BACKGROUND

• Spondyloarthritis (SpA) is a group of diseases that share common clinical, radiographic and genetic features including ankylosing spondylitis (AS), peripheral arthritis (PsA), reactive arthritis, enthesitis, inflammatory bowel disease-related arthritis, undifferentiated SpA.

• The ASAS axial SpA classification criteria was published in 2009 (Rudwaleit M, et al 2009), but so far there has been limited research on axial SpA patients in clinical practice.

• There is no diagnosis code for non-radiographic axial SpA (nr-axSpA) and it is unclear which diagnoses these patients receive in clinical practice.

• Characterization of nr-axSpA patients in clinical practice is lacking in comparison with radiographic axial SpA (rad-axSpA).

• Data on how the disease impacts patients health related quality of life (HRQoL) is scarce and comes mainly from randomized clinical trials (RCTs).

METHODS

STUDY DESIGN & PROCEDURES

• The study was designed as a prospective, cross-sectional, multi-center cohort study in 250 Swedish patients, who receive in clinical practice.

• The physician filled out the CRF once, at baseline.

• The aims of this study were:

  • To characterize patients with axial SpA in clinical practice
  • To investigate similarities/differences between radiographic and non-radiographic axial SpA with respect to their HRQoL.

METHODS (continued)

Main Inclusion Criteria

• Age ≥18 years old able to understand and sign the study informed consent form

• Patients were diagnosed as:

  - rad-axSpA (Figure 1)
  - nr-axSpA (Figure 1)

Main Exclusion Criteria

• Patient was unable to complete the patient surveys / not able to read and write Swedish

Physician Assessments

• In a first step the physician evaluated whether or not the ASAS criteria to classify axial SpA (Figure 2) were fulfilled

• In addition, the physician CRF included information on:

  • Patients symptoms such as onset of symptoms
  • Current diagnosis (ICD-10)
  • C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
  • Joint involvement
  • Extra-articular manifestations (EAMs)
  • Imaging performed to diagnose / monitor the disease

Patient surveys

• The patient survey included information on:

  • Patient demographics
  • Disease activity, function, and satisfaction (BASDAI, ASAS-24, VAS global and pain), PASI, BASFI, HAQ-DI
  • Quality of Life (AS-QoL, EQ-5D)

More information on the tools/patient reported outcome measures (PROMs) can be found in Table 1. The questionnaires were completed by the patient at baseline and at a monthly basis thereafter for 3 months. The current analysis includes the baseline data only.

RESULTS

• 251 patients were included at baseline. Of those, 197 patients fulfilled the ASAS axial SpA criteria and were included in the study (Figure 3).

• Of the 197 rad-axSpA patients, 63% were characterized as rad-axSpA and 37% as nr-axSpA.

• There were more women in the nr-axSpA group compared with the rad-axSpA group, 50% vs. 38%, respectively (Table 1).

• The nr-axSpA patients had a numerical shorter time between symptom onset and diagnosis (6.7 years vs. 9.0 years), however not significant (Table 2).

• The nr-axSpA patients were diagnosed with AS (35%), other specific inflammatory spondylarthropathies (31%), inflammatory spondylarthropathy unspecified (15%), psoriatic spondylitis (11%), and sacroilitis, not elsewhere classified (4%) (Figure 4).

• Data on disease activity and function was not available for all patients (nr-axSpA>rad-axSpA). BASDAI: 50/65%, BASFI: 65/65%, VAS-scale data (55/35%), and ASAS (58/57%)

• The nr-axSpA patients showed a significant higher disease burden compared with the rad-axSpA patients, e.g. higher BASDAI (4.1 vs. 2.7), VAS global (4.3 vs. 2.9), VAS pain (4.4 vs. 2.6), and ASAS/CRP (3.3 vs. 1.9) (Figure 5).

• There was a difference in disease activity over time (Figure 6). The mean of the ten scales gives the BASFI score. Median of the disease activity over time (Figure 6).

• Higher score in ASQoL indicate worse HRQoL. As with the rad-axSpA patients, higher scores in the EQ-5D indicate better HRQoL.

• Higher score in VAS assesses the amount of back pain during the week (0 being “no pain” and 10 “worst possible pain”).

• The two scores on morning stiffness are averaged to calculate the mean of the ten scales.

• Although there were some limitations with the study there is a need to characterize these patients since current ICD-10 diagnoses are lacking.

STRENGTHS/LIMITATIONS

• A strength with this study was that all patients were clinically assessed by a rheumatologist resulting in a more certain diagnosis as compared to current registry based studies.

• Limitations with this study were that:

  • all patients were recruited at specialized rheumatology centers, which may skew the population towards more severe patients, partly explaining the relatively high frequency of AS in the nr-axSpA group.

  • not all patients completed the patient questionnaire which could result in a skewed patient population.

  • Although there were some limitations with the study there is a need to characterize these patients since current ICD-10 diagnoses are lacking.

CONCLUSIONS

• In this study, from Swedish clinical practice, we included patients from rheumatology clinics with pre-specified diagnoses most likely to be classified as axial SpA.

• The results show that nr-axSpA reported a higher impact on HRQoL than patients with rad-axSpA.

• In addition, HRQoL is poorer in axial SpA patients compared to the general population.

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DISCLOSURES

L. Jacobsson has served as consultant for AbbVie, Pfizer, and UCB. T. Husmark has served as consultant for AbbVie. T. Theander has served as consultant for AbbVie. K. Henriksson has served as consultant for AbbVie. K. Blash is an employee of AbbVie and owns Abbvie stock; M. Jonasson is an employee of Abbvie.

REFERENCES

