I domini di malattia nella axSpA

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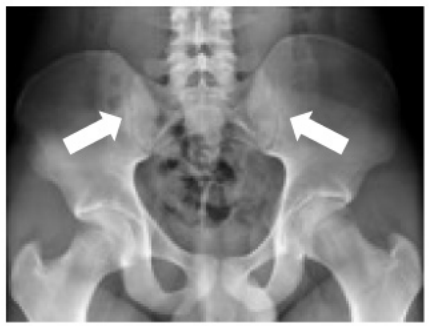
- *Janssen*

axSpA Disease Spectrum

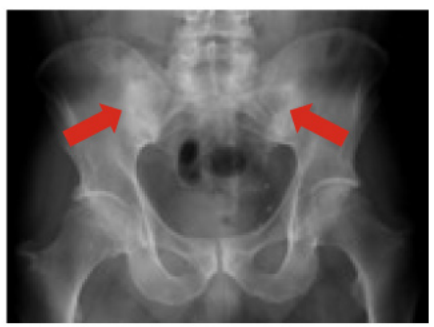
- Axial spondyloarthritis (axSpA) refers to the inflammation of the axial skeleton and encompasses two subtypes of the same disease: AS/r-axSpA and nr-axSpA[1]

- The difference between AS/r-axSpA and nr-axSpA is defined by the presence or absence, respectively, of radiographic changes of the sacroiliac joints consistent with sacroiliitis (as defined by specific criteria)[1,2]

- axSpA is defined as a chronic inflammatory disease of the sacroiliac joint and the axial skeleton that may involve other joints, entheses, and can have extra-articular manifestations in organs such as intestines, skin, eyes, lung, and heart[4]



No definite radiographic sacroiliitis[3]

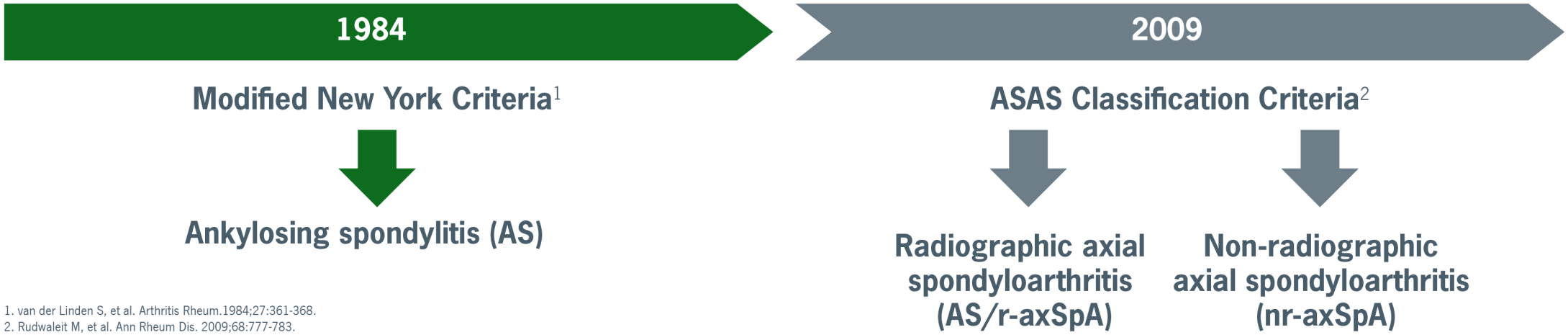


Definite radiographic sacroiliitis[3]

1. Taurog JD, et al. N Engl J Med. 2016;374:2563-2574.
2. van der Linden S, et al. Arthritis Rheum.1984;27:361-368.
3. Sieper J, et al. Ann Rheum Dis. 2009;68:ii1-44.
4. van der Heijde D. Ankylosing Spondylitis. In: Primer on the Rheumatic Diseases, Klippel JH, Stone JH, Crofford LJ, White PH (eds). Springer New York. 2008.

