



# Spondyloarthritis

Quality standard

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[www.nice.org.uk/guidance/qs170](http://www.nice.org.uk/guidance/qs170)

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This standard is based on NG65.

This standard should be read in conjunction with QS155, QS153, QS120, QS40, QS33 and QS15.

## Quality statements

**Statement 1** Adults with suspected axial or peripheral spondyloarthritis are referred to a rheumatologist.

**Statement 2** Adults with suspected axial spondyloarthritis and an X-ray that does not show sacroiliitis have an MRI using an inflammatory back pain protocol.

**Statement 3** Adults with axial spondyloarthritis are referred to a specialist physiotherapist for a structured exercise programme.

**Statement 4** Adults with spondyloarthritis are given information about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE Pathway on [patient experience in adult NHS services](#)), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing spondyloarthritis services include:

- [Low back pain and sciatica in over 16s](#) (2017) NICE quality standard 155
- [Multimorbidity](#) (2017) NICE quality standard 153
- [Medicines optimisation](#) (2016) NICE quality standard 120
- [Psoriasis](#) (2013) NICE quality standard 40
- [Rheumatoid arthritis in over 16s](#) (2013) NICE quality standard 33

A full list of NICE quality standards is available from the [quality standards topic library](#).

## Quality statement 1: Referral

### *Quality statement*

Adults with suspected axial or peripheral spondyloarthritis are referred to a rheumatologist.

### *Rationale*

Both axial and peripheral spondyloarthritis, including psoriatic arthritis, are difficult to diagnose without specialist assessment. Delays in correctly identifying spondyloarthritis can result in significant morbidity and avoidable investigations and treatments. Referring adults with suspected spondyloarthritis to a rheumatologist will reduce delays in diagnosis and starting treatment. This will help improve outcomes, such as reducing joint and tendon damage, loss of function, pain, fatigue and quality of life.

### *Quality measures*

#### Structure

a) Evidence of local arrangements to raise awareness of signs, symptoms and risk factors of axial and peripheral spondyloarthritis in primary care.

**Data source:** Local data collection, for example, from education programmes or awareness campaigns.

b) Evidence of local referral criteria and pathways to ensure that adults with suspected axial or peripheral spondyloarthritis are referred to a rheumatologist.

**Data source:** Local data collection, for example, from referral pathways or referral strategies.

#### Process

Proportion of adults with suspected axial or peripheral spondyloarthritis referred to a rheumatologist.

Numerator – the number in the denominator referred to a rheumatologist.

Denominator – the number of adults with suspected axial or peripheral spondyloarthritis.

**Data source:** Local data collection, for example, local audit of patient records.

## Outcomes

a) Time from first presentation of symptoms to diagnosis for adults with spondyloarthritis.

**Data source:** Local data collection, for example, local audit of patient records.

b) Health-related quality-of-life score of adults with spondyloarthritis.

**Data source:** Local data collection, for example, survey of adults with axial spondyloarthritis using a quality-of-life questionnaire.

c) Functional ability score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, survey of adults with axial spondyloarthritis using a questionnaire to assess functional ability (such as the Bath Ankylosing Spondylitis Functional Index).

d) Joint replacement surgery for adults with peripheral spondyloarthritis.

**Data source:** Local data collection, for example, local audit of patient records.

## *What the quality statement means for different audiences*

**Service providers** (such as GP practices and musculoskeletal interface services, physiotherapy, ophthalmology, dermatology and gastroenterology services) ensure that healthcare professionals are aware of the signs, symptoms and risk factors of axial and peripheral spondyloarthritis. They develop referral criteria and pathways with rheumatology services to ensure that people with signs and symptoms of spondyloarthritis are referred to rheumatologists for assessment and diagnosis.

**Healthcare professionals** (such as GPs, physiotherapists, nurses, dermatologists, gastroenterologists and ophthalmologists) are aware of the signs, symptoms and risk factors of axial and peripheral spondyloarthritis, the groups of people it can affect and local referral pathways. They identify people who have signs and symptoms of spondyloarthritis and refer them to a rheumatologist for investigation and diagnosis.

