Anti-TNF therapy and the spondyloarthritides: Who should be treated?

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Having read the papers published in this supplement it becomes clear that we need guidelines for the therapy of spondyloarthritides (SpA) with anti-TNF agents. This is especially true for ankylosing spondylitis (AS), the most frequent subset with the most severe outcome. In the absence of an international agreement at present, here is a list of the possibly relevant items which may help to select patients suitable for anti-TNF therapy (between parentheses we indicate the proposals and ranges that have emerged from ongoing discussions, as far as we are aware of them).

Intensity and duration (at least 2-3 months) of disease activity related to AS:

* Pain
* Stiffness
* Fatigue
* Spinal inflammation
* Peripheral arthritis
* Enthesitis

Composite index
* BASDAI > 4 (fatigue, spinal pain, arthritis, enthesitis, morning stiffness)

Presence of
* elevated CRP (> 10 mg/L), ESR (> 30 mm/1 hr.)
* spondylitis documented by MRI (STIR, post-gadolinium T1 sequence)
* rapid definite progression of ankylosis by x-rays (?)
* hip involvement (?)

Absence of
* advanced ankylosis by x-ray (bamboo spine, > 80% ankylosis?)
* treatment response to NSAIDs (2-3, at least 4 weeks, maximal dose)
* treatment failure of DMARDs (sulfasalazine, 2-3g, at least 3-4 months)

From the German RCT (1), there is some evidence that elevated CRP levels predict a good treatment response to infliximab. Otherwise there is a lack of data to answer the question of optimal patient selection for anti-TNF therapy.

Since we do not have definite prognostic parameters to date, we have to rely mainly on expert opinion and general agreement. M. Dougados has recently performed a Delphi exercise which will be published within the next months. Furthermore, there will be an ASAS meeting in the context of the 3rd Congress of Spondyloarthropathy taking place in early October 2002 in Gent which will further address this issue.

To describe how we handle the problem in daily practice at the moment, given as a personal opinion:

We try several NSAIDs at the maximal dose, rarely including phenylbutazone. We don't necessarily try corticosteroids systemically but always locally if possible. Usually we also try sulfasalazine 2-3 g/day for at least 3 months in all patients with peripheral joint involvement and in early patients with elevated CRP levels.

We assess hip involvement radiologically and by ultrasound depending on the acuity of the clinical situation. However, it is not clear whether coxitis responds to anti-TNF therapy. MRIs are not done as a routine measure, but STIR and post-contrast images may help by visualising spinal inflammation. Whether a positive MRI result predicts the treatment response is unclear.

We don't think that the presence of ankylosis or syndesmophytes should generally exclude anti-TNF therapy, but we assume that the efficacy will be rather limited in the presence of widespread ankylosis, especially in CRP-negative patients.

Hopefully, there will soon be a data-based solution for this problem to provide optimal benefit for patients and to avoid unnecessary expenses of these very effective but still expensive new therapies.

Reference

1. BRAUN J, BRANDT J, LISTING J, *et al*.: Treatment of active ankylosing spondylitis with infliximab - A double-blind placebo controlled multicenter trial. *Lancet* 2002; 359:1187-93.