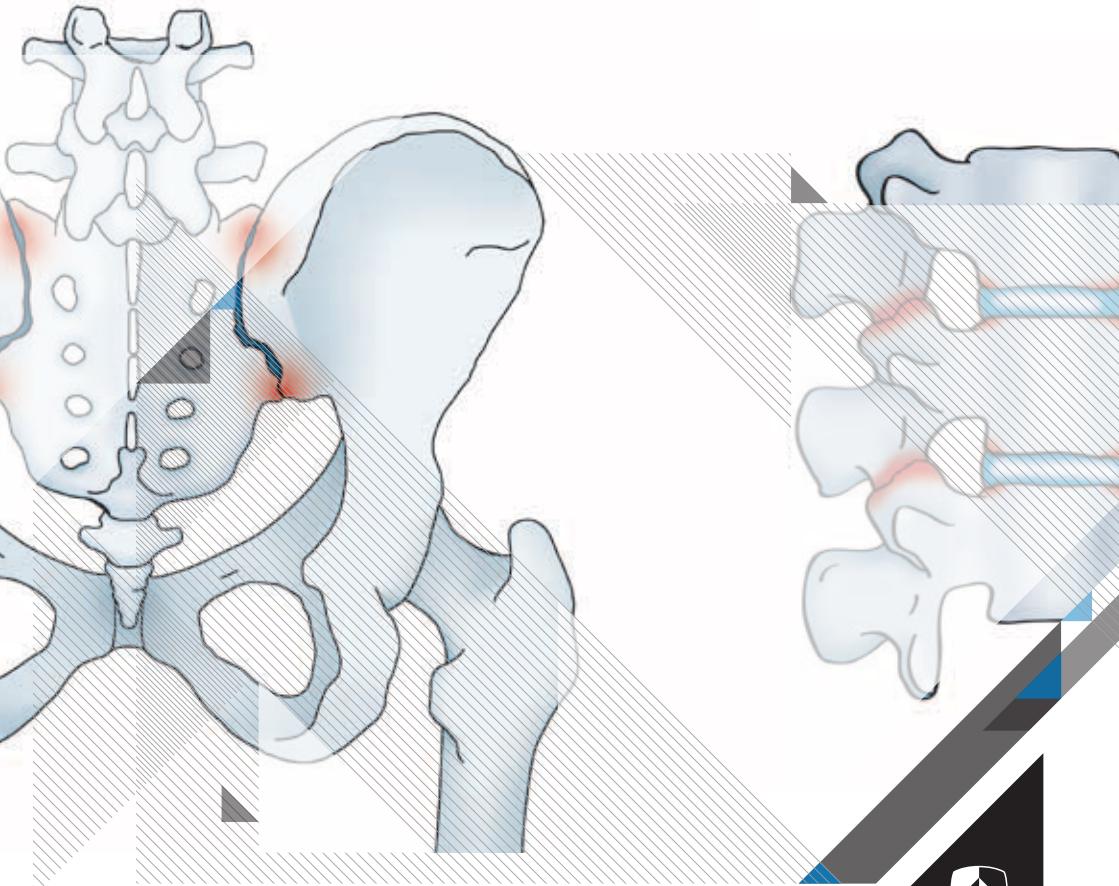


Patient information

Axial spondyloarthritis (axial SpA)



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Introduction

Axial spondyloarthritis (axial SpA) is a form of inflammatory arthritis; in the past it was commonly known as ankylosing spondylitis. The main areas of inflammation are in the spine, particularly the lower spine, and pelvis. Axial SpA may also affect peripheral joints, tendons and ligaments. The condition is very variable, some people are hardly troubled by the arthritis which causes pain and stiffness while others find it impacts greatly on their daily life.

Most people are diagnosed before the age of 35 years. Early diagnosis can be difficult due to the common occurrence of back pain in our society, but the earlier the diagnosis the easier it is to start treatment and exercises to prevent permanent deformities to the spine. Hospital services specialising in axial SpA are ideally placed to investigate inflammatory back pain and provide support, education and prompt treatment that can make all the difference to a person's quality of life.

The actual cause of axial SpA is unknown, although there is good evidence for a genetic susceptibility. There is currently no cure but it can often be successfully managed using a combination of anti-inflammatory drugs for pain relief, newer medications and exercise. It is a chronic disease but the majority of people with axial SpA are able to continue to lead an active life with treatment and it is far less likely to lead to severe disability with newer management options.

