

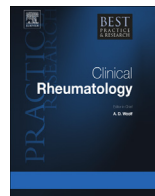


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The impact of ankylosing spondylitis/axial spondyloarthritis on work productivity



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A B S T R A C T

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Ankylosing spondylitis (AS) is a chronic inflammatory condition that has a significant impact on the quality of life and work productivity. New classification criteria have enabled earlier diagnosis of this condition. However, work productivity is an important issue that is still often overlooked during clinical assessments and consultations. This article focusses on the relationship between axial spondyloarthritis (axial SpA) and work productivity. It summarises the impact of this condition on work productivity, and it highlights the tools available to assess this. It also highlights the increasing role and potential of employers, health professionals and new treatments for enhancing work productivity for people with this condition.

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Introduction

Ankylosing spondylitis (AS)/axial spondyloarthritis (axial SpA) typically affects people from a young age, it often has a detrimental impact on health and well-being and it is associated with significant risk of limiting work productivity over the life course. Despite this, relatively little attention has been paid

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to issues regarding work productivity in this condition. Consequently, there is an urgent need not only to understand better the different perspectives of people with AS/axial SpA, of health professionals, of health service managers and of employers but also to embed issues pertinent to work productivity as a routine element of health care. Exciting opportunities now exist to bring together the key sectors to develop innovative solutions and processes to drive such advances, and to enable the potential of people with AS/axial SpA to succeed in workplace settings to be fully realised.

Key clinical features

AS/axial SpA is a chronic systemic inflammatory condition that primarily affects the axial skeleton [1]. Inflammation of the spinal joints and adjacent structures, with localised enthesitis, creates pain, stiffness and limitations in spinal movement [2,3] and it may lead to bony fusion of the spine [4]. Recent refinement in diagnosis has followed the introduction of the term ‘axial SpA’ by the Assessment of SpondyloArthritis International Society (ASAS) [5]. In axial SpA, the predominant symptom is chronic inflammatory back pain, but X-ray features of sacroiliitis may or may not be present. The new classification criteria enable earlier diagnosis of pre-radiographic axial SpA, compared to the previous modified New York criteria [6], in which X-ray changes at the sacroiliac joint were required. Previous dependence on radiographic changes contributed to people often experiencing long delays in diagnosis [7].

The prevalence of AS/axial SpA ranges from 0.5% to 1.8% in Caucasians [8–11]. It is likely that approximately 200,000 people have AS in the UK [12]. Among people with chronic back pain, the prevalence of AS/Axial SpA is only 5% [13], and many years may pass between the first symptoms and a definitive diagnosis [14–16]. About 50% of people with AS develop associated disorders, including episodic iritis (40%), psoriasis (16%) and inflammatory bowel disease (10%) [17]. The strong genetic association with HLA-B27 is well established [18–20], and much effort continues to be focussed upon identifying other key biomarkers.

Managing AS/axial SpA

ASAS/European League Against Rheumatism (EULAR) recommendations aim to maximise long-term health-related quality of life (HRQoL) through control of symptoms and inflammation, prevention of progressive structural damage and preservation/normalisation of function and social participation [21]. Education and physical exercise are key elements. People are encouraged to take responsibility for their own programmes, and physiotherapists play a key role in this. A recent Cochrane review [22] concluded there is ‘silver’-level evidence that exercise programmes, either home based or supervised, can improve movement and physical function.

Non-steroidal anti-inflammatory drugs (NSAIDs) together with physiotherapy are used to treat symptomatic inflammatory back pain [21]. Anti-tumour necrosis factor (TNF) therapy in people with high disease activity who have not responded to NSAIDs may reduce disease activity [4,23,24] but not radiographic progression [24–27]. In some people, joint replacement surgery or spinal corrective osteotomy for severe deformity may be required [21,28].

Assessment and monitoring

The National Ankylosing Spondylitis Society (NASS) ‘Looking Ahead’ document provides guidance for diagnosis and management, and a benchmark for accessing local services. All individuals with AS/axial SpA should be assessed by a physiotherapist at the time of diagnosis and at least annually thereafter [29,30], and these individuals should have regular contact with a multidisciplinary team (MDT) [21,28]. These principles are reiterated within the ‘2020 Health Report’ [31] which recommends that every person diagnosed with AS should receive an annual appointment with a specialist to review medication, range of movement, impact on work and social activities, co-morbidities and mental health. To inform regular monitoring, a range of composite indices and questionnaires are currently available. Disease status scores have been found to correlate with anxiety, depression and health status,

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