

Multidisciplinary Care Improves Spondyloarthritis Outcomes

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Spondyloarthritis (SpA) presents a complex clinical challenge, characterised by axial and peripheral arthritis alongside diverse extra-musculoskeletal manifestations (EMMs) such as uveitis, psoriasis, and inflammatory bowel disease. Optimal management requires a coordinated strategy to address this systemic burden. The EULAR 2026 congress highlighted that integrating multiple specialities into SpA care improves disease control and patient quality of life.

KEY TAKEAWAYS

- The Pivot: A shift from siloed rheumatology care to a multidisciplinary model for spondyloarthritis.
- The Data: Multidisciplinary clinics demonstrated improved patient-reported outcomes (PROs) and reduced disease activity scores.
- The Action: Clinicians should consider establishing or integrating into multidisciplinary teams for comprehensive SpA management.

Spondyloarthritis encompasses a group of chronic inflammatory diseases primarily affecting the axial skeleton, peripheral joints, and entheses. Beyond the musculoskeletal system, patients frequently experience extra-musculoskeletal manifestations (EMMs) including acute anterior uveitis, psoriasis, and inflammatory bowel disease (IBD). These EMMs contribute significantly to disease burden, morbidity, and reduced quality of life, often requiring management by specialists outside of rheumatology. The heterogeneous nature of SpA and its systemic involvement necessitates a comprehensive approach that extends beyond standard rheumatological care.¹

Traditional management often involves sequential referrals to different specialists as EMMs arise, potentially leading to delayed diagnosis, fragmented care, and suboptimal treatment outcomes. This fragmented approach can result in increased healthcare utilisation and patient dissatisfaction. The EULAR 2026 congress underscored the growing recognition that a coordinated, multidisciplinary strategy is essential for improving care in SpA, particularly in addressing its diverse manifestations effectively.²

The prevalence of SpA varies globally, with estimates ranging from 0.3% to 1.3% in the general population. Axial SpA, the most common subtype, often presents in young adults, leading to significant long-term disability if not managed effectively. The genetic predisposition, particularly the strong association with HLA-B27, further highlights the complex interplay of factors contributing to disease pathogenesis. Understanding these underlying mechanisms and the diverse clinical presentations is crucial for developing targeted and holistic treatment strategies. The chronic inflammatory process in SpA involves complex immune pathways, often leading to structural damage and functional impairment over

time. Therefore, early and integrated intervention is paramount to mitigate disease progression and preserve patient function.

The Multidisciplinary Approach

The EULAR 2026 presentations focused on models of care that integrate rheumatologists with ophthalmologists, dermatologists, gastroenterologists, and other relevant specialists, such as physiotherapists and specialist nurses, into a unified care pathway. These models aim to facilitate early detection and management of EMMs, optimise treatment strategies, and enhance patient education and self-management.³

One presented model involved a dedicated SpA clinic where patients were concurrently assessed by a rheumatologist and, if indicated, by an ophthalmologist, dermatologist, or gastroenterologist during the same visit or within a short, coordinated timeframe. This co-location or rapid referral system allowed for immediate specialist input on EMMs, enabling prompt initiation or adjustment of therapy. For instance, patients presenting with active uveitis could receive immediate ophthalmological assessment and treatment, preventing potential vision loss. Similarly, dermatological or gastroenterological input for psoriasis or IBD could be integrated into the overall SpA management plan, ensuring systemic therapies address all active disease components.⁴

Data presented from several observational studies and pilot programmes indicated that patients managed within these multidisciplinary frameworks experienced improved clinical outcomes. Specifically, these programmes reported a reduction in the mean Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores by an average of 1.5 points (P compared to historical controls receiving standard care. Patient-reported outcomes (PROs), including quality of life measures such as the ASQoL (Ankylosing Spondylitis Quality of Life) questionnaire, showed an average improvement of 2.1 points (P. Furthermore, the incidence of severe EMM flares, particularly acute anterior uveitis requiring hospitalisation, was reduced by approximately 30% in cohorts managed multidisciplinary.⁵

The integration of specialist nurses and physiotherapists was also highlighted as a key component. Specialist nurses provided education on disease management, medication adherence, and lifestyle modifications, while physiotherapists developed individualised exercise programmes to maintain mobility and reduce pain. This holistic support contributed to improved functional outcomes and patient empowerment.⁶

While the evidence presented was largely derived from observational studies and small-scale pilot programmes, the consistency of improved outcomes across different centres suggests a tangible benefit. Limitations included the lack of large-scale randomised controlled trials directly comparing multidisciplinary care to standard care, and potential selection bias in patient cohorts. The generalisability of these models to all healthcare systems, particularly those with resource constraints, also requires further investigation. The patient populations in these studies were often recruited from tertiary care centers, which may not fully represent the broader SpA population seen in primary or secondary care settings. This could influence the observed benefits and the feasibility of implementing similar models elsewhere. However, the EULAR 2026 discussions emphasised that even partial implementation of multidisciplinary principles, such as improved communication pathways between specialists, can yield benefits.⁷

CLINICAL IMPLICATIONS

The EULAR 2026 focus on multidisciplinary SpA care is a welcome, if overdue, acknowledgement of clinical reality. Rheumatologists have long managed the articular manifestations, but the systemic nature of SpA, with its frequent extra-musculoskeletal manifestations, demands more than a single-specialty perspective. The data, while not from definitive randomised controlled trials, consistently points to better patient outcomes when care is coordinated. This isn't about adding more appointments; it's about making existing appointments more effective and preventing complications.

For clinicians, this implies a necessary shift in practice. Establishing formal multidisciplinary clinics may not be feasible everywhere, but improving communication channels with ophthalmology, dermatology, and gastroenterology colleagues is imperative. Proactive screening for EMMs, rather than reactive referrals, should become standard. This approach could streamline patient pathways, reduce diagnostic delays for conditions like inflammatory bowel disease, and potentially lower the long-term healthcare burden associated with uncontrolled disease. It also highlights the critical role of specialist nurses and physiotherapists, whose integration can significantly enhance patient education and functional outcomes, often at a lower cost than physician-led interventions.

From an industry perspective, the emphasis on comprehensive care might influence future drug development and market access strategies. Therapies that demonstrate efficacy across multiple manifestations of SpA, or those that facilitate a multidisciplinary approach, could gain a competitive edge. Payers, too, should recognise the long-term cost-effectiveness of preventing severe EMMs through integrated care, potentially incentivising the development of such models. Ultimately, the goal is to move beyond treating symptoms in isolation and to manage the patient as a whole, a principle that should guide all chronic disease management.

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