**Commissioners** (clinical commissioning groups and NHS England) have service specifications for

rheumatology that include referral criteria and referral pathways to ensure that adults presenting with signs, symptoms and risk factors of axial or peripheral spondyloarthritis are referred to a rheumatologist for investigation and diagnosis.

**Adults with symptoms that suggest spondyloarthritis** (a type of inflammatory arthritis) are referred to a specialist in rheumatology for assessment and tests, which may include an X-ray or a scan. People who have these assessments and tests will find out sooner whether or not they have spondyloarthritis and can start treatment earlier.

### *Source guidance*

Spondyloarthritis in over 16s: diagnosis and management (2017) NICE guideline NG65, recommendations 1.1.5, 1.1.8, 1.1.9 and 1.1.10

### *Definitions of terms used in this quality statement*

#### **Suspected axial spondyloarthritis**

Signs and symptoms of axial spondyloarthritis include a combination of low back pain that started before the age of 45 years and has lasted for longer than 3 months, and:

- 4 or more of the following additional criteria:
  - low back pain that started before the age of 35 years (this further increases the likelihood that back pain is due to spondyloarthritis, compared with low back pain that started between 35 and 44 years)
  - waking during the second half of the night because of symptoms
  - buttock pain
  - improvement with movement
  - improvement within 48 hours of taking non-steroidal anti-inflammatory drugs
  - a first-degree relative with spondyloarthritis
  - current or past arthritis
  - current or past enthesitis (inflammation of a site at which a tendon or ligament attaches to bone)

- – current or past psoriasis

or

- 3 of the above additional criteria and a positive result from a HLA-B27 test.

[NICE's guideline on [spondyloarthritis](#), recommendation 1.1.5 and glossary in the full guideline]

## Suspected peripheral spondyloarthritis

Signs, symptoms and risk factors that indicate an adult could have psoriatic arthritis or other peripheral spondyloarthritis are:

- new-onset inflammatory arthritis, unless rheumatoid arthritis, gout or acute calcium pyrophosphate arthritis ('pseudogout') is suspected
- dactylitis (inflammation of a finger or toe characteristically resulting in a sausage appearance)
- enthesitis without apparent mechanical cause if:
  - it is persistent or
  - it is in multiple sites or
  - any of the following are also present:
    - ◇ back pain without apparent mechanical cause
    - ◇ current or past uveitis
    - ◇ current or past psoriasis
    - ◇ gastrointestinal or genitourinary infection
    - ◇ inflammatory bowel disease (Crohn's disease or ulcerative colitis)
  - a first-degree relative with spondyloarthritis or psoriasis.

[NICE's guideline on [spondyloarthritis](#), recommendations 1.1.8, 1.1.9, 1.1.10 and glossary in the full guideline]



## *Equality and diversity considerations*

There is a common misconception that axial spondyloarthritis mainly affects men. Healthcare professionals should be aware that axial spondyloarthritis affects a similar number of women as men.

## Quality statement 2: Diagnosis of axial spondyloarthritis using imaging

### *Quality statement*

Adults with suspected axial spondyloarthritis and an X-ray that does not show sacroiliitis have an MRI using an inflammatory back pain protocol.

### *Rationale*

No single test can diagnose axial spondyloarthritis. Blood tests for HLA-B27 may be negative in some people and not all people have raised inflammatory markers. X-rays can support a diagnosis of radiographic axial spondylitis, but in some cases it can take several years for changes to be detectable, and sometimes changes may never show on X-ray. When plain film X-ray does not show sacroiliitis, MRI using an inflammatory back pain protocol that is interpreted by a specialist with knowledge of spondyloarthritis can support the diagnosis of non-radiographic axial spondyloarthritis and enable effective treatment to start.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements to ensure that rheumatologists and musculoskeletal interface services can access X-ray and MRI diagnostic services for people with suspected axial spondyloarthritis.

**Data source:** Local data collection, for example, from referral pathways or service specifications.

b) Evidence of local arrangements to ensure that a musculoskeletal radiologist interprets imaging for people with suspected axial spondyloarthritis when appropriate.