Looking after your health and establishing a treatment plan is essential to reduce the long-term effects of this disease. A companion booklet to this one, *Exercises for axial spondyloarthritis*, describes the most common exercises that help to reduce the symptoms and daily burden of axial SpA. These should become a part of your regular routine.

The inflammatory process in axial SpA

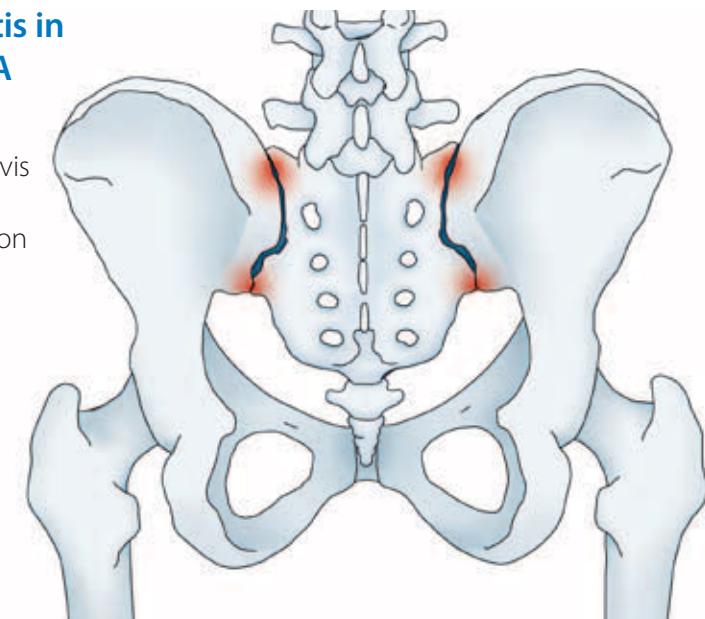
In axial SpA the sites where ligaments and tendons attach to bones tend to become inflamed. This is known as enthesitis and mainly occurs in the spine, but can happen at other joints. The inflammation can be severe enough to lead to a wearing away of the bone surface over time.

During the healing process new bone is slowly created to replace what was lost, and calcium is laid down in the elastic ligaments and tendons, a process known as calcification. This hardens these tissues and reduces flexibility and function.

Your spine is made up of 24 separate vertebrae and the lowest lumbar vertebra is attached to the diamond-shaped sacrum. The joints between the sides of the sacrum and the rest of the pelvis are the sacroiliac joints. This is where the inflammation of axial SpA, known as sacroiliitis, nearly always starts.

Sacroiliitis in axial SpA

Posterior view of pelvis showing inflammation at the sacroiliac joints



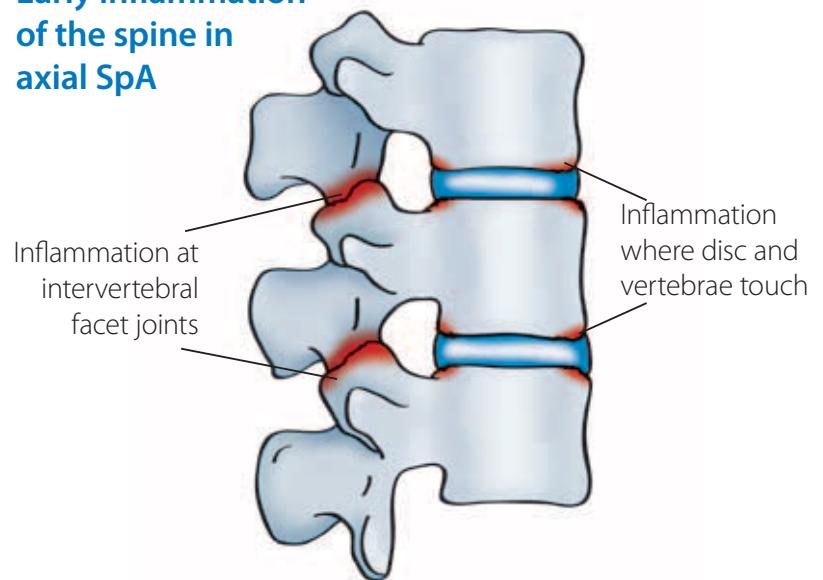
As the condition progresses, over months or years, inflammation can spread further up the spine, even as far as the neck.

