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## Is ankylosing spondylitis reversible

Ankylosing spondylitis (AS) is a type of arthritis that mainly affects the joints of the spine. Its name is Greek and means "stiffening of a joint"(ankylos) and "vertebrae" (spondylo). The vertebrae are the bones of the spine that, stacked one on top of the other, form the spinal column. Inflammation of the spaces between the vertebrae causes back pain and stiffness. The hallmark sign of AS is inflammation of the sacroiliac joints, where the base of the spine (the sacrum) meets the pelvis (ilic bone). AS is a lifelong disease with no cure. The symptoms typically begin in early adulthood and gradually worsen, but severity varies from person to person. What causes ankylosing spondylitis? Scientists believe that AS is caused by a combination of genetic and environmental factors. The vast majority of Caucasian people who develop AS have a genetic marker called HLA-B27; however, most people who have HLA-B27 do not develop AS. Also, not everyone who develops AS has the marker and the condition is much less common in some ethnicities. Over 60 genes associated with AS have been identified, so HLA-B27 does not tell the entire story. The working theory is that an infection, in particular an infection of the gastrointestinal (GI) system, may trigger the inflammation that causes AS in people who are genetically predisposed. People who have had frequent GI infections have a higher risk of developing AS. How is ankylosing spondylitis diagnosed? There is no single test that can show that a person has AS, so diagnosis depends on a thorough medical history and physical examination. Most important is the description of symptoms, in particular the nature of the pain and stiffness: Which joints are painful? What makes the pain worse or better (exercise versus rest)? The time of day the pain gets worse? How long has the patient been in pain? Are there other family members with similar joint pain? Has the patient had recent GI illness, or other symptoms such as eye pain or skin rashes? The most commonly affected joints are the sacroiliac, lower back vertebrae, the cartilage between the breast bone and the ribs, and the hip and shoulder joints. Pain and stiffness in the lower back and hips that is worse in the morning, neck pain, and fatigue are common early signs of the disease. Symptoms often come and go, with flares followed by periods of remission. What complications can develop? The long-term inflammation and joint damage that occurs with progressive, severe AS can cause extra bones to form between vertebrae, leading to fusion of the spine. Spinal fusion makes the spine stiff and inflexible and can be debilitating. AS also can lead to compression fractures due to bone weakness, inflammation of the eye (uveitis), and rarely, heart problems. Stiffness and pain in the joints that connect to the rib can make breathing difficult. How is ankylosing spondylitis treated? The goal of treatment is to manage pain, prevent or delay progression of the disease, and prevent spinal deformity and other complications, using a combination of medications, exercise, and surgery. Treatment is most effective if it begins before there is irreversible joint damage. Self-care includes staying active, working to maintain good posture, and using heat or cold to ease pain and inflammation. In general, AS is associated with a normal life expectancy and many patients are able to live fulfilling, productive lives. Note: Ankylosing Spondylitis News is strictly a news and information website about the disease. It does not provide medical advice, diagnosis, or treatment. This content is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read on this website. Every gift to the Arthritis Foundation will help people with arthritis across the U.S. live their best life. Join us and become a Champion of Yes. There are many volunteer opportunities available. Take part to be among those changing lives today and changing the future of arthritis. Proud Partners of the Arthritis Foundation make an annual commitment to directly support the Foundation's mission. Every gift to the Arthritis Foundation will help people with arthritis across the U.S. live their best life. Whether it is supporting cutting-edge research, 24/7 access to one-on-one support, resources and tools for daily living, and more, your gift will be life-changing. Make a Donation Help millions of people live with less pain and fund groundbreaking research to discover a cure for this devastating disease. Please, make your urgently-needed donation to the Arthritis Foundation now! Become a Member Become an Arthritis Foundation member today for just \$20 and you'll receive access to helpful tools..... and more. Make a Honor or Memorial Gift Honor a loved one with a meaningful donation to the Arthritis Foundation. We'll send a handwritten card to the honoree or their family notifying them of your thoughtful gift. Gift Planning I want information on ways to remember the AF in my will, trust or other financial planning vehicles. Other Ways to Give Match Gift Donate a Car Donor-Advised Funds By taking part in the Live Yes! INSIGHTS assessment, you'll be