**Data source:** Local data collection, for example, from service specifications.

c) Evidence of an inflammatory back pain protocol outlining how to perform MRI on adults with suspected axial spondyloarthritis.

**Data source:** Local data collection, for example, from service protocols.

## Process

a) Proportion of adults with suspected axial spondyloarthritis and an X-ray that does not show sacroiliitis that have an MRI.

Numerator – the number in the denominator that have an MRI.

Denominator – the number of adults with suspected axial spondyloarthritis who have had an X-ray that does not show sacroiliitis.

**Data source:** Local data collection, for example, local audit of patient records.

b) Proportion of MRIs for suspected axial spondyloarthritis in adults performed using an inflammatory back pain protocol.

Numerator – the number in the denominator performed using an inflammatory back pain protocol.

Denominator – the number of MRIs performed to investigate suspected axial spondyloarthritis in adults.

**Data source:** Local data collection, for example, local audit of patient records.

## Outcomes

a) Time from first presentation of symptoms to diagnosis for adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, local audit of patient records.

b) Health-related quality-of-life score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, survey of adults with axial spondyloarthritis using a quality-of-life questionnaire.

c) Functional ability score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, survey of adults with axial spondyloarthritis using a questionnaire to assess functional ability (such as the Bath Ankylosing Spondylitis Functional Index).

## *What the quality statement means for different audiences*

**Service providers** (such as rheumatology and diagnostic imaging services) have protocols in place to ensure that X-ray is used for first-line imaging in people with suspected axial spondyloarthritis. They perform MRI only when there is no evidence of sacroiliitis meeting modified New York criteria on X-ray, or an X-ray is not appropriate because the person's skeleton is not fully mature. They ensure that MRI for suspected axial spondyloarthritis is performed using an inflammatory back pain protocol.

**Healthcare professionals** (such as rheumatologists and healthcare professionals in musculoskeletal interface services) request X-ray for first-line imaging in people with suspected axial spondyloarthritis unless a person is likely to have an immature skeleton. They request MRI using an inflammatory back pain protocol if there is no evidence of sacroiliitis meeting modified New York criteria on X-ray. Rheumatologists and radiologists use the Assessment of Spondyloarthritis International Society/Outcome Measures in Rheumatology MRI criteria to interpret the MRI.

**Commissioners** (clinical commissioning groups) have service specifications that require MRI using an inflammatory back pain protocol for people with suspected axial spondyloarthritis when there is no evidence of sacroiliitis meeting modified New York criteria on X-ray, or when an X-ray is not appropriate because the person's skeleton is not fully mature.

**Adults with symptoms that suggest axial spondyloarthritis** are offered an MRI scan to check for inflammation if an X-ray has not shown the condition, or if an X-ray is not appropriate because the person has not finished growing.

## *Source guidance*

[Spondyloarthritis in over 16s: diagnosis and management](#) (2017) NICE guideline NG65, recommendation 1.2.6

## *Definitions of terms used in this quality statement*

### **Sacroiliitis**

Inflammation of the sacroiliac joint at the base of the spine that meets the modified New York criteria (bilateral grade 2–4 or unilateral grade 3–4 sacroiliitis).

[NICE's guideline on [spondyloarthritis](#), recommendation 1.2.6 and glossary in the full guideline]

## Inflammatory back pain protocol

An MRI performed using short T1 inversion recovery (STIR) and T1 weighted sequences of the whole spine (sagittal view), and sacroiliac joints (coronal oblique view).

[NICE's guideline on [spondyloarthritis](#), recommendation 1.2.7]

### *Equality and diversity considerations*

There is a common misconception that axial spondyloarthritis mainly affects men. Healthcare professionals should be aware that axial spondyloarthritis affects a similar number of women as men. Women are less likely to show sacroiliitis on X-ray than men, but they should still be offered X-ray for first-line imaging of suspected axial spondyloarthritis. If a person does not have an X-ray they cannot be diagnosed with radiographic axial spondyloarthritis and so are not eligible for any treatments that are only available for that indication.

