SpA Remission: Clinical Symptoms vs. Subclinical Inflammation at EULAR 2026

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Managing spondyloarthritis (SpA) presents a persistent challenge in defining true remission, as patient-reported symptom resolution frequently diverges from objective measures of inflammation. EULAR 2026 presentations underscored this diagnostic gap, indicating that relying solely on clinical symptom scores may lead to undertreatment and continued disease progression.

KEY TAKEAWAYS

- The Pivot: Subclinical inflammation persists in a significant proportion of SpA patients achieving clinical remission by symptom-based criteria.
- The Data: Up to 40% of patients in clinical remission (ASDAS The Action: Clinicians should consider objective inflammatory markers, such as MRI and CRP, even in asymptomatic SpA patients to guide treatment decisions and prevent long-term damage.

Spondyloarthritis (SpA) encompasses a group of chronic inflammatory diseases primarily affecting the axial skeleton and peripheral joints. The therapeutic goal in SpA is to achieve remission, defined as a state of minimal disease activity or absence of inflammation. Current clinical practice often relies on patient-reported outcome measures (PROMs) and composite indices like the Ankylosing Spondylitis Disease Activity Score (ASDAS) or Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) to assess disease activity and remission status.1 However, a growing body of evidence, reinforced by discussions at EULAR 2026, indicates a significant discrepancy between symptomatic remission and objective inflammatory control. This disconnect poses a clinical dilemma, as persistent subclinical inflammation can lead to irreversible structural damage and functional impairment despite patients feeling subjectively improved.2
The concept of 'remission' in SpA has evolved, moving beyond mere symptom control to encompass the absence of objective inflammation. This shift is driven by the understanding that structural damage, particularly in the sacroiliac joints and spine, can progress even when patients report low disease activity.3 The long-term implications of this subclinical inflammation include increased risk of vertebral fractures, reduced spinal mobility, and impaired quality of life.4 Therefore, identifying and addressing this hidden inflammatory burden is crucial for optimising patient outcomes and preventing disease progression.

What the study did

Multiple observational studies and post-hoc analyses presented at EULAR 2026 focused on evaluating the prevalence of objective inflammation in SpA patients classified as being in clinical remission based on symptom-driven criteria. These studies typically enrolled adult patients with axial SpA (axSpA) or psoriatic arthritis (PsA) who met established criteria for clinical remission, such as an ASDAS score of less than 1.3 (inactive disease) or less than 2.1 (low disease

activity).5

The primary objective measures used to detect subclinical inflammation included magnetic resonance imaging (MRI) of the sacroiliac joints and spine, specifically looking for active inflammatory lesions (e.g., osteitis, synovitis, capsulitis, enthesitis), and serum C-reactive protein (CRP) levels.6 Some studies also incorporated ultrasound for peripheral joint assessment in PsA cohorts. Patient cohorts ranged in size from N=150 to N=800 across various centres, reflecting real-world clinical populations.7 Data collection involved cross-sectional assessments at the point of clinical remission, with some longitudinal follow-up to observe the trajectory of inflammation and structural damage.8

Key Findings

A consistent finding across several presentations was the high prevalence of subclinical inflammation in patients deemed to be in clinical remission. One pooled analysis reported that approximately 30% to 40% of axSpA patients achieving an ASDAS score of less than 1.3 still demonstrated active inflammatory lesions on spinal or sacroiliac joint MRI.9 Specifically, active sacroiliitis on MRI was observed in 28% (95% CI: 24-32%) of these patients, and active spondylitis in 15% (95% CI: 12-18%).9

Elevated CRP levels (typically defined as >5 mg/L) were also frequently observed, with one study showing that 25% of patients in clinical remission had a CRP above the normal range.10 The presence of elevated CRP correlated with a higher likelihood of MRI-detectable inflammation (Odds Ratio: 2.8, P0.001).10 In PsA cohorts, up to 35% of patients in clinical remission (defined by minimal disease activity criteria) showed evidence of subclinical synovitis on ultrasound.11

These findings highlight a significant discordance: clinical remission, as assessed by symptom-based scores, does not reliably equate to inflammatory remission. The persistence of subclinical inflammation was associated with a higher risk of radiographic progression over a 2-year follow-up period (Hazard Ratio: 1.75, 95% CI: 1.21-2.53, P0.003) compared to patients with both clinical and inflammatory remission.12

The limitations of these analyses include their observational nature, which precludes definitive conclusions about causality. The heterogeneity in MRI protocols and interpretation across different centres could also introduce variability. Furthermore, the definition of 'clinical remission' itself varies slightly between studies, impacting direct comparability. Future research should focus on developing more precise, composite remission criteria that integrate both clinical and objective inflammatory markers, and on identifying biomarkers that can reliably predict structural progression in the absence of overt symptoms.

To explore foundational and advanced topics in rheumatology, including evolving diagnostic and management strategies for inflammatory conditions, refer to the Oxford Handbook of Rheumatology.

> **CLINICAL IMPLICATIONS**
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> The EULAR 2026 discussions on SpA remission underscore a fundamental flaw in current practice: our reliance on patient-reported symptoms often masks ongoing, destructive inflammation. For clinicians, this means that an ASDAS score of 1.2, while reassuring on paper, may be a false dawn. We are potentially leaving a significant proportion of patients vulnerable to irreversible structural damage, particularly in the spine and sacroiliac joints, simply because we are not looking beyond their subjective 'fine.' It is time to integrate objective measures like MRI and CRP more routinely, even in seemingly quiescent patients, to ensure true inflammatory control. This is not about over-investigating, but about preventing long-term disability.

> The pharmaceutical industry, particularly those developing biologics and targeted synthetic DMARDs for SpA, should take note. The goal should not merely be symptom suppression, but genuine inflammatory remission. This calls for trial endpoints that incorporate objective imaging and biomarker data, moving beyond composite scores that can be skewed by subjective reporting. If a drug achieves symptomatic remission but fails to clear inflammation on MRI, its long-term value in preventing structural progression is questionable. This also presents an opportunity for diagnostic companies to develop more accessible and cost-effective tools for detecting subclinical inflammation, perhaps moving beyond the current MRI bottleneck.
> For patients, this distinction between symptomatic and inflammatory remission is critical. It highlights that feeling 'better' does not always mean the disease is truly under control. Educating patients about the importance of objective measures, even when they are asymptomatic, is paramount. It empowers them to advocate for more thorough assessments and understand the rationale behind continued or adjusted therapy, even in the absence of overt pain. The 'Mind the Remission GAP' message from EULAR 2026 is a stark reminder that in SpA, what you don't see can still hurt you, and it is our collective responsibility to bridge that gap.

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