Rarely the vertebrae may fuse together or calcify if new bone is continually being formed to replace that lost, and the ligaments covering the spine become entirely calcified.

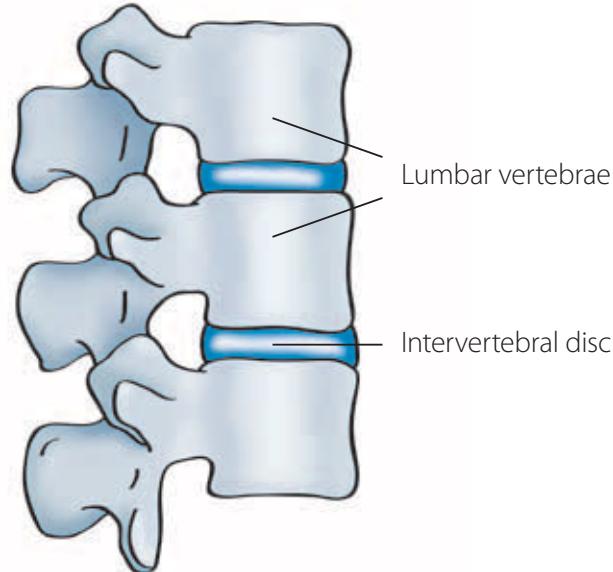
It is rare for the entire spine to fuse with the loss of all movement between the vertebrae, but fusion of the sacroiliac joints is not that unusual in long-standing axial SpA.

The aim of more modern treatments is to prevent fusion from happening.

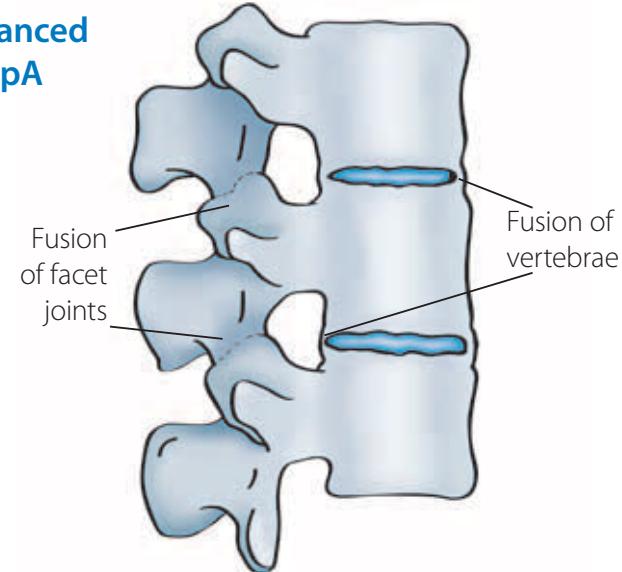
Early inflammation of the spine in axial SpA



Normal spine



Vertebral fusion in advanced axial SpA



The stages of axial SpA

The terminology used for axial SpA can be quite confusing especially as it has changed in recent years. Throughout this booklet we will use the newer term of axial SpA as it broadly covers both the early and late stages of the disease.

Alternative terms that might still be used by other health professionals treating you are non-radiographic axial SpA, radiographic SpA, sacroilitis, and ankylosing spondylitis. The following is an explanation of when and why these may be used.

Two of the most useful modern and longstanding diagnostic tests for axial SpA are magnetic resonance imaging (MRI) and plain x-rays. MRI scans give clearer images of soft tissues such as ligaments and tendons while plain x-rays are better for showing the details of denser materials such as bone. These scanning techniques are used to confirm the presence of axial SpA and to describe the stage the condition has reached.

In the very early stages of axial SpA inflammation causes back pain and morning stiffness but damage to the sacroiliac joints is limited and does not usually show up on an MRI scan or x-ray. In a small percentage of people with inflammation axial SpA does not progress beyond this first stage.

If inflammation is visible on MRI but not visible on a plain x-ray, axial SpA can be called non-radiographic axial spondyloarthritis (nr-axial SpA). Non-radiographic means 'not on x-ray'. This stage may be reached in the first year or two of axial SpA and shows the importance of MRI as a diagnostic tool able to detect early changes not yet visible on plain x-ray.

