HLA-B27 and spondyloarthropathy: value for early diagnosis?

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The seronegative spondyloarthropathy complex
The seronegative spondyloarthropathy complex embraces a group of inflammatory rheumatic disorders linked together by certain clinical, laboratory, and radiological manifestations.

Clinically, the disorders are characterised by asymmetrical peripheral oligoarthritis and involvement of the sacroiliac joints (table 1). Manifestations in the eyes, mucocutaneous membranes, and genitourinary system not infrequently accompany the often predominant arthritis. The patients lack detectable rheumatoid factors in serum, hence the term "seronegative". Other serum autoantibodies, often found in inflammatory rheumatic diseases, are notably absent in the spondyloarthropathies. Unlike in rheumatoid arthritis, radiological examinations of peripheral joints rarely show destructive changes. However, radiological sacroiliitis is essential for the diagnosis of many of these diseases.

ANKYLOSING SPONDYLITIS
Ankylosing spondylitis (AS) is regarded as the prototype of the seronegative spondyloarthropathies (table 1). In its classic but quite rare form, complete ankylosis of the whole spine develops within a few years. More often, however, the clinical picture is dominated by pain and stiffness of the back with radiological examination showing sacroiliitis and varying degrees of spinal inflammation.

Table 1 The seronegative spondyloarthropathy complex: disorders, common disease manifestations, and frequencies of HLA-B27

<table>
<thead>
<tr>
<th>Disorders</th>
<th>%</th>
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<tr>
<td>Ankylosing spondylitis</td>
<td>90-95</td>
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<tr>
<td>Reiter's disease</td>
<td>70-85</td>
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<tr>
<td>Reactive arthritis</td>
<td>36-100</td>
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<tr>
<td>Psoriatic arthritis</td>
<td>54</td>
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<tr>
<td>Arthritis in inflammatory bowel diseases</td>
<td>50</td>
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Manifestations
Seronegativity for rheumatoid factors
Absence of antinuclear antibodies
Absence of rheumatic nodules
Peripheral arthritis
Genitourinary (urethritis, vaginitis, balanitis)
Mucocutaneous ( stomatitis, dermatitis)
Intestinal (enteric infections or chronic inflammation)
Radiological sacroiliitis
Genetic (familial aggregation, HLA-B27)

REACTIVE ARTHRITIS
Reactive arthritis (ReA) is a term introduced by Aho et al in 1973. It denotes an asymmetrical non-infectious arthritis in a few joints, appearing days or weeks after infection elsewhere in the body, most often in the genitourinary or gastrointestinal system. Previously, the term postinfectious arthritis was preferred.

PSORIATIC ARTHRITIS
The arthritis associated with psoriasis is most often localised to a few joints in an asymmetrical pattern, frequently affecting the distal interphalangeal joints of the hands. It occasionally manifests radiological sacroiliitis, but complete ankylosis of the spine ("bamboo spine") is definitely less frequent than in AS. Psoriatic arthritis (PsA) may also present a clinical picture almost indistinguishable from that of rheumatoid arthritis. Although serum rheumatoid factors are notably absent, this form of psoriatic arthritis affecting peripheral joints bears little resemblance to the other spondyloarthropathies.

INFLAMMATORY BOWEL DISEASES
A seronegative arthritis may also accompany the inflammatory bowel disorders ulcerative colitis and Crohn's disease. As in other spondyloarthropathies, radiological sacroiliitis may be seen.

A striking feature of the seronegative spondyloarthropathies is the association with the histocompatibility antigen HLA-B27.

The association between HLA-B27 and spondyloarthropathy
The study of products of genes located on a region of chromosome 6, known as the major histocompatibility complex, has provided valuable insight into many diseases of as yet unknown aetiology. In 1973, two independent groups of workers found a striking association between one of these genes, HLA-B27 and AS. Subsequently, associations between HLA-B27 and ReA and PsA were established. Why subjects carrying HLA-B27 are prone to develop spondyloarthropathy is not fully understood.
The diagnosis of ankylosing spondylitis requires the presence of grade 3-4 bilateral sacroilitis with at least one clinical criterion, or grade 3-4 unilateral or grade 2 bilateral with criteria 1 or with both clinical criteria 2 and 3.