Classification Criteria

- Classification of AS has been based on the modified New York (mNY) criteria, for which the presence of definite radiographic sacroiliitis is mandatory (mNY criteria requires the presence of sacroiliitis + 1 out of the 3 clinical criterion)[1]
- The imaging arm of the ASAS classification criteria includes the presence of radiographic sacroiliitis (as per mNY criteria) as one of its criteria and therefore allows the classification of patients with r-axSpA (sacroiliitis per mNY criteria + ≥1 SpA feature)[2]
- **A recent publication by the ASAS concluded that the congruency between r-axSpA and AS is over 90%, thus supporting the interchangeable use of terms AS and r-axSpA**[3]
- **The ASAS criteria also allow for the classification of patients without radiographic changes as non-radiographic axSpA (nr-axSpA)**; the criteria use the findings of sacroiliitis on MRI (as defined by ASAS/OMERACT) + 1 SpA feature **or** presence of HLA-B27 + 2 SpA features[2]



1. van der Linden S, et al. Arthritis Rheum.1984;27:361-368.
2. Rudwaleit M, et al. Ann Rheum Dis. 2009;68:777-783.
3. Boel A, et al. Ann Rheum Dis. 2019;78:1545-1549.

Modified New York Criteria and ASAS Classification Criteria

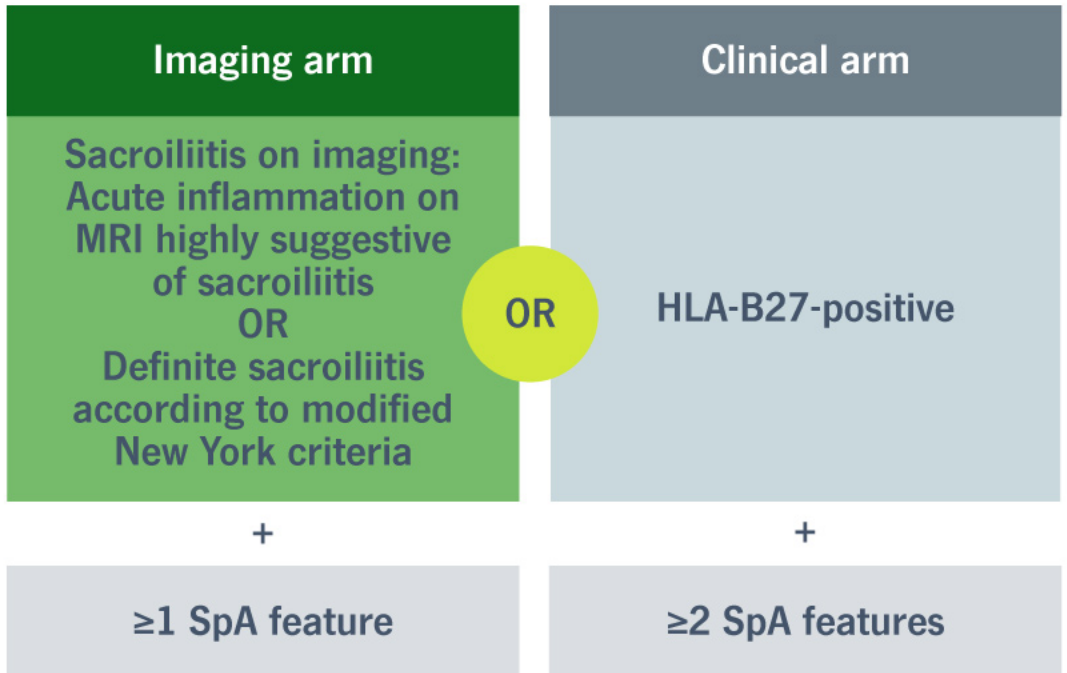
Modified New York Criteria[1]

1) Clinical criteria[1]:
a) **Low back pain** and **stiffness** for >3 months, which improves with exercise but is not relieved by rest
b) **Limitation of motion** of the lumbar spine in both sagittal and frontal planes
c) **Limitation of chest expansion** relative to normal values cor rected for age and sex
2) **Radiologic criterion[1]:**
Sacroiliitis grade ≥2 bilaterally or sacroiliitis grade 3-4 unilaterallya

Definite AS if the radiographic criterion is associated with ≥1 clinical criterion[1]

ASAS Classification Criteria[2]

In patients with ≥3 months chronic back pain and age at onset <45 years:[1]



The ASAS Classification Criteria can be applied across the entire disease spectrum[1]

nr-axSpA classification is based on a positive MRI (imaging arm) OR on clinical arm

No sacroiliitis grading can be achieved using plain radiographs.