among those changing lives today and changing the future of arthritis, for yourself and for 54 million others. And all it takes is just 10 minutes. Your shared experiences will help: - Lead to more effective treatments and outcomes - Develop programs to meet the needs of you and your community - Shape a powerful agenda that fights for you Now is the time to make your voice count, for yourself and the entire arthritis community. Currently this program is for the adult arthritis community. Since the needs of the juvenile arthritis (JA) community are unique, we are currently working with experts to develop a customized experience for JA families. By sharing your experience, you're showing decision-makers the realities of living with arthritis, paving the way for change. You're helping break down barriers to care, inform research and create resources that make a difference in people's lives, including your own. Get Started As a partner, you will help the Arthritis Foundation provide life-changing resources, science, advocacy and community connections for people with arthritis, the nation's leading cause of disability. Join us today and help lead the way as a Champion of Yes. Trailblazer Our Trailblazers are committed partners ready to lead the way, take action and fight for everyday victories. They contribute \$2,000,000 to \$2,749,000 Visionary Our Visionary partners help us plan for a future that includes a cure for arthritis. These inspired and inventive champions have contributed \$1,500,00 to \$1,999,999. Pioneer Our Pioneers are always ready to explore and find new weapons in the fight against arthritis. They contribute \$1,000,000 to \$1,499,999. Pacesetter Our Pacesetters ensure that we can chart the course for a cure for those who live with arthritis. They contribute \$500,000 to \$999,000. Signature Our Signature partners make their mark by helping us identify new and meaningful resources for people with arthritis. They contribute \$250,000 to \$499,999. Supporting Our Supporting partners are active champions who provide encouragement and assistance to the arthritis community. They contribute \$100,000 to \$249,999. More About Partnerships This is a big myth. Ankylosing Spondylitis (AS) is a form of inflammatory, painful arthritis that mainly affects the lower back and spinal joints (vertebrae). However, other joints such as the knee, shoulders, hips, ribs, heels and small joints of the hands and feet can be involved, too. Even the eyes can be affected with a condition known as uveitis, and rarely, the lungs and heart, too. The word spondylitis refers to inflammation of the spine; ankylosis means fusion of two bones into one. The joints between the vertebrae, and the joints between the spine and the pelvis eventually grow together (fuse). This can limit movement and cause severe pain. People with severe AS may stoop over due to the fixed position of the spine - this is termed kyphosis. This is also a myth. Ankylosing Spondylitis (AS) is uncommon and rarely begins after the age of 45. It occurs most frequently in white males 20 to 40 years old, although it can occur in children, too. Even though ankylosing spondylitis is a type of arthritis, it only affects about 1 in 1000 people. The exact cause of AS is not known, but there does appear to be a genetic link as it does run in families. About 90% of people with AS also have a gene that produces a "genetic marker" - a protein called HLA-B27. However, having the gene doesn't mean you will absolutely get AS - fewer than 5% of people with HLA-B27 get AS. Myth here, too. There is not a cure for Ankylosing Spondylitis (AS); however, there are FDA-approved medications that can reduce AS symptoms and help to manage the pain. AS is characterized by acute, painful relapses of back pain followed by periods of remission where symptoms subside. In some patients, pain may occur elsewhere - for example in the shoulders, hips, ribs, and small joints of the hands and feet. Pain may be worse in the morning and decrease during the day and with exercise. AS is an autoimmune disorder, which is an illness that occurs when the immune system wrongly attacks tissues in the body. NSAIDs are helpful for pain and studies show TNF blockers can slow or halt AS disease progression. Secukinumab (Cosentyx), the first in a new class of medicines called interleukin-17A (IL-17A) inhibitors was FDA approved in 2016 to treat AS. Cosentyx significantly reduces signs and symptoms of AS and increases overall mobility. Not really, this is a myth. Usually the diagnosis is fairly straightforward. A rheumatologist, a specialized arthritis doctor, will usually make the initial diagnosis. An X-ray or MRI can show if there is inflammation of the sacroiliac joint. The doctor may also run a blood test for the presence of genetic markers, and symptoms and history help to make the diagnosis. Evidence of low back pain and stiffness for a period of 3 months, which improves with exercise, but is not relieved by rest.Limits of lumbar spine motion while bendingLimits of chest expansion when breathing. This statement is a myth. While medications are one component, they aren't used alone. The goals of treatment with AS are fourfold: Lessen joint