In late axial SpA, when inflammation has been present for some years, bone erosion and calcification shows up on x-rays as well as MRI. The term typically used to describe this stage of the disease is radiographic

axial SpA or, used more commonly in the past, ankylosing spondylitis. Ankylosing means fusing together and spondylitis means spinal inflammation.

Advanced disease is characterised by fusion of the sacroiliac joints and eventually in the vertebrae. The goal of modern treatments is to prevent these changes from happening.

In the UK it is estimated that 200,000 people now have radiographic axial SpA, approximately 2–5 adults per 1,000. It is unknown how many more patients in the UK have early stage SpA with damage not visible on x-ray as the majority are symptomatic but do not have a confirmed diagnosis.

Axial SpA stage	MRI scan	X-ray	Term which may be used
Very early	No visible damage	No visible damage	Non-radiographic axial SpA (Nr-axial SpA)
Early	Inflammation of the sacroiliac joints	No visible damage	Non-radiographic axial SpA (Nr-axial SpA)
Late	Inflammation and erosion of the sacroiliac joints		Radiographic axial SpA or ankylosing spondylitis
Advanced	Fusion of the sacroiliac joints and in the vertebrae		Radiographic axial SpA or ankylosing spondylitis

What causes axial SpA?

A single cause is not known. We know that there is a strong genetic (hereditary) association between axial SpA and a gene called HLA B27. More than nine in ten people with axial SpA carry this gene, compared with just less than one in ten of the general population of white western Europeans.

However, many people with this gene do not develop axial SpA, and some people with axial SpA do not have this gene, so it cannot be responsible alone for causing the arthritis. It is probably through a series of linked genes that susceptibility to axial SpA develops. Recent genetic research has identified two other genes that may be involved: ERAP1 (or ARTS1) and IL23R.

If you have axial SpA there is an increased risk of your child developing the condition, estimated at around 8%. If you also carry the HLA B27 gene the risk doubles to about 15%. Overall, there is still a much greater chance that your child will not develop axial SpA.

Most common symptoms

The term inflammatory back pain (IBP) is used to describe the typical early and on-going symptoms of axial SpA. Symptoms of inflammatory back pain include:

- ◎ Gradual onset of low back or buttock pain and stiffness typically lasting more than three months
- ◎ Pain in the night that may wake you up
- ◎ Stiffness in the lower spine when waking in the mornings. This tends to improve with movement and exercise during the day but worsens after prolonged rest periods.

◎ Tiredness

These symptoms persist for longer than 3–6 months and rarely settle down.

Other joints, bones and tendons

Axial SpA can affect joints, bones and tendons other than those in the spine. Approximately 50% of patients with axial SpA have inflammation in the peripheral joints of the limbs, most commonly involving the larger joints (hips and shoulders).

Peripheral arthritis causes pain, stiffness, and sometimes swelling of the affected joint. Stiffness is typically worse in the mornings when you wake and the swelling persists. Sometimes a whole toe or finger becomes swollen and painful due to inflammation. This is called dactylitis.

Enthesitis – inflammation of the area where ligaments and tendons attach to the bone – is very common in axial SpA. You may experience tenderness under your heel (plantar fasciitis), or in the sole of your foot with your first few steps in the morning or after prolonged walking.

Pain at the back of the heel can also be due to Achilles tendinopathy, pain and swelling in the lower Achilles tendon. This tendon joins the lower calf muscle to the heel bone. Other places where enthesitis can typically occur are the elbows (commonly called tennis elbow or golfers' elbow) and the front of the knees (patellar tendinosis).

Less common symptoms

The inflammation associated with axial SpA can affect other areas of the body. These symptoms are less common but you need to be aware of them so that you can reduce their effect by taking appropriate action.

Eyes

About 30–40% of people with axial SpA will develop uveitis, inflammation in the anterior chamber of the eye between the cornea and the lens. If you find one or both of your eyes is painful, gritty and red and you are sensitive to light you should visit a walk-in eye clinic as soon as possible. Treatment, usually steroid eye drops, is very effective if started early enough.

Lungs

As you become older you may notice tightness or stiffness around your rib cage and upper back that limits your ability to expand your ribs with each breath. Sneezing, coughing and taking deep breaths may become painful and stop you using your full lung capacity.