1. van der Linden S, et al. Arthritis Rheum.1984;27:361-368.
2. Rudwaleit M, et al. Ann Rheum Dis. 2009;68:777-783

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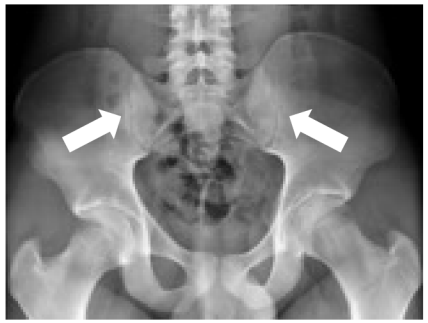
SpA features:

- Inflammatory back pain
- Arthritis
- **Enthesitis (heel)**
- Uveitis
- **Dactylitis**
- **Psoriasis**
- Ulcerative colitis/Crohn's disease
- Good response to NSAIDs
- Family history of SpA
- HLA-B27 positive
- Elevated CRP

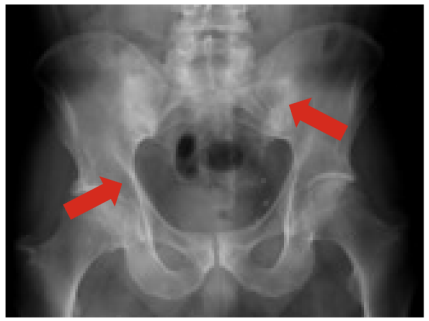
No sacroiliitis grading can be achieved using plain radiographs.
1. van der Linden S, et al. Arthritis Rheum.1984;27:361-368.
2. Rudwaleit M, et al. Ann Rheum Dis. 2009;68:777-783

High Disease Activity is Associated with Significantly Greater Radiographic Progression

OASIS 12-Year Study (N=184)[1]



No definite radiographic sacroiliitis[2]



Definite radiographic sacroiliitis[2]

Patients with **inactive** or **low disease activity**	ASDAS <1.3 (inactive disease) at baseline: **0.71** mSASSS units/2 years	BASDAI <4 (low disease activity) at baseline: **1.41** mSASSS units/2 years
Patients with **high disease activity**	ASDAS >3.5 at baseline: **3.05** mSASSS units/2 years (p<.001)	BASDAI ≥4 at baseline: **2.71** mSASSS units/2 years (p=.023)

1 ASDAS unit increase = **0.72 mSASSS** unit progression over 2 years

The OASIS study was the first to show an association between disease activity and radiographic progression in the spine in AS[1]
However, a recent investigation reports patients with nr-axSpA do not always progress to AS[3]

Image reproduced with permission from ASAS International Society (http://slides.asas-group.org/app/slides/search?q=).

1. Ramiro S, et al. Ann Rheum Dis. 2014;73:1445-1461.
2. Sieper J, et al. Ann Rheum Dis. 2009;68:ii1-44.
3. Wang R, et al. Arthritis Rheumatol. 2016;68:1415-1421

axSpA Carries a High Disease Burden Beyond Physical Symptoms

Sacroiliitis is a hallmark of AS leading to **chronic inflammatory back pain**[1]

~80% of patients develop their first symptom when they are <30 years of age[2]

Patients with AS/r-axSpA and nr-axSpA share a similar disease burden[3]

1. Braun J, et al. *Lancet*. 2007;369:1379-1390. 2. Wenker KJ, et al. NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK470173/. 3. Mease PJ, et al. *Arthritis Care Res*. 2018;70:1661-1670. 4. Deodhar A et al, Rheumatol Ther (2019) 6:487–501 https://doi.org/10.1007/s40744-019-00176-5 5. De Winter JJ, et al. *Arthritis Res Ther*. 2016;18:196. 6. Osterhaus JT. *Arthritis Res Ther*. 2014;16:R16. 7. Zhao S, et al. *Arthritis Res Ther*. 2018:140.