pain and stiffnessSlow disease progressionPrevent joint deformity, such as kyphosisMaintain posture and daily work/life functionTreatment for AS involves a multi-stepped approach: medication, exercise and/or physical therapy, applying heat/cold for muscle relaxation and to relieve joint pain. Joining an ankylosing spondylitis support group may provide benefits, as well, like discussion among your peers and keeping up with the latest news. Absolutely not, another myth. A defined plan of physical therapy and individualized exercise is important for everyone with AS. Back stiffness, especially in the morning, is one feature of AS that often improves with activity. People who have this disorder may get worse if they do not exercise regularly. The physician may send the patient to the physical therapist who can develop a plan of stretching, deep breathing and range-of-motion exercises. Hydrotherapy may be used as well. Physical therapy can help to keep the back flexible, prevent stooping, make daily activities easier, and lower the chances of severe pain or further injury. This is a myth, too. In fact, initial drug treatment can be quite affordable. Drug treatment with anti-inflammatory NSAIDs or analgesics are usually the first drugs used for ankylosing spondylitis treatment. Treatment might include one of these medications: These drugs are readily available either over-the-counter (OTC) or with a prescription and most come in a low-cost generic option. However, NSAIDs can be associated with serious side effects such as stomach bleeding, heart attack, and stroke - patients should discuss these side effects with their doctor, especially with long-term, chronic use of NSAIDs. Myth. Not everyone with ankylosing spondylitis has severe disease or physical disability - the disease course is variable and differs greatly among patients. It is not a life-threatening disease and many people are able to work and function normally throughout their day. In most cases, AS is characterized by painful episodes followed by remissions, a time where the pain subsides. Studies have shown that patients who have disease onset at an older age may be more prone to severe joint damage. In addition, smokers were more than four times as likely to have severe damage as nonsmokers. For severe ankylosing spondylitis or other joint problems, surgery or joint replacement may rarely be required. This statement could not be further from the truth. Patients who are able to engage in an active lifestyle, maintain a regular exercise program and body weight, refrain from smoking, and keep up with clinic appointments and treatments will have a better outcome. A firm mattress may help to decrease morning stiffness. Some patients like to exercise in a pool or swim for exercise as it is easier on the joints. Studies have shown a diet high in omega-3 fatty acids (found in cold water or oily fish like salmon, flax seeds, and walnuts) can reduce joint inflammation in rheumatoid arthritis patients, and there is some evidence it might be helpful in ankylosing spondylitis, as well. Definitely not true. The biologics, or tumor necrosis factor (TNF)-alpha inhibitors (TNF blockers), can play a key role in those who do not respond to NSAIDs. TNF blockers can lead to less back pain, stiffness, and inflammation; they may also slow progression of AS. TNF blockers may be used in conjunction with NSAIDs for symptom control. FDA-approved biologics for ankylosing spondylitis include: They are administered in the clinic or given by self-injection at home. Some patients with AS may see results as soon as 2 weeks, but for others it may take several months. A Cochrane Review from Maxwell and colleagues concluded that there is moderate to high quality evidence that anti-TNF agents improve clinical symptoms in the treatment of ankylosing spondylitis. Not always. But you should educate yourself. As with most medicines, TNF blockers have some serious side effects. However, most of the very serious side effects are also very rare. An increased frequency of infections, including tuberculosis (TB) or fungal infections, may occur. However, prior to beginning treatment with TNF blockers, a TB test is given to rule out an active infection. Also, a very rare side effect is the increased frequency of certain cancers, for example: Infliximab has also been linked with a severe allergic reaction (facial swelling, difficult breathing, low blood pressure). Wrong. All TNF blockers target an inflammation-causing substance called TNF, but there are some differences, too. Costs can vary, too. Be sure to check with your insurance carrier for their covered TNF blockers (those that are on their formulary), which will save you money. Ask about the use of a specialty pharmacy, if needed. If you do not have insurance, call the manufacturer to inquire about patient assistance programs. Remember, many patients experience significant improvements in their ankylosing spondylitis using a TNF blocker, no matter which one they use. Definitely a myth. In fact, the most common side effect seen with the TNF blockers are injection site reactions on the skin. A localized rash, burning, or itching may occur and can last up to one week. Roughly 10% to 