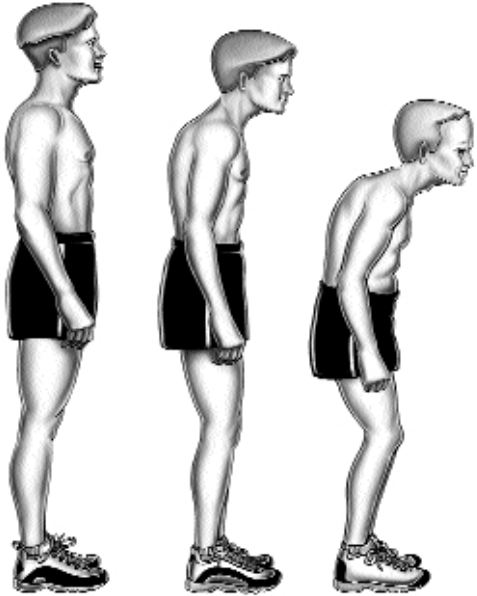


## Clinician's Guide

### When Back Pain Means Spondylitis



By diagnosing ankylosing spondylitis early, you can reduce the risk of disability and deformity

### Four Myths About Spondylitis

**Myth:** Ankylosing spondylitis and associated diseases are rare.

**Fact:** Spondylitis is more common than multiple sclerosis, cystic fibrosis and Lou Gehrig's Disease combined.

**Myth:** Spondylitis always results in a fused spine.

**Fact:** Symptoms and severity vary from patient to patient. Many people with spondylitis do not progress to complete bony fusion of the whole spine.

**Myth:** Spondylitis does not affect women.

**Fact:** Spondylitis affects women about half as frequently as men. However, in women, the symptoms or progression of the disease may be "atypical", and the clinician must have a high index of suspicion to prevent unfortunate delays in diagnosis.

**Myth:** Nothing can be done to help the patient.

**Fact:** Early diagnosis and proper medical management can minimize back pain and stiffness, and help reduce the risk of disability and deformity.

**Fact:** YOU can make a difference.

### Follow these Pointers to Early Diagnosis

Most cases of spondylitis (ankylosing spondylitis or AS) can be diagnosed, or at least initially suspected, based upon a good history and clinical examination. And yet, delays and failures in diagnosis persist.

YOU can help prevent this delay in diagnosis by distinguishing back pain due to spondylitis from other common causes of back pain.

#### IMPORTANT POINTS TO LOOK FOR:

- 1 Onset is usually under 35 years of age and is insidious.
- 2 Pain persists for more than three months (i.e. it is chronic).
- 3 The back pain and stiffness worsen with immobility, especially at night and early morning.
- 4 The back pain and stiffness tend to ease with physical activity and exercise.
- 5 NSAIDs are very effective in relieving pain and stiffness in most patients.



## Look for signs that strengthen the diagnosis

- **SITES OF INFLAMMATION** – Spondylitis primarily affects cartilaginous joints and entheses, where ligaments, joint capsules and tendons attach to bone, primarily in the spine. Check for pain and tenderness to palpation along the back, pelvic bones, sacroiliac joints, chest and heels.
- **LIMITED MOBILITY** – Check for limitation of spinal mobility in all directions and for any restriction of chest expansion.
- **X-RAY EVIDENCE OF INFLAMMATION** – Spondylitis typically begins with inflammation of the sacroiliac joints (sacroiliitis). A presumptive clinical diagnosis of spondylitis can be confirmed by finding erosions and/or narrowing or fusion of the sacroiliac joints on standard AP radiographic view of the pelvis. However, x-rays can be normal in early disease in some patients.



### Characteristics of Pain

- The back pain of early spondylitis is usually a dull ache, difficult to localize, and felt deep in the buttock or lower back. The back pain is frequently associated with stiffness and spasm of paraspinal muscles, especially in early stages of the disease.
- Prolonged inactivity usually worsens the pain and stiffness. Pain may awaken the patient at night. Some patients find it necessary to exercise or move about for a few minutes before returning to bed, and may have considerable difficulty in getting out of bed in the morning. Hot showers help minimize the pain and stiffness.

### Variations

- In children under 17, knee, hip, ankle or foot arthritis may appear as the first symptom.
- In women, the disease may progress more slowly, and in some, neck and peripheral joint involvement may be the main manifestation. Symptoms may resemble “fibrositis” or rheumatoid arthritis in some patients.
- Unilateral acute uveitis occurs in at least 25% of patients with AS, sometimes preceding the onset of spondylitis, and is often recurrent.



## Treatment can help your patients

Although there is no known cure as yet, spondylitis can be successfully managed to minimize spinal deformity and retard progressive loss of mobility of the spine and other affected joints.

The objectives of treatment – reducing pain and stiffness, maintaining erect posture and preserving mobility -- can only be achieved with the patient’s active participation. Educating patients to their role is essential for success.

Most treatment regimens consist of:

- non steroidal anti-inflammatory drugs (NSAIDs) in doses sufficient to reduce pain and suppress inflammation.
- encouraging patients to practice good posture habits at all times.
- initiating an exercise program of stretching and strengthening to keep the spine mobile and erect.
- practicing deep breathing exercises to help maintain chest expansion.

**“With medication and exercise, I can continue playing professional baseball.”**

–Rico Brogna  
Major League Baseball Player

## Resources for Clinicians

You may wish to refer your patient to a rheumatologist to confirm the diagnosis or to provide overall management in cases that are not well-controlled by conventional treatment.

• The American College of Rheumatology at  
(404) 633-3777  
[www.rheumatology.org](http://www.rheumatology.org)

• The Spondylitis Association of America at  
(800) 777-8189  
[www.spondylitis.org](http://www.spondylitis.org)

The Spondylitis Association of America, a national non-profit organization, is the leading information source in the United States for patients with spondylitis, their families and physicians. We will gladly provide your patients with books, pamphlets and videotapes needed to help manage the disease.

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