Current ASAS-EULAR Treatment Recommendations for axSpA[1]

Goal of axSpA Treatment is Best Possible QoL

Rheumatologist's diagnosis of axSpA and elevated CRP and/or positive MRI and/or radiographic sacroiliitis[a]

↓

At least 2 NSAIDs over 4 weeks (up to maximum doses)
Only in patients who are symptomatic
No firm evidence of any disease-modifying effects or prevention of radiographic syndesmophytes[2]

↓

High disease activity: ASDAS ≥2.1 or BASDAI ≥4

↓

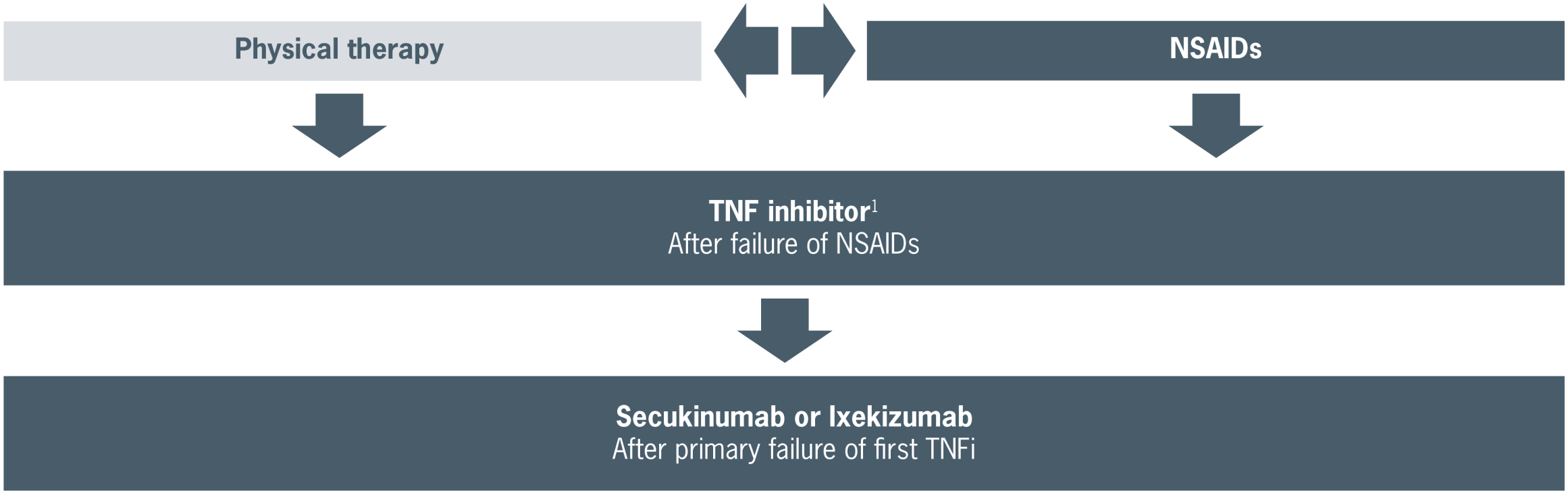
Biologic DMARDs
In patients with persistently high disease activity despite conventional treatments (2 NSAIDs)

~50% of patients with r-axSpA continue to have active disease after 4 weeks of NSAID treatment[3]

[a]Radiographic sacroiliitis is mandatory for infliximab and IL-17 inhibitors.