Inflammation of the rib joints or muscles attached to the ribs at the front or back can cause this tightness and pain across the chest. It can be reduced by medication and by breathing exercises that will help you improve your lung function.

If you find you have intermittent pain across your chest it is a good idea to visit your GP to rule out other more serious conditions such as cardiac angina or pleurisy (inflammation of the outer surface of the lung).

A small number of people develop inflammation with scarring or fibrosis of the lungs which is usually detected by a chest x-ray or CT scan.

Heart and circulation

The inflammation caused by axial SpA can affect the heart and there is evidence of a link between the condition and cardiovascular problems

in 2–10% of people with axial SpA. This risk can be reduced by treating your axial SpA with medication, exercise, and regular check-ups. It is also very important to stop smoking.

Some people develop anaemia, a lack of red blood cells, which leads to general fatigue.

Bowel

On average about one in twelve people with axial SpA will have inflammatory bowel disease (IBD) in the form of Crohn's disease or ulcerative colitis. This can start before or after axial SpA has been diagnosed as the conditions are known to overlap.

Skin psoriasis

A small number of people or their family members also have psoriasis that causes scaly red patches on the skin that may be widespread. These patches can appear anywhere but are more common on the scalp, elbows and knees.

Symptoms include itchiness, tenderness, burning and stinging which can be relieved with topical creams or medication.

Osteoporosis

Osteoporosis, weakening of the bones, is more common in people with axial SpA due to local inflammation and reduced flexibility. Having osteoporosis means your bones break more easily and in people with axial SpA this typically involves the spine.

The risk of osteoporosis is greater in those who smoke, drink alcohol excessively, have a poor dairy intake or do not exercise regularly.

Osteoporosis can be detected by measuring the density of the bones using a machine called a DEXA scanner. People with a higher risk of fracture are offered treatment.

The treatment of axial SpA

There is no cure, but with a combination of medicines and physiotherapy axial SpA can be managed well. Management options include physiotherapy, medical and surgical treatment, and lifestyle modifications where necessary. Exercise is essential.

Medical treatment involves using simple painkillers, anti-inflammatory medications and newer biologic drugs that are highly effective.

The majority of people with axial SpA do not require surgical treatment. However, if persistent inflammation in the joints, most commonly in the hips, causes irreversible damage it can be treated by total joint replacement.

Drug treatment

Analgesics

Painkillers like paracetamol may be used in combination with other medicines. They can be useful in managing your pain, especially during a flare-up of axial SpA.

Non-steroidal anti-inflammatory drugs (NSAIDs)

Although there have been important advances in the treatment of axial SpA in the past two decades, many people still manage well on non-steroidal anti-inflammatory drugs (NSAIDs) and these remain the first choice of treatment. They reduce pain and inflammation and taken continuously have been shown to slow down spinal calcification in some individuals.

A wide range of NSAIDs is available in the UK and some such as ibuprofen (Nurofen) can be bought over the counter. NSAIDs differ in their side effects and there is a small risk attached to their regular use.

You should discuss which NSAIDs to try and for how long with your GP or specialist to find the right make for you.

NSAIDs are generally not recommended for those who have kidney or liver disease or have suffered a stroke or heart problems. They can make asthma attacks worse and asthmatic people should generally avoid taking them.

NSAID	Frequency of dosing	Maximum DAILY dose
Ibuprofen	Three times daily	1200–2400 mg
Naproxen	Twice daily	500 – 1000 mg
Diclofenac	Twice or three times daily	75 – 150 mg
Meloxicam	Once daily	7.5 – 15 mg
Celecoxib	Once or twice daily	200 – 400 mg
Etoricoxib	Once daily	60 – 120 mg

Corticosteroids

If you have a flare-up of peripheral joint disease, corticosteroids injected directly into the joint can reduce inflammation and relieve symptoms very effectively. You may also be prescribed corticosteroids in a tablet form (prednisolone) or be given an intramuscular injection, the effect of which generally lasts weeks to months. Due to their many side effects steroids are not offered for long-term treatment.

Disease-modifying anti-rheumatic drugs (DMARDs)

Drugs such as methotrexate, leflunomide or sulfasalazine are commonly used in other forms of inflammatory arthritis such as rheumatoid arthritis. In axial SpA they are typically used for treating

inflammation in peripheral joints. They do not just relieve symptoms, they target and switch off inflammation and therefore reduce stiffness and swelling in the joints. There is also good evidence that they prevent joint damage.

