The concept of axial spondyloarthritis. Lessons from the INFAST study

Sieper et al evaluated whether combination therapy with infliximab (IFX) and naproxen (N PX) was superior to treatment with N PX alone in patients who had active moderate-to-severe early (disease duration under 3 years) active axial spondyloarthritis (SpA) and who were naive to non-steroidal anti-inflammatory drugs (NSAIDs) or had only been treated with a submaximal dose of NSAIDs. This study is the first investigation of the potential benefits of early tumour necrosis factor (TNF) antagonist treatment in active axial SpA patients who are not yet refractory to NSAID therapy. Additionally, this represents the first randomised controlled clinical trial to use the imaging portion of the Assessment of SpondyloArthritis International Society criteria for axial SpA with active inflammation of the sacroiliac joints on MRI at baseline. Most importantly, the evidence from this study supports early diagnosis and treatment of SpA with a full dose of NSAIDs first, escalating to combination NSAID+TNF antagonist treatment in patients who have insufficient response.

Moreover, this study provides important insights about the application of the new classification criteria for axial SpA in a clinical trial.

Approximately 60% of patients had ankylosing spondylitis (AS) fulfilling the modified New York radiographic criteria. Thus, 40% of patients had non-radiographic axial SpA classified by MRI; it would be of interest to know if in these patients the additional SpA features for classification were different from AS patients. Arthritis was quite often in both treatment arms and significantly better for swollen joints with NSAID+TNF antagonist treatment. Also in other studies testing adalimumab against placebo and etanercept against sulfasalazine, respectively, arthritis was found in 29% up to 52% of patients with early axial SpA. Evidently, simultaneous peripheral symptoms are frequent in non-radiographic and early axial SpA.

This raises the question if future studies should include together patients fulfilling the axial and/or peripheral SpA criteria to establish treatment evidences for SpA in general; thus would be possible to promote approval of established and new treatments for most conditions unified under the umbrella of SpA instead of testing for each individual diagnosis and subgroup of clinical manifestations. However, this requires more attention to infections associated with reactive arthritis which have been included in the criteria for peripheral but not for axial SpA.

Preceding infections (balanitis, urethritis, cervicitis and/or acute diarrhoea) are noted in 37% of patients with peripheral SpA. Furthermore, 35% of the patients with peripheral SpA have radiographic sacroiliitis. This overlap between axial and peripheral symptoms demonstrates that the construct of separating SpA into predominant clinical manifestations is somewhat artificial and only partially reflects the clinical reality given the heterogeneous character and fluctuating course of the diseases belonging to the SpA concept. Especially in the early years of the disease, the main target of the new classification criteria, AS progresses by a series of flares involving localised areas such as the knee, neck, ankle or localised area of the back.

Many patients with SpA at some time of the disease can have either prominent peripheral and axial symptoms concurrently or peripheral and axial symptoms successively. The classification may change from axial to peripheral and vice versa at different times in a given study, compromising the consistency of classification in long-term trials. Finally, the description of increased frequency of Chlamydia-positive synovial tissue samples in patients with chronic undifferentiated SpA, the growing insight into the aetiology of persistent chlamydial infection and the promising treatment of Chlamydia-induced arthritis with combination antibiotic therapy indicate the necessity of further splitting SpA into underlying disease entities such as reactive arthritis (c.f. ref. 12).

Henning Zeidler

Correspondence to Professor Henning Zeidler, Emeritus, Hannover Medical School, Hannover, Germany, Wolfburgler Damm 26c, Hannover 30625, Germany; zeidler.henning@mh-hannover.de

Competing interests None.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Zeidler H. Ann Rheum Dis Published Online First: [please include Day Month Year] doi:10.1136/annrheumdis-2013-204940

Received 19 November 2013

Accepted 21 November 2013

Ann Rheum Dis 2013;0:0. doi:10.1136/annrheumdis-2013-204940

REFERENCES


7 Zeidler H. The historical concept of interrelated conditions lumped together as a family of distinct diseases is not outdated. Arthritis Rheum 2013;65:2214–5.