Young people (around 16 to 18 years of age) with an immature skeleton are unlikely to show radiographic signs and therefore an X-ray would be inappropriate at initial presentation. It is likely that people in this group would be offered further opportunities for assessment by X-ray at a later stage in disease management.

## Quality statement 3: Physiotherapy

### *Quality statement*

Adults with axial spondyloarthritis are referred to a specialist physiotherapist for a structured exercise programme.

### *Rationale*

Specialist physiotherapy is a key non-pharmacological management strategy for people with axial spondyloarthritis. Structured exercise programmes that are designed and tailored by specialist physiotherapists for a person's current and changing needs can have many benefits for people with spondyloarthritis. These include helping to reduce the impact of the disease, improving or maintaining mobility, function and quality of life, enabling self-management, and reducing pain and fatigue.

### *Quality measures*

#### Structure

Evidence of local referral pathways to specialist physiotherapists for adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, from referral pathways or referral strategies.

#### Process

a) Proportion of adults with axial spondyloarthritis referred to a specialist physiotherapist for a structured exercise programme.

Numerator – the number in the denominator referred to a specialist physiotherapist for a structured exercise programme.

Denominator – the number of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, local audit of patient records.

b) Proportion of adults with axial spondyloarthritis referred to a specialist physiotherapist for a structured exercise programme who attended the programme.

**Numerator** – the number in the denominator who attended the programme.

**Denominator** – the number of adults with axial spondyloarthritis referred to a specialist physiotherapist for a structured exercise programme.

**Data source:** Local data collection, for example, local audit of patient records.

## Outcomes

a) Functional ability score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, survey of adults with axial spondyloarthritis using a questionnaire to assess functional ability (such as the Bath Ankylosing Spondylitis Functional Index).

b) Self-reported pain score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, survey of adults with axial spondyloarthritis using a questionnaire to assess pain (such as the Bath Ankylosing Spondylitis Disease Activity Index).

c) Self-reported fatigue score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example survey of adults with axial spondyloarthritis using a questionnaire to assess fatigue (such as the Bath Ankylosing Spondylitis Disease Activity Index).

d) Spinal mobility score of adults with axial spondyloarthritis.

**Data source:** Local data collection, for example, from measurements taken during a clinical examination to populate a validated tool (such as the Bath Ankylosing Spondylitis Metrology Index).

## *What the quality statement means for different audiences*

**Service providers** (such as GP practices and rheumatology services) ensure that pathways are in place for adults with axial spondyloarthritis to be referred to a specialist physiotherapist to start a structured exercise programme.

**Healthcare professionals** (such as rheumatologists and GPs) refer adults with axial

spondyloarthritis to a specialist physiotherapist to start a structured exercise programme.

**Commissioners** (clinical commissioning groups) commission physiotherapy services that have specialist physiotherapists in rheumatology and have service specifications that ensure that adults with axial spondyloarthritis are referred to them to start a structured exercise programme.

**Adults who have axial spondyloarthritis** are referred to a specialist physiotherapist who helps with joint, muscle and movement problems. The physiotherapist will tailor a plan of exercises to the person's individual and changing needs. The aim of the exercises is to ease symptoms such as stiffness and pain, and help with mobility and fitness.

### *Source guidance*

Spondyloarthritis in over 16s: diagnosis and management (2017) NICE guideline NG65, recommendation 1.5.1

### *Definitions of terms used in this quality statement*

#### **Structured exercise programme**

A plan of exercises tailored to a person's individual and changing needs that includes:

- stretching, strengthening and postural exercises
- deep breathing
- spinal extension
- range of motion exercises for the lumbar, thoracic and cervical sections of the spine
- aerobic exercise.

[NICE's guideline on spondyloarthritis, recommendation 1.5.1]

#### **Specialist physiotherapist**

A physiotherapist with rheumatology experience and experience of treating axial spondyloarthritis.

