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Exploring the Underdiagnosis of AS Within & Around Rheumatology Practices

Announcer:
This is ReachMD. Welcome to 'Spotlight on Rheumatic Diseases". This episode titled, "Exploring the Underdiagnosis of AS Within & Around Rheumatology Practices" sponsored by Lilly. The views and/or opinions expressed are of the medical expert and not necessarily by Eli Lilly & Company.

Here's your host, Dr Matt Birnholz.

Dr. Birnholz:
Coming to you from the annual rheumatology meeting in Atlanta, Georgia, this is ReachMD. I'm Dr. Matt Birnholz. Joining me today is Dr. Sanjay Chabra, Director of Rheumatology at the Texas Arthritis Center, in El Paso, Texas. Dr. Chabra has been among Orange County California's top doctors in rheumatology for six consecutive years and was twice-named America's Top Physician in Rheumatology. Today, we'll be exploring the underdiagnosis of ankylosing spondylitis within and around rheumatology practices. So, Dr. Chabra, welcome to the program.

Dr. Chabra:
Thank you for having me.

Dr. Birnholz:
It's so good to have you here. So maybe to start, I'd like to get a refresher for our audience on some of the epidemiology; the scope and burden of this disease. What can you tell us about the prevalence of ankylosing spondylitis? And back pain in general?

Dr. Chabra:
You know, I'm really glad you asked that. When we look at back pain in general, it's the second leading cause for folks in the United States to go to their doctor. It's the fifth leading cause for hospitalization. When we look at folks from an inflammatory back pain, we have to look at back pain at large. And chronic back pain, anything that's over three months, if you look at the U.S. population, about 19% of folks will have chronic back pain. When you distill that down to inflammatory back pain, it goes down to about 30% of that, so 6% of the folks will have this. We're familiar with the data on rheumatoid arthritis, which has a prevalence of 0.6, so really these two illnesses are almost neck and neck.

Dr. Birnholz:
Well, that's a particular point I really want to focus with you on is that delay. But maybe before we get there, as a preface, we can try to understand better the distinction in differentiating mechanical back pain from inflammatory back pain. What can you tell us about that? Because I imagine there is some continued confusion around that in the general practice arena.

Dr. Chabra:
There definitely is. You know, the mechanical back pain patient is going to be somebody who has a history of injury, they could be at any age, they can have had a reason as far as if you look at imaging, disc disease, degenerative disease, they could have stenosis; usually their pain is going to be something that happens with activity. So, they're the couch potato, they don't want to move. They're the ones that feel worse with movement, and they tend to sleep well through the night because they're not necessarily moving. When you look at a person with inflammatory back pain, this is a younger person, somebody under the age of 40 or 45. They don't have a dramatic history; they just had a backache that creeped up on them. No motor vehicle accident, no fall from a ladder so to speak; they just have insidious onset of pain and their pain seems to be a little different in a sense that they feel better when they're moving. These are folks

that are your runners, your bike riders, the swimmers, they're the ones that want to stay in motion because when they do become a couch potato and watch a football game, they're going to feel pain getting up. They also have pain at night. So, the mechanical back pain, we know movement hurts. With the inflammatory back pain, movement makes them better.

Dr. Birnholz:
So, if we come back to ankylosing spondylitis, from your vantage point, how often is it underdiagnosed, perhaps both in the primary care arena and the rheumatology arena?

Dr. Chabra:
It is probably, aside from lupus in our field of rheumatology, one of the most unrecognized illnesses. The delay in illness is anywhere from 8 to 11 years, in women in particular. Their presentation is different in that further delays their illness by another 2 to 3 years such that they'll have more upper back pain, thoracic back pain, neck pain that is more diffuse in nature, there is more fatigue associated with it, more muscular complaints. The traditional male presentation of the SI joint being inflamed or low back pain. There is still a lot of work to do to recognize that history. And as we start to have therapies that are more targeted and more effective, hopefully we can also bring this to the forefront where people think about it earlier to narrow that down.

Dr. Birnholz:
Now, it sounds like you're already alluding to this, but I'm sure one question that comes up among those who don't have quite the same expertise in inflammatory diseases is trying to ascertain whether there are multifactorial reasons for the under-recognition of this disease or if there is a smoking gun, as it were.

Dr. Chabra:
You know, I think it's just because no two patients with AS are going to be alike. There is so much heterogeneity in the illness. People perceive pain differently. It's not like a blood pressure or a cholesterol where we can be targeted with a number. We're asking them about something that's emotional and personal to them. And one person's level of tolerance for pain may be completely different from another. The key thing is to try to educate the community that the back pain that is persistent over three months or back pain that occurs without a history of injury needs to be treated differently than typical physiotherapy and over-the-counter intervention.

Dr. Birnholz:
Yeah, clearly that's really an important takeaway in our discussion today. One question that comes up then is how the disease is classified and whether current classifications of the disease help clarify or actually further obscure our ability to recognize it faster. What are your thoughts on those classification symptoms?

Dr. Chabra:
That's a very good question. That's the alphabet soup of all our illnesses here. We use a treat-to-target methodology when we're looking at rheumatoid arthritis, but when we use different functional components, different criteria, it's very overwhelming to teach even a medical student about all of these criteria. But what's held kind of as a benchmark is the ASAS criteria. In addition, you'll have spondyloarthritis features. And by doing that, you funnel things down to try and decipher that inflammatory back pain from wear-and-tear arthritis. It is helpful, but it requires somebody to really have a passion or see enough of this to recognize it. If you're seeing the whole spectrum of diseases as a primary care doctor and know what studies to look for. So, there's a great deal of education that can be overwhelming.