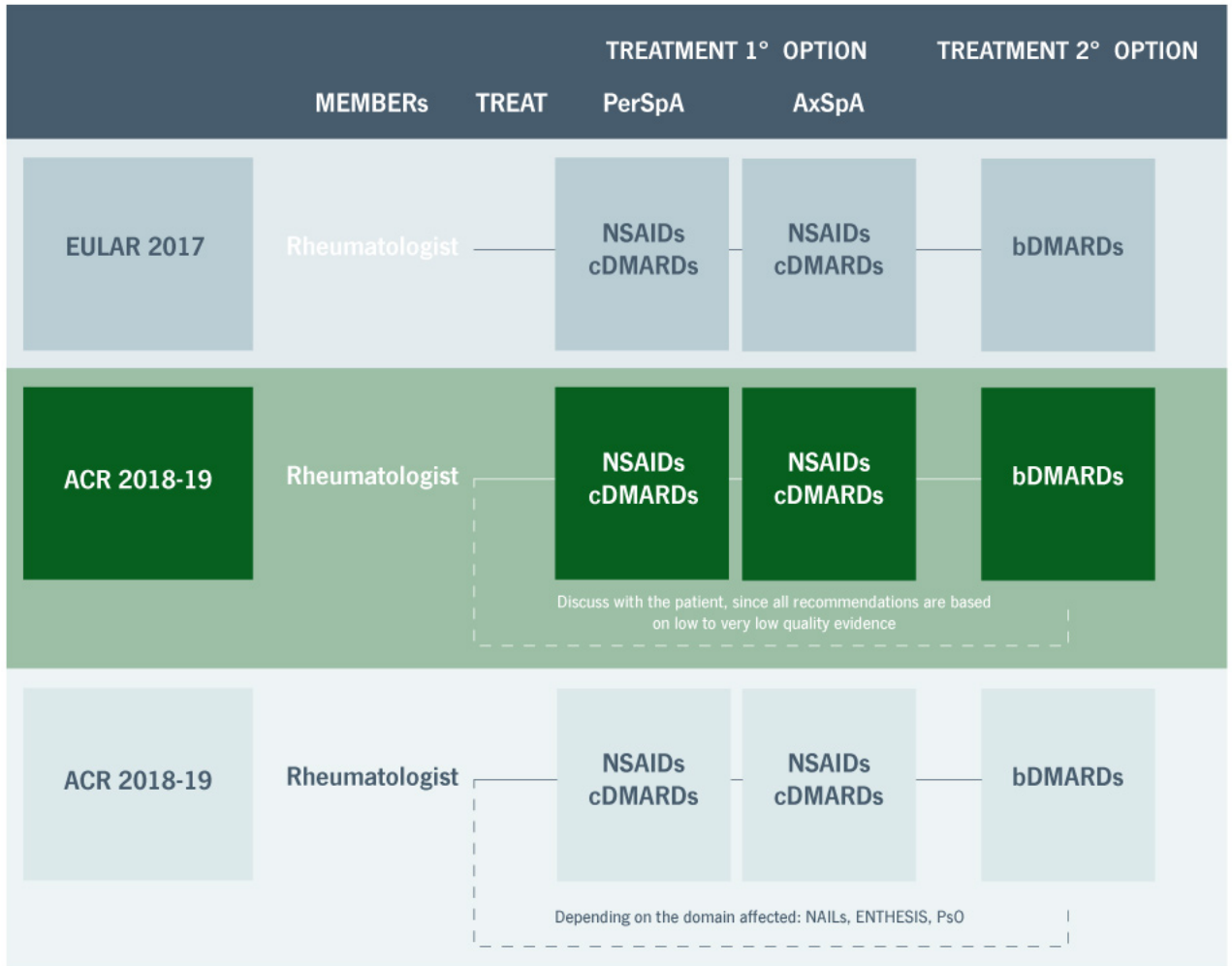
1. van der Heijde D, et al. Ann Rheum Dis. 2017;76:978-991. 2. Aouad K, et al. Joint Bone Spine. 2019; doi: 10.1016/j.jbspin.2019.04.006. 3. Baraliakos X, et al. Rheumatology. 2017;56:95-102.

Current ACR/SPARTAN Treatment Recommendations for axSpA[1,2]



1. Ward MM, et al. Arthritis Care Res (Hoboken). 2019;71:1285-1299. 2. Ward MM, et al. Arthritis Rheumatol. 2019;71:1599-1613

