EULAR 2026: Earlier AxSpA Recognition Improves Disease Burden

Written by The Life Science Feed Editorial Team · Published 2 June 2026 · Edited by William Lopes

Axial spondyloarthritis (axSpA) frequently presents with diagnostic delays, leading to prolonged patient suffering and irreversible structural damage. Data presented at EULAR 2026 underscore that timely recognition and comprehensive management are paramount to mitigating long-term disease impact and improving patient outcomes.

KEY TAKEAWAYS

- The Pivot: Early diagnosis of axSpA, particularly non-radiographic axSpA (nr-axSpA), is crucial for preventing disease progression and reducing long-term burden.
- The Data: Patients diagnosed within 12 months of symptom onset demonstrated significantly lower Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores at 5 years compared to those diagnosed after 5 years (mean BASDAI 2.8 vs 4.7, p0.001).
- The Action: Clinicians should actively screen for inflammatory back pain characteristics and utilise imaging modalities such as MRI of the sacroiliac joints to facilitate earlier diagnosis in suspected axSpA cases.

Axial spondyloarthritis (axSpA) is a chronic inflammatory rheumatic disease primarily affecting the axial skeleton, including the sacroiliac joints and spine. It encompasses both ankylosing spondylitis (AS), where radiographic changes are evident, and non-radiographic axSpA (nr-axSpA), where such changes are absent but inflammatory signs persist. The clinical presentation, often characterised by inflammatory back pain, can be insidious and non-specific in its early stages, contributing to significant diagnostic delays.1 These delays are a recognised challenge in rheumatology, frequently extending beyond five years from symptom onset to definitive diagnosis.2 The consequence of delayed diagnosis includes prolonged pain, functional impairment, reduced quality of life, and the potential for irreversible structural damage, particularly in AS.3

Current management strategies for axSpA aim to control inflammation, alleviate symptoms, prevent structural damage, and maintain physical function. These strategies typically involve non-steroidal anti-inflammatory drugs (NSAIDs) as first-line therapy, followed by biological disease-modifying antirheumatic drugs (bDMARDs), such as TNF inhibitors, for patients with persistent high disease activity.4 However, the efficacy of these interventions is often maximised when initiated earlier in the disease course, before significant structural damage has occurred.5 The EULAR 2026 presentations focused on optimising axSpA care by addressing these diagnostic and management gaps, emphasising the benefits of earlier recognition and more comprehensive approaches to disease burden.

What the EULAR 2026 presentations highlighted

Multiple presentations at EULAR 2026 underscored the importance of reducing diagnostic delays in axSpA. One key analysis, drawing from a multinational registry of 3,500 axSpA patients, demonstrated a clear correlation between time to diagnosis and long-term disease outcomes. Patients diagnosed within 12 months of symptom onset exhibited significantly lower disease activity and better functional status at 5 years compared to those diagnosed after 5 years. Specifically, the mean Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score at 5 years was 2.8 (standard deviation 0.9) in the early diagnosis group, compared to 4.7 (standard deviation 1.2) in the late diagnosis group (p0.001).6 Similarly, the Bath Ankylosing Spondylitis Functional Index (BASFI) scores showed a mean of 2.1 versus 3.8, respectively (p0.001).6
Further analyses presented at the conference highlighted the utility of specific diagnostic tools. Magnetic resonance imaging (MRI) of the sacroiliac joints, demonstrating active inflammation (osteitis/bone marrow oedema), was re-emphasised as a critical tool for early diagnosis, particularly in patients with inflammatory back pain who do not yet meet radiographic criteria for AS.7 The sensitivity of MRI for detecting sacroiliitis in patients with inflammatory back pain was reported at 78%, with a specificity of 85%, in a cohort of 450 patients with suspected axSpA.8 The presentations also discussed the role of clinical assessment, advocating for increased awareness among primary care physicians and non-rheumatology specialists regarding the characteristic features of inflammatory back pain, such as insidious onset before age 40, improvement with exercise but not rest, and nocturnal pain.9
Beyond early diagnosis, EULAR 2026 also addressed optimised management strategies. Data from a prospective cohort study of 800 axSpA patients demonstrated that a treat-to-target approach, aiming for a BASDAI score below 4 or Ankylosing Spondylitis Disease Activity Score (ASDAS) below 2.1, resulted in a 30% reduction in radiographic progression over 2 years compared to standard care (p=0.02).10 This approach involved regular monitoring and timely escalation of therapy, including the initiation of bDMARDs when NSAID monotherapy was insufficient. The importance of non-pharmacological interventions, such as regular exercise and physical therapy, was also reiterated, with evidence showing that structured exercise programmes reduced BASDAI scores by an average of 1.0 point (p0.01) and improved spinal mobility by 15% over 6 months.11
While the benefits of early diagnosis and optimised management are clear, challenges remain. Access to timely MRI scans can be limited in some healthcare systems, and there is still a need for greater awareness of axSpA among general practitioners. The presentations acknowledged that the heterogeneity of axSpA presentation can complicate early identification. Future research should focus on developing more accessible and cost-effective screening tools and on implementing educational programmes to reduce diagnostic delays globally. Further studies are also warranted to identify specific biomarkers that could predict disease progression and treatment response more accurately, allowing for even more personalised management strategies.

CLINICAL IMPLICATIONS

The consistent message from EULAR 2026 regarding axSpA care is not revolutionary, but it is a vital reinforcement: earlier diagnosis unequivocally leads to better patient outcomes. The data presented, showing significantly lower disease activity and improved function with prompt intervention, should serve as a stark reminder to primary care physicians and specialists alike. The current diagnostic delay, often stretching years, is a disservice to patients and a missed opportunity for effective disease modification. We have the tools, particularly MRI, to identify inflammatory sacroiliitis before irreversible damage sets in; the bottleneck is often

awareness and timely referral.

For clinicians, this means a heightened index of suspicion for inflammatory back pain. Simply asking about the characteristics of back pain – onset before 40, improvement with exercise, nocturnal pain – can be the first, most crucial step. Relying solely on radiographic changes for diagnosis in early disease is no longer acceptable given the evidence for nr-axSpA. Pharmaceutical companies developing bDMARDs, such as TNF inhibitors and IL-17 inhibitors, have long advocated for earlier treatment. These EULAR presentations provide further clinical justification for that stance, suggesting that the therapeutic window for preventing long-term disability is narrower than previously appreciated. This should encourage payers to reconsider restrictive criteria that delay access to advanced therapies until significant radiographic damage has occurred.

Ultimately, the onus is on the entire healthcare system to streamline the diagnostic pathway for axSpA. This includes better education for GPs, improved access to MRI, and a willingness to initiate effective therapies based on clinical and MRI evidence, rather than waiting for established radiographic changes. Patients with axSpA deserve a proactive approach that minimises their suffering and preserves their function, rather than a reactive one that addresses damage after it has become entrenched.

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