Reactive arthritis
A seronegative arthritis occurring shortly after infection in the genitourinary or gastrointestinal canal.

Reiter's syndrome
One or more episodes of urethritis or conjunctivitis in connection with seronegative arthritis.

Psoriatic spondylitis
Pain/stiffness of the spine with radiological examination showing sacroilitis/spondylitis in a patient with psoriasis.

Spondylitis in inflammatory bowel disease
Pain/stiffness of the spine with radiological examination showing sacroilitis/spondylitis in a patient with either Crohn's disease or ulcerative colitis.

HLA-B27 in spondyloarthropathies
Approximately 95% of white patients with AS are HLA-B27 positive (10) (table 1). The prevalence of HLA-B27 among patients with ReA appears somewhat less, about 70-85% (7) (table 1). In PsA, there is a clear association between HLA-B27 and the group of patients exhibiting radiological sacroilitis (8), whereas the frequency of this tissue antigen among cases with symmetrical polyarthritis resembling rheumatoid arthritis equals that in the general population. (8)

In the inflammatory bowel disorders, HLA-B27 does not confer an increased risk of contracting peripheral arthritis, (4) but a moderate association between HLA-B27 and spondylitic disease is present. (4)

HLA-B27 in various populations
The distribution of HLA-B27 among various ethnic groups appears strikingly uneven. (11) Among certain North American Indians, Lapps, and inhabitants of northern Scandinavia the frequency of HLA-B27 ranges from 26 to 50%. (11) Most European populations show B27 prevalences between 7 and 10%. (11) In blacks, HLA-B27 is virtually absent. (11)

Diagnostic value of HLA-B27 in spondyloarthropathy
Definite diagnoses
The diagnostic criteria and tentative definitions of various seronegative spondyloarthropathies are given in table 2. Clearly, none of the diseases under consideration requires a positive HLA-B27 test for a definite diagnosis. All diagnoses are based on the appearance of certain clinical signs and symptoms, and for AS the demonstration of radiological sacroilitis is mandatory for diagnosis. (12)

Pretest likelihood
In epidemiological surveys it has been found that the prevalence of AS among HLA-B27
positive persons with back pain or stiffness is as high as 22.5%. This figure clearly contrasts the estimate of a 1 to 6% prevalence of AS among a random sample of B27 positive people. Thus, selecting people with back pain and stiffness for B27 testing increases the likelihood of finding AS.

However, more than 75% of cases with back pain and stiffness suffer from diseases other than AS. Thus, the pretest likelihood must be increased further to meet the cost-benefit demands. It has been calculated that for a positive HLA-B27 test to provide an acceptable 95% chance that the diagnosis is correct, the physician must be more than 50% certain of the diagnosis before the test is performed. Unfortunately, the many attempts at constructing useful clinical diagnostic criteria for AS independent of radiological examination have all been unsuccessful. At present it seems difficult to diagnose AS clinically with a 50% chance of correct diagnosis. Consequently, HLA-B27 does not appear helpful in differentiating spondyloarthropathies meeting traditional definitions from other causes of back complaints.

**THE CONCEPT OF UNDIFFERENTIATED SPONDYLOARTHRATHROPY AND SPONDYLITIC DISEASE**

It has been suggested recently that the traditional clinical view on diagnosing seronegative spondyloarthropathies should be broadened. Some workers have suggested that AS may manifest with clinical symptoms of inflammatory back pain but without the radiological features of classical AS. In family studies this clinical picture appears significantly associated with HLA-B27. It has been found that between 13 and 18% of B27 positive first degree relatives of B27 positive cases express clinical symptoms of inflammatory spinal disease without concomitant radiological signs of the disease. The clinical picture has been entitled "spondylitic disease". A new set of classification criteria for spondyloarthropathies has also been suggested (table 3). According to these criteria, a diagnosis of undifferentiated spondyloarthropathy is preferred in patients who complain of inflammatory spinal pain or synovitis and in addition have psoriasis, inflammatory bowel disease, positive familial history, or enthesopathy.

If the concept of AS is broadened to include such clinical pictures, the value of HLA-B27 testing, especially in first degree relatives of AS probands, should be re-evaluated. Until the aetiology of AS has been described, these suggestions cannot be proven nor refuted.