SpAs THERAPY: 3-SIDES OF THE SAME STORY IN THE EXPERT RECOMMENDATION



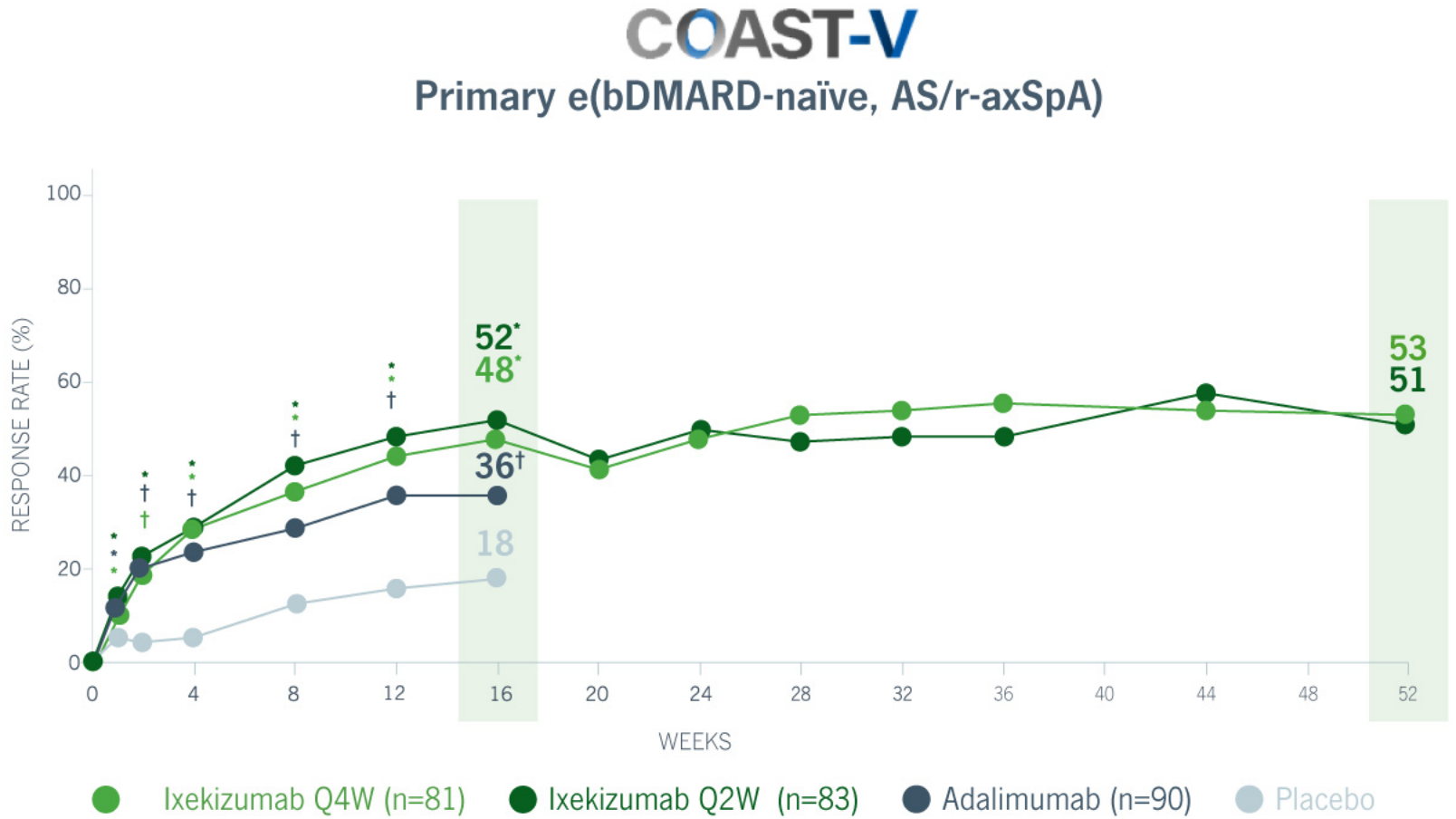
csDMARDs (MTX, Szp, LEF; + apremilast in USA)
bDMARDs (biological drugs)

Expedited Route

1. Ward MM, et al. Arthritis Care Res (Hoboken). 2019;71:1285-1299.
2. Ward MM, et al. Arthritis Rheumatol. 2019;71:1599-1613

ASAS40 Response Rates Through Week 52, NRI[1,2]

Double-Blind PBO-Controlled and Dose Double-Blind Extended Treatment Periods, ITT Population



*p≤.001 vs. PBO; †p<.01 vs. PBO; ‡p<.05 vs. PBO.

Note: ADA represents an active reference; COAST-V was not powered to test equivalence or noninferiority of active treatment groups to each other, including IXE vs. ADA.

1. van der Heijde D, et al. Lancet. 2018;392:2441-2451. 2. Dougados M, et al. Ann Rheum Dis. 2020;79:176-185.

Product information

Classe H - Medicinale soggetto a prescrizione medica limitativa, vendibile al pubblico su prescrizione di centri ospedalieri o di specialisti - internista, reumatologo, dermatologo (RRL).

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