Your blood will need to be monitored regularly if you have been prescribed one of these drugs. They act slowly and it may be six weeks or more before you notice any benefit.

Anti-TNF biologic drugs

A recent breakthrough that has revolutionised the treatment of axial SpA is anti-TNF treatment with biologic drugs. These drugs block a protein called TNF-alpha which switches on and drives inflammation. In axial SpA TNF-alpha is excessively produced by the body: it can be found in high levels in the blood, affected joints and the spine. Reducing these levels with anti-TNF drugs is a highly effective treatment for spinal and peripheral joint inflammation.

Anti-TNF treatment can be offered if you have severe disease (several active inflammatory sites) and you have tried at least two NSAIDs without benefit. Before starting anti-TNF treatment you would need to go through a screening process to minimise the risk of side effects. This would include screening you for previous known or unknown infections including viral hepatitis and TB.

These drugs are generally given by injection delivered via a prefilled syringe or auto-injector device. Most people easily learn how to give themselves these injections. We can recommend a healthcare company that delivers the syringes and other equipment and will train you on the injection technique.

There are several biologic drugs available and the main differences are in the frequency of injections and in the device used. Your rheumatologist will discuss the options with you. The chart on page 15 gives a summary of the main drugs.

Side effects of anti-TNF/IL-17 biologic drugs

The commonest side effects are injection site reactions in the skin and increased susceptibility to minor infections. If you develop signs of an infection while on this treatment you should contact your GP, rheumatology nurse or physiotherapy specialist for advice. You may need to stop your anti-TNF medication until the infection is treated.

Biologic agent	Method of delivery	Frequency of dosing	Dose
Infliximab (Remicade, Inflectra)	By infusion into a vein	Every 4–8 weeks	3–10mg/kg
Etanercept (Enbrel, Benepali)	Prefilled syringe or injection pen	Every week	50mg
Adalimumab (Humira)	Prefilled syringe or injection pen	Every two weeks	40mg
Certolizumab (Cimzia)	Prefilled syringe or injection pen	Every two weeks	200mg
Golimumab (Simponi)	Prefilled syringe or injection pen	Every month	50mg
Secukinumab (Cosentyx)	Prefilled syringe or injection pen	Every month	150mg

Anti-IL-17 biologic drugs

IL-17 is another key molecule that drives inflammation in axial SpA. Blocking IL-17 with newer IL-17 inhibitors such as secukinumab (Cosentyx) has been shown to be beneficial.

Vaccinations

If you have been prescribed a DMARD or one of the biologic drugs and you need a vaccination please ask your GP for advice.

You should not receive live vaccine (eg measles, mumps, rubella, varicella-zoster, polio, BCG, typhoid and yellow fever) if you are taking one of these medications.

Those of you on a biologic drug should also make sure you are given a pneumococcal vaccination once (a repeat vaccination may be recommended for some people) and the flu vaccine every year.

Exercise

General exercise

Exercise has been shown to help patients with axial SpA at all stages so it is looked upon as a vital part of your treatment. Exercise improves cardiovascular health, flexibility, strength, posture and sleep and thus your quality of life. There will be times during your illness when pain and stiffness becomes worse and the fitter and more flexible you are to deal with these flare-ups the better the outcome.

Government guidelines suggest that adults should try to be active daily and undertake at least 20 minutes of moderate aerobic activity such as cycling or fast walking five times per week. Moderate activity raises your heart rate and makes you breath faster. Choose an exercise that you enjoy as you will find it easier to keep it up.

Specific exercises

Specific stretching and strengthening exercises, many based on those found in yoga and pilates, are very important and must be included in your exercise programme. Make sure that you have been given the companion booklet to this one, *Exercises for axial spondyloarthritis*, and that you have received advice from a physiotherapist about which exercises will be best for you.

Join NASS (National Ankylosing Spondylitis Society)

Joining NASS will enable you to access regular exercise sessions tailor-made for those with axial SpA. Your local NASS group is Whipps Cross/Wanstead.

The group runs weekly exercise sessions in the gym and hydrotherapy pool at Whipps Cross Hospital under the supervision of a qualified physiotherapist. Hydrotherapy – exercising in warm water – can be particularly helpful in reducing the impact of axial SpA.

