prevalence of manifestations were also seen in the early vs. late RA populations as well as by RA serostatus. This suggests that an earlier and comprehensive evaluation, including advanced imaging of peripheral manifestations such as enthesitis, dactylitis, axial symptoms, and skin signs such as psoriasis and nail disease, among RA and SpA patients may reduce misclassification and inappropriate treatment. Further research is needed to confirm these findings.

References:

P. J. Mease, M. K. Bhati, P. Hur, E. Yi, N. Kim. Swedish Medical Centre. Providence St Joseph Health and University of Washington, Seattle, WA, United States of America; Novartis Healthcare Pvt Ltd, Hyderabad, India; Novartis Pharmaceuticals Corporation, East Hanover, NJ, United States of America; Baylor Scott & White Health, Temple, TX and University of Texas at Austin, Austin, TX, United States of America

Background: Delayed diagnosis is associated with worse outcomes and poor treatment responses in patients with SpA, including psoriatic arthritis (PsA) and axial spondyloarthritis. Misclassification may be associated with this delay, as SpA and RA, especially seronegative RA, may present with similar manifestations such as joint pain, swelling, fatigue, and disability. Key features that typically distinguish SpA from RA include spine pain, dactylitis, enthesitis, psoriasis, and nail psoriasis. Increased physician awareness of the potential overlap and distinctions between SpA and RA manifestations is needed for the early diagnosis and appropriate treatment for SpA.

Objectives: To identify and summarise the published literature on the prevalence of SpA-related clinical manifestations among patients with RA and SpA.

Methods: Publications were retrieved from Embase®, Cochrane, MEDLINE®, and MEDLINE® In-Process databases. Studies were included if they were non-interventional, recruited patients with RA and SpA, or patients with seronegative/seropositive RA, and reported the following manifestations: enthesitis, dactylitis, axial symptoms, psoriasis, or nail psoriasis. Two reviewers assessed each citation against predefined eligibility criteria, with discrepancies reconciled by a third independent reviewer.

Results: Of the 4479 publications retrieved, 18 studies were included (Figure 1). All studies compared SpA populations to patients with RA. Of the 18 studies, 11 studies reported patients with only PsA, 2 studies reported patients with only ankylosing spondylitis (AS), and 5 studies reported mixed SpA populations. Three studies each reported data pertaining to seropositive/seronegative RA and early RA, defined as symptom onset <1 year. The majority (N=12) of studies used ultrasound imaging to identify manifestations of interest. Enthesitis (N=17) was the most frequently evaluated manifestation while axial symptoms (N=2) was least evaluated. Of the studies reporting enthesitis, the majority (N=14) reported a higher prevalence of enthesitis in the SpA cohort compared to the RA cohort. The remaining studies (N=3) reported no significant difference in enthesitis between the SpA and RA cohorts. Notably, these 3 studies comprised of the 2 studies evaluating only AS patients, and all 3 studies evaluated late RA patients. In contrast, the 3 studies that reported early RA and PsA patients found a significantly higher prevalence of enthesitis in early PsA vs. early RA cohort. Two of the 3 studies reporting RA serostatus found a higher prevalence of enthesitis, psoriasis, and/or nail psoriasis in the SpA population compared to seronegative and seropositive RA cohorts. All studies reporting axial symptoms, dactylitis, psoriasis, and nail psoriasis found a higher prevalence of the corresponding manifestation in the SpA vs. RA cohort.

Conclusion: While this review found a higher prevalence of key SpA-related clinical manifestations in SpA vs. RA, overlap was present suggesting that misclassification could occur. Differences in the prevalence of manifestations were also seen in the early vs. late RA populations as well as by RA serostatus. This suggests that an earlier and comprehensive evaluation, including advanced imaging of peripheral manifestations such as enthesitis, dactylitis, axial symptoms, and skin signs such as psoriasis and nail disease, among RA and SpA patients may reduce misclassification and inappropriate treatment. Further research is needed to confirm these findings.

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