Dr. Birnholz:
And you talked about some of the testing that goes into the classification; from a research standpoint, there is HLA-B27 blood testing, imaging; how do you incorporate these in a way that speaks to other rheumatologists that practically helps them say, 'This is the direction I should go in to make sure I'm not missing this?'

Dr. Chabra:
That's definitely the crux of helping our patients is to identify and know what we're treating and think about this. So, when we look at the role of HLA-B27, sadly enough, so many folks will think that's the Holy Grail to ankylosing spondylitis. It can be negative, depending on different population subsets. It's more positive in the Caucasian population, and those in African American descent, they're going to have about 30-40% reduction in the findings for HLA-B27. So it is theoretically possible to have true AS without an HLA-B27, although when you do have it, it is helpful because one in three individuals who has an HLA-B27 finding is going to have AS; however, we can't just rely on this with the highest degree of sensitivity and specificity because we'll miss folks. When we look then to the next level of identification, we're going to look at imaging. There is nothing more devastating than seeing severe sacroiliitis or erosive changes of the SI joint for a young individual, as the disease tends to affect, and then now try and put them back together again with therapy. So when we look at the imaging, the MRI has changed our early identification access, so when we use the MRI, we're able to use the STIR images where you don't have to expose the patient to radioactive dye. So that, combined with the laboratory studies, now we're able to

look at sed rates and CRPs. The story starts to evolve from a scientific standpoint whether you're looking at labs or imaging, but the real crux of it is getting that history from a patient.

Dr. Birnholz:
Yeah, certainly it sounds so. And your elusion to radiologists was a really good one in this case because I think of radiology training along the lines of exactly as you put it, pattern recognition. You see 100 million normal radiographs, so when they see anything that's vaguely off, it catches really fast and there's a pattern that goes into that. It seems like a similar process in rheumatology towards being able to know that something's off. You get that instinct based on a pattern recognition and be able to pursue it aggressively further. Is that the case?

Dr. Chabra:
Very much so. I think if we understand that everybody's disease may be unique in how they present, that there is a crux or a framework to the illness that if we can recognize it and tease it out, it may take an extra few minutes to do that, but it can have a real rewarding experience for the patient who has struggled for many years to identify what it is that they have, and then the next step is to also recognize what appropriate treatments they need. Because if we identify the illness and we don't have an opportunity to help them with a therapy, then we haven't done them any good. So, it takes the tools of asking the appropriate questions, but also being aware of what to do next.

Dr. Birnholz:
And are there any educational principles that you find yourself from a pattern standpoint teaching or coming back to again and again to try to help other healthcare professionals get this on their radar a little faster?

Dr. Chabra:
The biggest thing I use is kind of a pneumonic called I-pain, and with I that stands for insidious amounts of people that didn't have a dramatic injury, and when we look at their pain, we're going to see that their age of onset is going to have been under the age of 45. They have pain at night. They don't have improvement with rest, but they do have improvement with activity. We can do the Schober's test, the physical movement, try and check chest to wall, occiput to wall, all of those physical exam findings in our office. Inflammatory back pain by just asking a little bit more historical questions, and you see the patient, if they're somebody who is 65 or 70 with back pain, it's clearly likely to be spinal stenosis or degenerative in nature; however, somebody in their 20s and 30s to think a little differently. The other thing that I teach a lot of our physical therapists who deal with these folks is I ask them, you know, you're doing your best, your patients are trying to be compliant, have you ever found someone who doesn't get better? And usually both their hands go up. And what we take from that discussion is well how do we improve things, if they're not getting better from movement, maybe we could explore further, and that's when they become our wind in identifying they have inflammatory back pain.

Dr. Birnholz:
That's excellent. And you mentioned physical therapists, which brings up another good subject area. Who's critical on the multidisciplinary team front to get incorporated a little bit sooner to help shore that gap in the delay in diagnosis?

Dr. Chabra:
It takes a village. I've had the relationship over the years with spine surgeons, before they bring the scalpel to the patient, to look at the age, ask these kinds of questions that we're sharing now, and send the patient our way. We might find someone who could benefit from intervention and not have surgery. The last thing that the surgeons want is to have a surgery with a bad outcome, and so they're looking forward to find a way to help those patients just the same. And so, I've gone through and taught them about what we learned with inflammatory back pain and they've been happy to send patients our way. See, unconsciously, these folks will have learned how to ambulate, how to get through their day using certain muscles and avoiding others. And if we don't recognize it early enough, they will lose that spinal mobility. And so we talked to the primary care doctors, and we're trying to get them to recognize a younger person hasn't walked the earth long enough to have had degenerative changes, and when we speak to physical therapists, we're trying to see where is the asymmetric person who's not responding to intervention. Our pain management specialists are doing all sorts of maneuvers now with trigger injections and laser treatments, and when they can't get the patient chronically under control, they need to consider other options. That's when we try to say think of inflammatory back pain early, not later.

Dr. Birnholz:
Well, with that great parting takeaway comment on keeping an open mind, which I think is a beautiful way to close our interview, I do want to thank you, Dr. Sanjay Chabra, for joining us to talk about back pain, inflammatory versus mechanical, the underdiagnosis of ankylosing spondylitis, and what we can do about it to get better and shore that gap in the delay of diagnosis. Thanks so much for your time.

Dr. Chabra:

Oh, thank you.

Announcer:
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