Contact branch secretary Colin Anderson on 07770 236691 for more information.

What else you can do

Learn

Find out about your condition and what you can do to manage it better.

Relaxation and meditation

These can help you to relax your body and mind and therefore reduce muscle spasms.

Hot baths

Many patients find taking a hot bath or applying heat packs to painful areas of the body can be helpful, especially during a flare-up.

Healthy diet

A balanced diet is important for your general health. There is very little scientific evidence that any particular foods can help in axial SpA. However, omega 3 has been shown to reduce inflammation. Foods rich in omega-3 include fish such as salmon, mackerel and sardines, cod liver oil, flaxseed and nuts.

Stop smoking

Axial SpA has been shown to be more aggressive in smokers. Talk to your healthcare team if you need help in quitting smoking.

Surgery

Surgery plays a small part in the treatment of axial SpA. Less than 10% of people with axial SpA have a hip replaced and surgery to the spine is even more rare. An operation can be used to straighten out the spine if it has fused leaving the back in a stooped position.

Flares-ups

Even with treatment there may be times when axial SpA seems less manageable than usual and you experience a flare-up. When this happens painkillers, NSAIDs and, occasionally, short courses of corticosteroids can offer relief.

In most rheumatology departments with a dedicated axial SpA service there will be a telephone advice line so make sure that you know how to contact them for help.

Planning a family

If you plan to start a family speak to your rheumatologist. Our general recommendation is to start trying for a baby once your axial SpA has been well under control for at least three months. Axial SpA does not affect fertility but some of drugs prescribed for the disease should be stopped a few months before conception and during a pregnancy.

The DMARD sulfasalazine can cause a fall in sperm count and thus decrease fertility but this effect is reversed in a few weeks after medication is stopped.

Pregnancy and childbirth

Pregnancy can reduce the symptoms of axial SpA or increase them and predicting what will happen is difficult. Many pregnant women experience back pain during pregnancy and this can be worse for those with axial SpA.

You can deliver a full-term healthy baby with a normal labour. Talk to your midwife in advance about pain relief during labour.

Peripheral joint arthritis can flare-up one to three months after delivery.

Monitoring

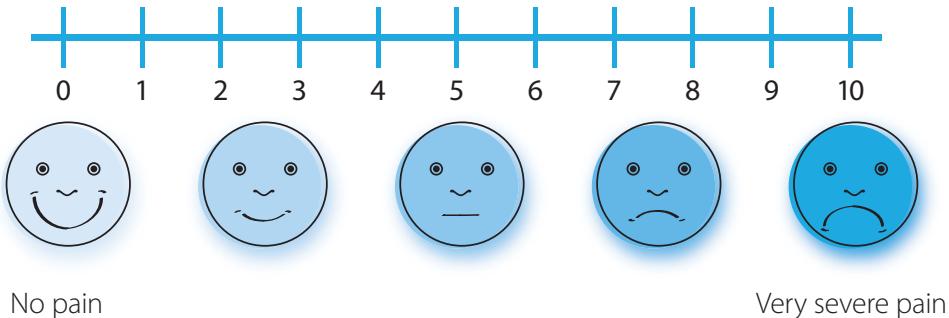
Your healthcare professionals will regularly monitor your disease activity and your response to treatment. There are several scales that we ask you to score yourself for this monitoring process and once a year we will ask you to come in for an assessment of your flexibility (BASMI).

The three main scales that you will be asked to score yourself are the VAS, BASDAI and the BASFI. Examples of these scales are shown on the following pages and you will be given them separately to fill in.

On page 24 is a BASMI chart which will be completed when you come for your annual assessment for flexibility.

Visual analogue scale (VAS)

Please indicate your overall spinal pain by circling a number on this 0–10cm scale.



Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)

Please indicate your state of health in the **past week** by circling a number.

- How would you describe the overall level of fatigue/tiredness you have experienced?

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
None	Very severe									

- How would you describe the overall level of AS neck, back or hip pain you have had?

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
None	Very severe									

- How would you describe the overall level of pain/swelling in joints other than neck, back or hips you have had?

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
None	Very severe									

- How would you describe the overall level of discomfort you have had from any areas tender to touch or pressure?

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
None	Very severe									

- How would you describe the overall level of morning stiffness you have had from the time you wake up?

