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Recommendations and metaanalyses

2018 update of French Society for Rheumatology (SFR) recommendations about the everyday management of patients with spondyloarthritis

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ABSTRACT

Objective: To update French Society for Rheumatology recommendations about the management in clinical practice of patients with spondyloarthritis (SpA). SpA is considered across the range of clinical phenotypes (axial, peripheral, and entheseal) and concomitant manifestations. Psoriatic arthritis is included among the SpA phenotypes.
Methods: According to the standard procedure advocated by the EULAR for developing recommendations, we first reviewed the literature published since the previous version of the recommendations issued in June 2013. A task force used the results to develop practice guidelines, which were then revised and graded using AGREE II.
Results: Four general principles and 15 recommendations were developed. The first four recommendations deal with treatment goals and general considerations (assessment tools and comorbidities). Recommendations 5 and 6 are on non-pharmacological treatments. Recommendation 7 is about non-steroidal anti-inflammatory drugs, which are the cornerstone of the treatment, and recommendations 8 to 10 are on analgesics, glucocorticoid therapy, and conventional disease-modifying antirheumatic drugs. Biologics are the focus of recommendations 11 through 14, which deal with newly introduced drug classes, including their indications (active disease despite conventional therapy and, for nonradiographic axial SpA, objective evidence of inflammation) and monitoring, and with patient management in the event of treatment failure or disease remission. Finally, recommendation 15 is about surgical treatments.
Conclusion: This update incorporates recent data into a smaller number of more simply formulated recommendations, with the goal of facilitating their use for guiding the management of patients with SpA.

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1. Introduction

Spondyloarthritis (SpA) is a complex disease that has a variety of clinical phenotypes [1–4]. Patients with SpA are managed by rheumatologists, who can find guidance in various sets of recommendations. In 2013, the French Society for Rheumatology (SFR) issued recommendations for the everyday management of patients with SpA [5] and predicted that an update would be in order after a few years. This prediction has been borne out by the introduction of new drug classes and the publication of international recommendations for axial SpA [6] and psoriatic arthritis (PsA) [7,8].

Here, our objective was to update the 2013 SFR recommendations for the everyday management of patients with SpA, in order to incorporate the new data into a smaller number of simpler recommendations.

2. Methods

This update and adaptation of the 2013 SFR recommendations was conducted in compliance with the general principles put forth in AGREE II and the standard procedure advocated by the European League against Rheumatism (EULAR), as was the case for the 2013 recommendations [5].

We started from the 2013 SFR recommendations on SpA [5], updated ASAS/EULAR recommendations for axial SpA [6], and recommendations on PsA [7,8], with the references supporting these three sources [9–11].

Two university-hospital rheumatologists (CL and CP) specifically trained in systematic literature reviews used appropriate key indexing terms to search the PubMed-Medline, Cochrane, and Embase databases for relevant work published between June 17, 2013, and May 1, 2017. In addition, reference lists of selected articles and proceedings of EULAR and ACR meetings were searched manually. The level of evidence of each publication was assessed.

A task force composed of rheumatologists deemed to be SpA experts by the SFR was established. Most of the experts had contributed to develop the 2013 recommendations. One of us (DW) was designated by the SFR to be the project manager. Preliminary work by the task force identified previously unrecognized issues, as well as points that required updating. The task force members then attended an in-person meeting to work on the wording of the recommendations (reformulation, reorganization, deletion, or addition) based on the results of the literature review and on a discussion among the experts. Recommendations were accepted if they were agreed on by at least two-thirds of the experts.

Subsequently, the same experts revised the wording of the recommendations then validated the revised version, assessing the level of agreement on a 0–10 visual analog scale where 0 indicated complete disagreement and 10 complete agreement.

3. Scope

The updated recommendations are intended for physicians and all other healthcare professionals involved in managing patients with SpA. They apply to all adults with SpA diagnosed by a rheumatologist based on a set of arguments from the medical history, clinical examination, laboratory tests, and imaging studies. If needed, the rheumatologist may obtain additional assistance from classification criteria sets such as the Amor criteria or Assessment in Spondyloarthritis International Society (ASAS) criteria, taking care to apply the exact definitions of each item (e.g., uveitis and/or inflammatory bowel disease [IBD] must be diagnosed by a physician) [12]. The degree of confidence of the rheumatologist in the diagnosis is crucial [13]. The updated recommendations apply to all the clinical phenotypes of SpA including radiographic and nonradiographic axial disease, peripheral arthritis, and peripheral enthesitis. Non rheumatic manifestations associated with SpA such as psoriasis, uveitis, and IBD are also included. PsA is a form of SpA and is covered by the updated recommendations [2,5].

4. Results

Four general principles and 15 recommendations were developed. The grade of each recommendation (based on the underlying level of evidence) and the level of agreement among experts (see above) are reported for each recommendation. As with the 2013 SFR recommendation, grade A recommendations were based on level 1 evidence (meta-analysis of randomized controlled trials or at least one randomized controlled trial), grade B recommendations on level 2 evidence (at least one non randomized controlled trial or quasi-experimental study) or an extrapolation of level 1 evidence, grade C recommendations on level 3 evidence (descriptive study) or an extrapolation of level 1 or 2 evidence; and grade D recommendations on level 4 evidence (expert opinion) or an extrapolation of level 1, 2, or 3 evidence.

4.1. General principles

4.1.1. SpA is a potentially severe and disabling chronic disease that produces both rheumatic and extra-rheumatic manifestations. The management of SpA often requires a multidisciplinary approach, which is coordinated by the rheumatologist, in collaboration with the primary-care physician

This general principle mirrors recommendation 1 and encompasses recommendations 13 and 14 in the 2013 version. Extra-rheumatic manifestations (psoriasis, uveitis, and IBD) should be managed in collaboration with the relevant specialist. As part of the monitoring of patients with this chronic disease, the rheumatologist must provide screening and management of comorbidities, including osteoporosis, in compliance with current recommendations [14].

4.1.2. The treatment objectives are to improve quality of life; bring the symptoms and inflammation under control; prevent structural damage; and preserve or restore functional capabilities, self-sufficiency, and participation in social activities

This general principle has the same content, with different wording, as recommendation 2 in the 2013 version.

4.1.3. The diagnosis must be established, and the treatment started, as early as possible.

This principle echoes recommendation 5 in the 2013 version. Early recognition of the disease directly benefits the patient by avoiding prolonged diagnostic wanderings, which add to the patient's anxiety and result in unnecessary investigations and/or inappropriate, inefficient, and/or hazardous therapeutic interventions, while delaying the initiation of the optimal treatment. In addition, there is evidence for a window of opportunity in SpA, most notably in its peripheral form associated with psoriasis, with the best outcomes being achieved when specific drug therapy is initiated early [15–19].

4.1.4. The management and monitoring strategies should be tailored to the presentation of the disease

This general principle is a rewording of part of the previous recommendation 9 and was kept in this updated version to emphasize the considerable variability of SpA presentations and the need to tailor the evaluation and treatment to each situation.

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