2022 ASAS-EULAR Recommendations for the Management of axSpA

1. The treatment of patients with axSpA should be individualized according to the current signs and symptoms of the disease (axial, peripheral, extramusculoskeletal manifestations) and the patient characteristics including comorbidities and psychosocial factors.

2. Disease monitoring of patients with axSpA should include patient-reported outcomes, clinical findings, laboratory tests, and imaging, all with the appropriate instruments and relevant to the clinical presentation. The frequency of monitoring should be decided on an individual basis depending on symptoms, severity, and treatment.

3. Treatment should be guided according to a predefined treatment target.

4. Patients should be educated about axSpA and encouraged to exercise on a regular basis and stop smoking; physiotherapy should be considered.

5. Patients suffering from pain and stiffness should use an NSAID as first-line drug treatment up to the maximum dose, taking risks and benefits into account. For patients who respond well to NSAIDs, continuous use is preferred if needed to control symptoms.

6. Analgesics, such as paracetamol and opioid-(like) drugs, might be considered for residual pain after previously recommended treatments have failed, are contraindicated, and/or poorly tolerated.

7. Glucocorticoid injections directed to the local site of musculoskeletal inflammation may be considered. Patients with axial disease should not receive long-term treatment with systemic glucocorticoids.

8. Patients with purely axial disease should normally not be treated with csDMARDs; sulfasalazine may be considered in patients with peripheral arthritis.

9. TNFis, IL-17is,* or JAKis† should be considered in patients with persistently high disease activity despite conventional treatments; current practice is to start a TNFi or IL-17i.*

10. If there is a history of recurrent uveitis or active IBD,‡ preference should be given to a monoclonal antibody against TNF.§ In patients with significant psoriasis, an IL-17i* may be preferred.

11. Absence of response to treatment should prompt re-evaluation of the diagnosis and consideration of the presence of comorbidities.

12. Following a first b/tsDMARD failure, switching to another bDMARD (TNFi or IL-17i*) or a JAKi† should be considered.

13. If a patient is in sustained remission, tapering of a bDMARD can be considered.

14. Total hip arthroplasty should be considered in patients with refractory pain or disability and radiographic evidence of structural damage, independent of age; spinal corrective osteotomy in specialized centers may be considered in patients with severe disabling deformity.

15. If a significant change in the course of the disease occurs, causes other than inflammation, such as a spinal fracture, should be considered and appropriate evaluation, including imaging, should be performed.

ASAS, Assessment of SpondyloArthritis international Society; **axSpA**, axial spondyloarthritis; **bDMARD**, biologic DMARD; **csDMARD**, conventional synthetic DMARD; **DMARD**, disease-modifying antirheumatic drug; **EULAR**, European Alliance of Associations for Rheumatology; **IBD**, inflammatory bowel disease; **IL-17i**, interleukin-17 inhibitor; **JAKi**, Janus kinase inhibitor; **NSAID**, nonsteroidal anti-inflammatory drug; **RCT**, randomized controlled trial; **TNF**, tumor necrosis factor; **TNFi**, TNF inhibitor; **tsDMARD**, targeted synthetic DMARD.

*IL-17i refers only to IL-17A inhibitors. †The following risk factors for cardiovascular events and malignancies must be considered when intending to prescribe a JAKi: age over 65 years, current or past smoking, other cardiovascular risk factors, other risk factors for malignancy, risk factors for thromboembolic events. ‡In patients with active IBD, IL-17i are contraindicated. §This includes a pegylated Fab' fragment. Level of recommendation: level 1a, systematic review with homogeneity of RCTs; level 1b, individual RCT (with narrow CI); level 1c, all or none; level 2a, systematic review with homogeneity of cohort studies; level 2b, individual cohort study (including low-quality RCT); level 2c, 'outcomes' research, ecological studies; level 3a, systematic review (with homogeneity) of case–control studies; level 3b, individual case–control study; level 4, case series (and poor-quality cohort and case–control studies); level 5, expert opinion without explicit critical appraisal or based on physiology, bench research, or 'first principles'. Grade of recommendation: grade A, consistent level 1 studies; grade B, consistent level 2 or 3 studies, or extrapolations from level 1 studies; grade C, level 4 studies or extrapolations from level 2 or 3 studies; grade D, level 5 evidence or troublingly inconsistent or inconclusive studies of any level.

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