However, the eventual clinical usefulness of expanding the diagnostic net of spondyloarthropathies may be disputed. Evidently, no effective prophylaxis is available for either the classical spondyloarthropathies or for the "new" group of spondylitics. Thus, adding a new group of patients to the already existing cases of AS does not help to solve the primary task of medicine, to prevent disease development.

Moreover, we do not know the effect of therapy on these new syndromes. To diagnose "spondylitic disease" for the benefit of early therapy, whether physical therapy or administration of drugs, does not seem justified. Furthermore, whether or not undifferentiated spondyloarthropathy in due time will lead to restricted mobility of the spine and chest as seen in AS is not yet known, so the purpose of physical therapy directed at increasing spinal mobility appears limited.

Finally, another important problem is adequate patient information. At present, the possible risk of developing disease complications, such as cardiac conduction disturbances, dislocations of the upper cervical spine, and renal amyloidosis has not been studied properly. Thus, defining a new group of spondylitics creates the problem of offering adequate patient information regarding disease outcome. However, the concept of a wider spectrum of HLA-B27 associated spondyloarthropathy is intriguing and the cases under consideration should be subjected to research based follow up and further clinical and laboratory analyses.

It should also be stressed that the new criteria were primarily meant to serve as classification criteria and not as a diagnostic aid in everyday clinical practice. Unfortunately, classification criteria are often confused with diagnostic criteria and the confusion is not infrequently enhanced by the general accessibility of the HLA-B27 test. Therefore, it seems necessary to review the individual clinical syndromes of the seronegative spondyloarthropathy complex and their associations with HLA-B27.

**VALUE OF THE B27 TEST IN PATIENTS WITH ASYMMETRICAL PERIPHERAL OLIGOARTHRITIS**

The presence of asymmetrical peripheral arthritis in a few joints may raise the suspicion of either psoriatic arthritis (PsA) or reactive arthritis (ReA).

In young and middle aged patients with an acute onset of oligoarthritis in the absence of psoriasis, ReA is a likely diagnosis. A definite diagnosis is based on the findings of serological or microbiological evidence of genitourinary or gastrointestinal infection antedating the arthritis. As the prevalence of HLA-B27 among cases with ReA is lower than in AS, the predictive value of both a positive and a negative test is less when compared to AS. Although the presence of HLA-B27 may increase the

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*Table 3: European Spondyloarthopathy Study Group (ESSG) preliminary classification criteria for spondyloarthropathies*

<table>
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<tr>
<th>Inflammatory spinal pain or synovitis</th>
<th>Asymmetrical</th>
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<td>Predominantly in the lower limb</td>
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And one of the following:
- Positive family history
- Psoriasis
- Inflammatory bowel disease
- Alternate buttock pain
- Enthesopathy
suspicion of ReA, it remains unhelpful as an aid to diagnosis.

In PsA, the association between spondylitis and HLA-B27 is less pronounced than that of AS and ReA. At most, the frequency of HLA-B27 in psoriatic spondylitis is about 50%. Consequently, the predictive diagnostic value of the HLA-B27 test in psoriatic spondylitis does not meet the demands of clinical medicine.

THE VALUE OF HLA-B27 IN JUVENILE CHRONIC ARTHRITIS
In contrast to adult AS, juvenile AS less frequently causes symptoms of axial skeleton disease at onset. Perhaps as few as 24% of children complain of pain and stiffness of the lumbar spine. Instead, manifestations from the peripheral joints often dominate the initial clinical picture. The association between juvenile AS and HLA-B27 is, however, as strong as that in adult disease. In patients with established juvenile chronic arthritis a positive HLA-B27 test can be of help in focusing the diagnosis towards development of AS later on. However, the test shows the same limitations as in adult AS, and cannot be regarded as of diagnostic value.

THE VALUE OF HLA-B27 IN ACUTE UVEITIS
It has been found that the prevalence of HLA-B27 is increased to about 50% in acute anterior uveitis (AAU), and that between 15 and 25% of the patients have clinical and radiographic evidence of AS. Thus, even in the absence of concomitant AS, AAU seems to be associated with HLA-B27, and the test appears to be of limited value in diagnosing coexisting AS.

