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Assessing Disease Activity in Clinical Practice: Tools to Monitor axSpA

Announcer:

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Here's your host, Dr Ethan Craig.

Dr Craig:

For many rheumatic conditions, disease activity can be monitored relatively simply and with straightforward measures with the RA Clinical Disease Activity Index being a great example. But for axial spondyloarthritis, this can be a little bit more complicated, as presentations of this condition can be difficult to measure, and a lot of our activity measures involve patient-reported outcomes. So, what are some of our primary obstacles that we run into when we're thinking about how to monitor disease activity in axial spondyloarthritis?

This is ReachMD, and I'm Dr Ethan Craig. And joining me to talk about some of the obstacles disease activity monitoring for patients with axial spondyloarthritis is Dr Lianne Gensler. Dr Gensler is a rheumatologist and the Director of the UCSF Spondyloarthritis Clinic at the University of California San Francisco Medical Center. Dr Gensler, thanks for being here today.

Dr Gensler:

Pleasure to be here. Thanks for having me.

Dr Craig:

So, let's dive right in and talk about, you know, one of the I guess granddaddies of the outcome measures for spondyloarthritis, the Bath Ankylosing Spondylitis Disease Activity Index, or BASDAI for short. So, Dr Gensler, what does this tool measure? And what kind of role does it have in your clinical practice?

Dr Gensler:

Yeah, so you know, I run a spondyloarthritis clinic. And so, I measure this in all my patients that are coming in because all of my patients have spondyloarthritis. So, I recognize that it's actually a little bit more challenging if you're seeing patients with many different rheumatic diseases because to have a specific PRO for individual patients with a disease is a little bit more challenging. The BASDAI itself measures several components. It measures of course pain, both axial pain and peripheral pain. It measures morning stiffness, it measures fatigue, and it measures, in a sense, tender areas that might be tender to touch that might suggest enthesitis. And it is a non-weighted PRO that allows us to get a quantitative amount of disease activity in the ways that these diseases manifest with active disease, fatigue, pain, morning stiffness.

It does have limitations because it is purely subjective. And partly because of that, and because of its redundancy a new disease activity was developed, and this is now several years ago, which is the ASDAS, which actually is definitely more robust, and allows us to incorporate the patient global and the C-reactive protein as an objective measure of inflammation. It's also not redundant, and it's weighted. But the problem with that, of course, is that it requires you to have a CRP with a patient in clinic and that obviously has limitations, because many of us don't get labs before the patient comes into clinic.

The other measures, of course, that can be used include the RAPID3, and we've talked about this a little bit before, which at least is generic and can be measured in any patient coming into a rheumatology practice.

Dr Craig:

And that's a great overview of some of the at least partially patient-reported outcomes that we use. And to switch gears a little bit what do you see is the clinical utility? And how often are you checking the metrics that we use in spondyloarthritis, like the Schober's test, the occiput or tragus to wall, lateral lumbar, flexion, etc, in axial spondyloarthritis?

Dr Gensler:

So, patients love these, by the way. So, if you're sitting in clinic with a patient, they like to follow their own metrology. I never do a tragus-to-wall. I know it's included in the BASMI, but I actually don't think the overall composite of metrology is that helpful in clinical practice. I do do a measure of cervical rotation and of thoracic mobility and lumbar mobility. And I do those once a year. These measures typically do change slowly over time, and so more frequent measuring will not necessarily yield a difference. They are also helpful if a patient has increasing disease activity or symptoms that you're worried about, because the things that will drive limitation in mobility include disease activity and damage. So, I do them once a year, and really, that's an assessment of a surrogate for is the patient progressing, and if I see a change in the mobility from any of these measures, then I might go on to imaging to look for radiographic progression, and then I definitely also consider them in the patient that has active disease.

If you're looking for them to respond to treatment, they take a while. So, you know, we typically wait 12 weeks to assess response to a biologic treatment. And I would say be careful repeating these at 3 months or 12 weeks because you may not see the change yet, it can often take up to 6 months to see these measures change if disease activity is driving mobility limitation.

Dr Craig:

Now let's turn it a little bit to biomarkers, specifically talking about the CRP, or C-reactive protein. So, what role does this biomarker have on monitoring activity? And what do we know about how it impacts disease outcomes and treatment escalation?

Dr Gensler:

Yeah, so I think about CRP, first of all, CRP is not elevated in all patients with axial spondyloarthritis, and less so in women than in men. When it's elevated, it is a proxy for prognosis, and it definitely is a risk factor for progression. It also is the most predictive biomarker we have for response to treatment. So, if you have a patient with axial spondyloarthritis and an elevated CRP, they are more likely to respond to biologic treatment than someone with a normal CRP. It's the only biomarker we have. I mean, we have said obviously the erythrocyte sedimentation rate too, but that is less helpful than the CRP in most patients with axial spondyloarthritis. And I like it because obviously it can change and it can go down when you treat a patient, so it is a helpful proxy for response to treatment.

If I have a patient that has a persistent CRP elevation despite treatment, I definitely consider ongoing disease activity, but I also consider other drivers of CRP. And in an axial spondyloarthritis population, if I have a CRP that's persistently elevated, I definitely think about inflammatory bowel disease, because that could also be driving inflammation.

Dr Craig:

Finally, let's take a moment to think about imaging. Do you tend to repeat imaging in patients with axial spondyloarthritis, and do you find that this helps to guide therapy to inform disease activity?

Dr Gensler:

So, what you're asking about MRI imaging for disease activity. So, for radiographic imaging, we don't repeat imaging as a standard approach anymore. I think we used to do this more, but it's a slow-to-change disease, and so you need at least 2 years before x-rays if you're going to look. I do repeat x-rays in a patient that I am worried about has progressed, whether they have poor prognostic markers, like persistently elevated C-reactive protein, they're smoking, they have a change in their mobility, and I'm looking for progression, then I might do that. I only repeat MRI imaging in patients where I have uncertain disease activity on a biologic and I'm considering switching them.

Dr Craig:

Well, that's a great way to round out our discussion on this topic. And I want to thank my guest again, Dr Gensler, thank you for taking a look at monitoring disease activity in axSpA with us. It was really, as always, a great pleasure to talk to you today.

Dr Gensler:

Thank you for having me.

Announcer:

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