# PATIENT FACT SHEET

# Spondyloarthritis

## CONDITION DESCRIPTION

**Spondyloarthritis, or spondyloarthropathy, is an inflammatory arthritis affecting the spine.** In some patients, arm and leg joints, or the skin, intestines and eyes are affected too. Spondyloarthritis often inflames the entheses, the sites where ligaments and tendons enter bone. Many patients progress to a degree of spinal fusion, or ankylosing spondylitis (AS).

Spondyloarthritis more often affects males in their teens or 20s. It may run in families. Ankylosing spondylitis (AS) is associated with the HLA-B27 gene. Alaskan or Siberian Eskimos and Samis have higher frequency of HLA-B27 and more likely to have AS. Up to 30 genes may cause types of spondyloarthritis.

Psoriatic arthritis, reactive arthritis and enteropathic arthritis associated with inflammatory bowel disease, such as Crohn's disease and ulcerative colitis, are types of spondyloarthritis.

## SIGNS/ SYMPTOMS

**Early spondyloarthritis may present as inflammation that causes pain and stiffness, often in the spine.** Low back pain is the most common symptom. Some spondyloarthropathies may affect the hands, feet, arms or legs. Later signs may be bone destruction that deforms the spine and lowers function in the hips or shoulders. Patients may have pain, fatigue or stiffness that is continuous or comes and goes.

A rheumatologist diagnoses spondyloarthritis with a medical history and physical examination. Symptoms may suggest spondyloarthritis. X-rays of the sacroiliac joints in the pelvis may show inflammation, or sacroiliitis. In early spondyloarthritis, magnetic resonance imaging (MRI) may show joint changes before they can be seen on an x-ray.

Blood tests for the HLA-B27 gene do not confirm spondyloarthritis. Many people with this gene never develop disease. In the end, the doctor's judgment, based on clinical signs, is most important. Patients with a diagnosis of spondyloarthritis who experience a severe red, painful eye need to see an Ophthalmologist as uveitis (eye inflammation) can be associated with spondyloarthritis.

## COMMON TREATMENTS

**Spondyloarthritis patients should get physical therapy and do joint-directed exercises to promote spinal extension and mobility.** First-line medications for symptom relief are nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen (Advil, Motrin), naproxen (Aleve, Naprosyn), indomethacin (Indocin) or meloxicam (Mobic).

For localized joint swelling, corticosteroid injections into the joint or tendon sheath are quickly effective. If patients do not respond, disease-modifying antirheumatic drugs (DMARDs), such as sulfasalazine (Azulfidine), may be used to relieve symptoms and prevent joint damage. Oral corticosteroids are not recommended. Antibiotics are used to treat reactive arthritis only.

Biologic medications including TNF-alpha and IL-17 blockers may treat spinal or peripheral symptoms. The TNF inhibitors adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade), certolizumab (Cimzia) and golimumab (Simponi), as well as the IL-17 blocker secukinumab (Cosentyx) are approved for treating ankylosing spondylitis.

Surgery, such as total hip replacement, may be helpful for some patients. Spinal surgery is rarely needed, except to treat traumatic fractures or excess flexion deformities of the neck, where the patient cannot straighten the neck.

## CARE/ MANAGEMENT TIPS

**With newer treatment options, most people with spondyloarthritis lead normal, productive lives and have a normal lifespan.** People with spondyloarthritis should exercise frequently to maintain joint and heart health.

People with spondyloarthritis who smoke should quit or get help to do so. Smoking aggravates spondyloarthritis and may speed up the rate of spinal fusion.

Patient support groups for people with spondyloarthritis may be helpful and informative. The Spondylitis Association of America, the National Psoriasis Foundation and the Arthritis Foundation have support groups in many communities or online

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