REBELLIOUS MEDIC · RHEUMATOLOGY ALGORITHM SERIES

Axial Spondyloarthritis — Management

Overarching principles and 15 recommendations covering treatment target, non-pharmacological care, NSAIDs, glucocorticoids, csDMARDs, biologic/targeted therapy selection, and surgery.

2022 ASAS-EULAR Update
Recommendations for the Management of Axial Spondyloarthritis
Ramiro et al. · Ann Rheum Dis 2023;82:19-34

GOR — A · Strongest Evidence | B | C | D · Expert Opinion | OAP · Overarching Principle

1 Overarching Principles

OAP — axSpA is a potentially severe disease with diverse manifestations, usually requiring **multidisciplinary management coordinated by the rheumatologist**.

OAP — Primary goal: maximise long-term HRQoL through **control of symptoms/inflammation**, prevention of structural damage, and preservation of function and social participation.

OAP — Optimal management requires a **combination of non-pharmacological and pharmacological** modalities; treatment must be based on **shared decision-making**; individual/societal costs should be considered without over-ruling best individual care.

2 Treatment Target, Monitoring & Non-Pharmacological Care

D 5 — **Rec 1–3:** Individualise treatment to current disease domains (axial, peripheral, extra-musculoskeletal) and patient characteristics; monitor with patient-reported outcomes, clinical findings, labs, and imaging (frequency individualised); guide treatment toward a **predefined target** (e.g. ASDAS).

A 1a–2b — **Rec 4:** Educate patients and encourage **regular exercise** (2b/B) and **smoking cessation** (5/D); **physiotherapy** should be considered (1a/A).

3 Pharmacological Therapy — NSAIDs, Analgesics, Glucocorticoids, csDMARDs

A 1a — **Rec 5: NSAIDs** are first-line drug treatment up to maximum dose (weigh risks/benefits); continuous use preferred over on-demand if needed to control symptoms.

D 5 — **Rec 6: Analgesics** (paracetamol, opioid-like drugs) may be considered for residual pain after recommended treatments fail, are contraindicated, or poorly tolerated — caution with long-term opioid use.

B 2/5 — **Rec 7:** Local **glucocorticoid injections** to the site of musculoskeletal inflammation may be considered (2/B); patients with axial disease should **not** receive long-term systemic glucocorticoids (5/D).

A 1a — **Rec 8:** Purely axial disease should **not normally** be treated with csDMARDs; **sulfasalazine** may be considered for patients with peripheral arthritis (methotrexate/leflunomide lack demonstrated efficacy).

4 Biologic & Targeted Synthetic Therapy Selection

A 1a — **Rec 9: TNFi, IL-17Ai, or JAKi** should be considered for persistently high disease activity despite conventional treatment; current practice is to start a TNFi or IL-17Ai.

B 1a–2b — **Rec 10:** History of recurrent **uveitis** or active **IBD** — prefer a monoclonal antibody against TNF (IL-17i contraindicated in active IBD); significant **psoriasis** — an IL-17i may be preferred.

B 1b–2b — **Rec 12:** After first b/tsDMARD failure — switching to another bDMARD (TNFi or IL-17i) or a JAKi should be considered.

B 1a/5 — **Rec 13:** In sustained remission, **tapering** of a bDMARD can be considered (1a/B for TNFi, 5/D for IL-17i).

5 Non-Response, Surgery & Special Situations

D 5 — **Rec 11:** Absence of response to treatment should prompt **re-evaluation of the diagnosis** and consideration of comorbidities.

C 4 — **Rec 14: Total hip arthroplasty** should be considered for refractory pain/disability with radiographic structural damage, independent of age; spinal corrective osteotomy in specialised centres for severe disabling deformity.

D 5 — **Rec 15:** A significant change in disease course should prompt evaluation for causes other than inflammation, such as **spinal fracture**, including appropriate imaging.

Format note: Grade of Recommendation (GoR): A = consistent level-1 studies → D = expert opinion/level-5 evidence. Level of evidence (LoE, second line) per Oxford CEBM scale. Condensed from Table 1.

Ramiro S, Nikiphorou E, Sepriano A, et al. ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. *Ann Rheum Dis.* 2023;82(1):19-34.