Patients with AAU should not undergo routine rheumatological examinations. Only those cases with AAU who report significant stiffness or pain of the back or peripheral joints should be referred to a rheumatologist for further examination.

SCREENING FOR HLA-B27 IN FAMILIES OF AS PROBANDS
As HLA-B27 is inherited in a codominant fashion, the prevalence of HLA-B27 among first degree family members will be in the order of 25 to 100%, depending on homozygosity and HLA status of the mate. The prevalence of AS among first degree relatives of AS probands has been estimated as 1–3 to 11%. Consequently, only a small proportion of HLA-B27 positive probands will develop AS as defined by traditional diagnostic criteria. Moreover, as no prophylaxis is available to prevent the development of AS, there is no cause for routine testing of HLA-B27 among family members. The determination of HLA-B27 in first degree relatives of AS probands will only increase the risk of introducing “iatrogenic HLA-B27itis”.

As discussed earlier, clinical spondylitic disease is suggested to occur quite frequently among HLA-B27 positive family members of AS probands. It is the authors’ opinion that the problems associated with this diagnosis are so significant that HLA-B27 typing based on the assumption of clinical spondylitic disease is not justified.

HLA-B27 AS A CONFIRMATORY TEST IN AS
The diagnosis of AS rests on the demonstration of radiological sacroiliitis in patients having pain or stiffness of the back. The demonstration of a negative HLA-B27 test in such cases will not alter the diagnosis. The absence of HLA-B27 in a patient with AS should, however, alert the physician to the possibility of concurrent psoriasis or inflammatory bowel disease. There are undoubtedly, however, true cases of HLA-B27 negative cases of AS showing no signs of concurrent dermatological or intestinal disease.

HLA-B27 AND PROGNOSIS IN AS
Apart from a higher prevalence of AAU in B27 positive subjects compared to B27 negative cases, the clinical picture appears similar in B27 positive and B27 negative AS. As more than 90% of AS patients carry B27, and only 25% contract AAU, tissue typing is of no help in selecting those cases that are prone to develop eye complications.

Conclusions
HLA-B27 is essential to the aetio-pathogenesis of spondyloarthropathies. This statement has been so widely accepted that the term “HLA-B27 associated disease” is sometimes used to replace “the seronegative spondyloarthropathy complex” introduced by Moll et al. However, for the practising physician it is important to bear in mind that only a minority of HLA-B27 positive subjects contract a “B27 associated disease” and that the overwhelming majority of patients with musculoskeletal complaints do not suffer from inflammatory rheumatic disease. These two simple facts should serve as guidelines to the use of the HLA-B27 test in everyday clinical practice.

It is our conviction that the benefit of the HLA-B27 test is very limited. The test cannot be used for confirming a diagnosis of spondyloarthropy or predicting the prognosis in patients with an established diagnosis of inflammatory rheumatic disease. The test can be used in three ways.

First, if the likelihood of spondyloarthropy based on symptoms and signs is greater than 50%, a B27 positive test result significantly increases the chance of a correct diagnosis. Such a high pretest likelihood, however, requires reliable clinical diagnostic criteria which are not readily available in rheumatology. It is, however, our hope that such criteria will be developed in the near future.

Secondly, in patients with back pain and stiffness, a negative B27 test result very strongly indicates that the complaints are caused by diseases other than AS. In the absence of concurrent psoriasis or inflammatory bowel disease, a negative B27 test result virtually excludes a diagnosis of AS, provided the test is properly done.
Thirdly, a positive B27 test in children with an established inflammatory joint disease may help establish the physician focus on a possible development of seronegative spondyloarthropathy.

Today's increasing demands for an effective and rationalised health system do not allow uncritical use of expensive laboratory tests. The results of such tests may at worst lead to incorrect diagnoses and initiation of therapeutic strategies of virtually no benefit to the patients.

23 Moll JM, Haslock IF, Macrae IF, Wright V. Associations between ankylosing spondylitis, psoriatic arthritis, Reiter's disease, the intestinal arthropathies and Behcet's syndrome. Medicine (Baltimore) 1974;53:343-64.