NHS
Vale of York
Clinical Commissioning Group

Referral Support Service

Rheumatology

RH02
Referral for suspected Spondyloarthritis in adults

Definition

Spondyloarthritis is a group of inflammatory conditions that have a range of manifestations. Spondyloarthritis may be predominantly:

axial:
- radiographic axial spondyloarthritis (such as ankylosing spondylitis)
- non-radiographic axial spondyloarthritis or

peripheral:
- psoriatic arthritis
- reactive arthritis
- enteropathic spondyloarthritis.

People with predominantly axial spondyloarthritis may have additional peripheral symptoms, and vice versa.

Axial presentations of spondyloarthritis are often misdiagnosed as mechanical low back pain, leading to delays in access to effective treatments. Peripheral presentations are often seen as unrelated joint or tendon problems, and can be misdiagnosed because problems can move around between joints.

Do not rule out the possibility that a person has spondyloarthritis solely on the presence or absence of any individual sign, symptom or test result.

Recognise that spondyloarthritis can have diverse symptoms and be difficult to identify, which can lead to delayed or missed diagnoses. Signs and symptoms may be musculoskeletal (for example, inflammatory back pain, enthesitis and dactylitis) or extra-articular (for example, uveitis and psoriasis [including psoriatic nail symptoms]). Risk factors include recent genitourinary infection and a family history of spondyloarthritis or psoriasis.

Be aware that axial and peripheral spondyloarthritis may be missed, even if the onset is associated with established comorbidities (for example, uveitis, psoriasis, inflammatory bowel disease [Crohn's disease or ulcerative colitis] or a gastrointestinal or genitourinary infection).

Be aware that axial spondyloarthritis:
- affects a similar number of women as men
- can occur in people who are human leukocyte antigen B27 (HLA-B27) negative
- may be present despite no evidence of sacroiliitis on a plain film X-ray.

Urgent referral for suspected acute anterior uveitis:

Refer people for an immediate (same-day) ophthalmological assessment if they have symptoms of acute anterior uveitis (for example, eye pain, eye redness, sensitivity to light or blurred vision)

Referral Information

Referral criteria for suspected axial Spondyloarthritis

The person has low back pain that started before the age of 45 years and has lasted for longer than 3 months, with:

- 4 or more of the additional criteria below OR
- Exactly 3 of the additional criteria below and a positive HLA-B27 test. (HLA B27 tests are not normally indicated in primary care. Occasionally the rheumatologists might ask for this to help triage patients and help diagnosis prior to being seen in their clinics but GPs are asked not to check HLA B27 status routinely)

Additional criteria are:

- low back pain that started before the age of 35 years waking during the second half of the night because of symptoms
- buttock pain
- improvement with movement
- improvement within 48 hours of taking **non-steroidal anti-inflammatory drugs (NSAIDs)**
- a first-degree relative with spondyloarthritis
- current or past arthritis
- current or past enthesitis (inflammation at site of tendon insertion)
- current or past psoriasis

Referral criteria for suspected peripheral Spondyloarthritis

For guidance on identifying spondyloarthritis in people with an existing diagnosis of psoriasis, see what NICE says on assessment for psoriatic arthritis.

Urgently refer people with suspected new-onset inflammatory arthritis to a rheumatologist for a spondyloarthritis assessment, unless rheumatoid arthritis, gout or acute calcium pyrophosphate (CPP) arthritis ('pseudogout') is suspected. If rheumatoid arthritis is suspected, see what NICE says on when to refer for specialist opinion for rheumatoid arthritis in adults.

Refer people with dactylitis (inflammation of a whole digit often referred to as a sausage toe or finger) to a rheumatologist for a spondyloarthritis assessment.

Refer people with enthesitis (e.g. epicondylitis, trochanteric bursitis, Achilles' or plantar fasciitis etc) without apparent mechanical cause to a rheumatologist for a spondyloarthritis assessment if:

- it is persistent **or**
- it is in multiple sites **or**
- any of the following are also present:
- back pain without apparent mechanical cause
- current or past uveitis (see urgent referral for suspected acute anterior uveitis for guidance on immediate [same-day] ophthalmological assessment for people with acute anterior uveitis)

- current or past psoriasis
- gastrointestinal or genitourinary infection
- inflammatory bowel disease (Crohn's disease or ulcerative colitis)
- a first-degree relative with spondyloarthritis or psoriasis.

Recognising psoriasis

If a person with suspected spondyloarthritis has signs or symptoms of undiagnosed psoriasis, follow NICE's recommendations on psoriasis.

Investigations prior to referral

- Nil required

Information to include in referral letter

- Date of onset
- Frequency of attacks
- Medication history including **NSAID** response if not contraindicated
- Duration of early morning stiffness
- Personal or family history of associated disorders e.g. inflammatory bowel disease, psoriasis, uveitis, etc
- History of pro-dromal illness e.g. URTI, GU/ GI infection etc

Treatment

- Consider starting an anti-inflammatory such as Naproxen 500mg bd or alternative with PPI cover
- Advise patients to be active

Patient information leaflets/ PDAs

- Ankylosing spondylitis
- Psoriatic arthritis
- Reactive arthritis
- Arthritis Treatments

References

- Spondyloarthritis in over 16s: diagnosis and management (2017) NICE guideline NG65

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