TNF-alpha inhibitors for ankylosing spondylitis and axial spondyloarthritis without radiographic evidence of ankylosing spondylitis (including a review of technology appraisal 143 and technology appraisal 233)
Response to assessment report from the current spondyloarthritis clinical guideline committee

I am putting in writing my concerns that there is a risk that the SpA guideline could be negatively impacted upon, if there cannot be more clarity on advice for clinical preferences for biologic choice in the context of HLA-B27 associated diseases.

There is a need to include in the SpA guidelines, suggestions on which of the available biologics (particularly anti-TNF subtypes) would be preferable to use in patients starting these medications for SpA, but with HLA-B27 associated diseases such as psoriasis, colitis and uveitis.

There may well be little evidence of response to individual anti-TNFs in patients with psoriasis, uveitis, colitis in the context of SpA as well. However, for the SpA guideline – looking at preferential responses of these essentially equivalent drugs in SpA, which are known to be different in these other diseases is clinically important.

For example – if a patient with SpA is to be started on anti-TNF (for their SpA - which could be etanercept, adalumimab, golumimab) and they have concurrent active uveitis – then this would be likely to improve with adalumimab but potentially there could be harm or at least much less likelihood of response if that individual started etanercept. This is in the context of very similar costs.

Clinically as a specialist in SpA, I personally have a working knowledge of this type of data – but this is not the case for many less specialised consultant rheumatologists prescribing these drugs in SpA patients in the UK.

I am concerned it was reported in the GDG meeting above that the TA group found little/no data to support TA advice on preferential use – and I strongly suspect that this is because they have only looked for supporting data for B27 comorbidity treatment in SpA cohorts.

I would suggest that this is too narrow a viewpoint and the strong evidence for anti-TNF treatment of these other diseases should be reviewed (or cross referenced to – esp in the case of colitis and psoriasis where I believe there may well be existing NICE / Cochrane guidance).

I believe that failing to provide this additional data within the guidelines would constitute a completely avoidable clinical risk.

Authored by:
[redacted]

Submitted by: [redacted]