20% of patients (10 to 20 out of 100) might experience injection site reactions, which are usually described as mild. However, if the reaction still persists after one week, contact your doctor to discuss. In addition, patients using TNF blockers should consult with their health care provider before receiving any "live" vaccine (for example, FluMist or BCG vaccine) as TNF blockers may make the vaccine less effective. This is a controversial topic. Several studies have suggested no effect of TNF blockers to slow disease progression in AS. However, a study by Haroon and colleagues suggests that TNF blockers can reduce progression of spinal damage as seen on an X-ray by up to 50%. Researchers state that treatment needs to be started early and continued long-term. In the study, a benefit was seen at 4 years. Compared to patients who started treatment earlier, those who waited 10 or more years to begin TNF blockers were twice as likely to progress. In this study, NSAID use did not have a significant effect on progression; but patients may still need to use NSAIDs for 'rescue' pain control. Think about this: TNF blockers are some of the most expensive drugs on the market today. For example, Humira can run from \$5000 to \$6000 per month if you are paying out-of-pocket, even with a coupon discount. Biosimilars may be more affordable, but your doctor will need to write your prescription specifically for the biosimilar, as TNF blockers cannot be substituted at the pharmacy level. And not all approved biosimilars are on the market yet. However, there may be ways to help offset the cost. Each manufacturer has a patient assistance program in place, so check their websites or ask your doctor about patient assistance programs. If you have insurance, check with your plan to determine the preferred treatments and copays for ankylosing spondylitis. The manufacturer may be able to assist you with these copay costs as well, if you qualify. Wrong, a myth for sure. TNF blockers are effective for many patients with ankylosing spondylitis (AS), but there are still other options for patients who do not respond or cannot use them. Local injections of corticosteroids, such as methylprednisolone (Solu-Medrol), can be used intermittently if there is evidence of local joint swelling. Long-term, chronic use of corticosteroids is discouraged due to serious side effects. Oral use of corticosteroids is also discouraged. Sulfasalazine, an oral disease-modifying drug often used in rheumatoid arthritis, may be used in AS patients with symptoms in other areas besides just the spine. In general, opioid pain medications should be avoided due to side effects and concern for addiction. Approximately 20% to 40% of patients do not respond well to standard of care biologic drugs, and there are few other options. In 2016, the FDA approved Cosentyx (secukinumab) for AS, offering a totally new type of treatment option. Cosentyx is the brand name for the drug secukinumab and is administered by subcutaneous injection, usually every four weeks. Secukinumab inhibits interleukin-17A (IL-17A), effectively blocking the release of chemicals by the immune system responsible for inflammation. Fever, headache, muscle aches, sore throat, fatigue and a stuffy or runny nose are common side effects. Cosentyx also increases your risk of infection and patients treated with Cosentyx should not receive live vaccines. Studies have shown that 61% of patients had an improvement of at least 20% in their ankylosing spondylitis symptoms after 16 weeks of Cosentyx treatment, with 36% experiencing over 40% improvement. Many of these patients had failed to respond to or were intolerant of biologics. In June 2020, the FDA also approved Cosentyx to treat active non-radiographic axial spondyloarthritis (nr-axSpA). nr-axSpA is part of the axSpA spectrum, which is characterized by inflammatory arthritis of the spine associated with chronic inflammatory back pain, but may not show on X-ray studies. In August 2019 the FDA approved Eli Lilly's Taltz (ixekizumab) injection for the treatment of adults with active ankylosing spondylitis (AS). Like Cosentyx, Taltz is also classified as a humanized interleukin-17A antagonist. Taltz works to lower pain and swelling by inhibiting the release of pro-inflammatory cytokines and chemokines. It's also approved for the treatment of plaque psoriasis and psoriatic arthritis. FDA approval was based on Phase 3 studies in 657 adults. At 16 weeks, patients achieved ASAS40 (improvement by at least 40 % in various signs and symptoms of AS) at the following significant response rates: COAST-V study (biologic DMARD-naive group): 48% of patients treated with Taltz every 4 weeks versus 18% of patients treated with placebo. COAST-W study (adequate response or intolerant to TNF inhibitors group): 25% of patients treated with Taltz every 4 weeks versus 13% of patients treated with placebo. The safety profile observed in patients with AS treated with Taltz was consistent with the safety profile in patients with psoriasis. The most common side effects of Taltz include: Injection site reactions Upper respiratory infections Nausea Fungal infections

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