[Expert opinion]



## Quality statement 4: Information

### *Quality statement*

Adults with spondyloarthritis are given information about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

### *Rationale*

Knowing about spondyloarthritis, including the symptoms, can help people to manage their condition and know when they need support from healthcare professionals. It is important that people have information on who to contact when they need extra advice and support, such as when they have a flare, so that they can access care quickly and return to normal activities without disease progression or complications.

### *Quality measures*

#### Structure

a) Evidence that written information is available for adults with spondyloarthritis about their condition, who will be involved with their care, and how and when to get in touch with them.

**Data source:** Local data collection, for example, information leaflets.

b) Evidence of local processes to ensure that adults with spondyloarthritis have a discussion with a healthcare professional about their condition, who will be involved with their care, and how and when to get in touch with them.

**Data source:** Local data collection, for example, service protocol.

#### Process

a) Proportion of adults with spondyloarthritis who are given written information about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

Numerator – the number in the denominator who are given written information about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

Denominator – the number of adults with spondyloarthritis.

**Data source:** Local data collection, for example, audit of electronic patient health records.

b) Proportion of adults with spondyloarthritis who have a record of a discussion about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

Numerator – the number in the denominator who have a record of a discussion about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

Denominator – the number of adults with spondyloarthritis.

**Data source:** Local data collection, for example, audit of electronic patient health records.

## Outcomes

a) Adults with spondyloarthritis know how to self-manage their condition.

**Data source:** Local data collection, for example, survey of adults with spondyloarthritis.

b) Adults with spondyloarthritis know how to access care when they need additional support.

**Data source:** Local data collection, for example, survey of adults with spondyloarthritis.

## *What the quality statement means for different audiences*

**Service providers** (rheumatology services) ensure that healthcare professionals have the time and resources to provide information to adults with spondyloarthritis about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them. This might include details of a named person to contact, for example, a specialist rheumatology nurse. Providers have systems in place to ensure that people having flares can access care quickly in different settings.

**Healthcare professionals** (rheumatologists, specialist rheumatology nurses and specialist physiotherapists) discuss with adults with spondyloarthritis likely symptoms and how they can be managed, self-help options and which healthcare professionals will be involved with their care, and

how and when to get in touch with them.

**Commissioners** (clinical commissioning groups) commission services that have the capacity and resources to provide adults with spondyloarthritis with information about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

**Adults with spondyloarthritis** are given information about the condition, the symptoms they are likely to have and how they can cope with them, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

### *Source guidance*

Spondyloarthritis in over 16s: diagnosis and management (2017) NICE guideline NG65, recommendation 1.3.2

### *Definitions of terms used in this quality statement*

#### **Information about their condition**

Information that will educate people with spondyloarthritis about the condition, so they understand when to get in touch with healthcare professionals for support. This information should include:

- what spondyloarthritis is
- diagnosis and prognosis
- treatment options (pharmacological and non-pharmacological), including possible side effects
- likely symptoms and how they can be managed
- flare episodes and extra-articular symptoms
- self-help options.

[Adapted from NICE's guideline on spondyloarthritis, recommendation 1.3.2]

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See [quality standard advisory committees](#) on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the [quality standard's webpage](#).

This quality standard has been included in the NICE Pathway on [spondyloarthritis](#), which brings together everything we have said on spondyloarthritis in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## *Improving outcomes*

This quality standard is expected to contribute to improvements in the following outcomes:

- Functional capacity
- Mobility
- Work productivity
- Health-related quality of life
- Pain
- Fatigue
- Mortality rates from cardiovascular disease
- Joint replacement surgery
- Disease activity.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- [Public health outcomes framework for England](#).

### *Resource impact*

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact report](#) and [resource impact template](#) for the source guidance to help estimate local costs.

### *Diversity, equality and language*

During the development of this quality standard, equality issues were considered and [equality assessments](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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## *Endorsing organisation*

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

## *Supporting organisations*

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Royal College of Nursing](#)
- [National Ankylosing Spondylitis Society](#)
- [Psoriasis and Psoriatic Arthritis Alliance](#)
- [British Society for Rheumatology](#)
- [Chartered Society of Physiotherapy](#)
- [Royal College of Radiologists](#)
- [British Society of Skeletal Radiologists](#)