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
None	Very severe									

- How long does your morning stiffness last from the time you wake up?

0 hour | $\frac{1}{2}$ hour | 1 hour | $1\frac{1}{2}$ hours | 2 or more hours

Bath Ankylosing Spondylitis Functional Index (BASFI)

Please indicate your level of ability with each of the following activities during the **past week** by circling a number.

1. Putting on your socks or tights without help or aids (eg sock aid).

2. Bending from the waist to pick up a pen from the floor without aid.

3. Reaching up to a high shelf without help or aids (eg a helping hand).

A horizontal scale with numbered boxes from 0 to 10. The numbers 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 are each enclosed in a blue rounded rectangular box. Below the scale, the word "Easy" is positioned under the first few boxes, and the word "Impossible" is positioned under the last few boxes.

4. Getting up from an armless chair without your hands or any other help.

A horizontal scale consisting of eleven numbered boxes from 0 to 10. The first box is labeled 'Easy' and the last box is labeled 'Impossible'. The boxes are arranged in a row with small gaps between them.

5. Getting up off the floor without help from lying on your back.

A horizontal scale consisting of eleven numbered boxes from 0 to 10. The first box is labeled 'Easy' and the last box is labeled 'Impossible'. The boxes are arranged in a row with small gaps between them.

6. Standing unsupported for 10 minutes without discomfort.

A horizontal scale consisting of eleven numbered boxes from 0 to 10. The first box is labeled 'Easy' and the last box is labeled 'Impossible'. The boxes are arranged in a row with small gaps between them.

7. Climbing 12–15 steps without using a handrail or walking aid.

A horizontal scale consisting of ten blue-outlined boxes numbered 0 through 10. Below the scale, the word "Easy" is positioned under the first two boxes, and the word "Impossible" is positioned under the last two boxes.

8. Looking over your shoulder without turning your body.

A horizontal scale consisting of eleven numbered boxes from 0 to 10. Below the scale, the word "Easy" is positioned under the first two boxes, and the word "Impossible" is positioned under the last two boxes.

9. Doing physically demanding activities (eg physiotherapy exercises, gardening or sports).

10. Doing a full days activities whether it be at home or at work.

Bath Ankylosing Spondylitis Metrology Index (BASMI)

Once a year a health professional will assess your condition using the BASMI monitoring system. They will take various measurements to monitor how supple you are and as a result you may be given specific exercises to do to maintain your flexibility over time.

Date	Tragus to wall (cm)	Lumbar side flexion (cm)		Cervical rotation (degree)		Modified Schobers (cm)
		R	L	R	L	

Please bring this booklet to your annual assessment of flexibility (BASMI) so we can record your measurements

Chest expansion (cm)	Intermalleolar distance (cm)	BASDAI	Spinal pain	Recommended exercises

Further information

NASS

(National Ankylosing Spondylitis Society)

Website: www.nass.co.uk

Helpline: 020 8741 1515 Mondays to Fridays, 9am–1pm

Whipps Cross/Wanstead NASS group

Branch secretary Colin Anderson: 07770 236691

Whipps Cross walk-in Eye Casualty

Open 8.30am–4.30pm, Monday–Friday

Arthritis Research UK

Website: www.arthritisresearchuk.org

For up-to-date information on rheumatology research and general advice.

Citizens Advice Bureau (CAB)

Website: www.citizensadvice.org.uk

Advice line: 0300 3301175

Provides information, advice and advocacy services for residents.

Giving up smoking

Smokeline (national helpline)

Tel: 0300 123 1044

Waltham Forest Stop Smoking Service

Tel: 020 3644 2682 or 0800 032 0102

Email: stopsmokingservice@nelft.nhs.uk

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Do not forget to bring this booklet to your annual assessment of flexibility (BASMI)

Patient Advice and Liaison Service

If you need general information or advice about Trust services, please contact the Patient Advice and Liaison Service (PALS) on 020 3594 2040 or visit www.bartshealth.nhs.uk/pals.

Alternatively, please contact staff who are providing your care if you require clinical advice.

Large print and other languages

For this leaflet in large print, please speak to your clinical team.

For help in interpreting this leaflet in other languages, please ring **020 8223 8934**.

Reference: BH/PIN/517

Publication date: November 2016

All our patient information leaflets are reviewed every three years

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