ACR Guideline Summary

2026 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Axial Spondyloarthritis in Adults and Children/Adolescents

Below is a summary of recommendations for two guidelines for diagnosis and management of axial spondyloarthritis (axSpA). The first is an update to the 2019 ACR/SAA/SPARTAN guideline for treatment of ankylosing spondylitis and axSpA. The second is a new guideline that outlines specific recommendations for management of children and adolescents with juvenile axSpA, which was developed in conjunction with the adult guideline.

These two guidelines provide evidence-based and expert guidance for the diagnosis and management of axSpA and associated extra-musculoskeletal manifestations (EMMs) in adults and children and adolescents. Due to the low level of evidence for many of the statements, shared medical decision-making between the rheumatologist and the patient/family is strongly encouraged. Many of the recommendations are consistent between the two guidelines; however, some statements differ due to the differences in the balance of benefits and harms and clinical considerations in children and adults.

For initial diagnosis, radiograph of the sacroiliac joints is the preferred test for adults. For children and adolescents, MRI of the sacroiliac joints without contrast is the preferred diagnostic test. If the diagnosis of axSpA is confirmed, NSAIDs are appropriate initial therapy in most patients, although additional treatment is recommended in patients at risk for progression or in whom NSAIDs are ineffective or not tolerated. TNFi and IL-17i are equally recommended as initial biologic DMARD (bDMARD) therapy over JAKi; no other biologic or targeted synthetic DMARD (b/tsDMARD) is recommended for the management of axSpA. Use of conventional synthetic DMARDs (csDMARDs) is not recommended in the absence of EMMs.

If initial b/tsDMARD treatment is ineffective, we recommend switching to a treatment employing a different mechanism of action. If an individual fails two or more therapeutic classes, the rheumatologist should re-evaluate the reason for non-response, e.g., non-adherence, nociplastic pain, etc. In select cases, dose escalation of bDMARDs or dual-targeted therapy can be considered.

The presence of EMMs alters recommended treatment. Acute anterior uveitis or inflammatory bowel disease favors use of monoclonal antibodies against TNF, while psoriasis favors the use of IL-17i. If the underlying joint disease or EMMs remains uncontrolled, csDMARDs are also recommended.

In the setting of inactive disease, dose reduction can be considered. However, abrupt discontinuation of b/tsDMARDs is not recommended.

Recommendations for the Treatment of Adults with Axial Spondyloarthritis (axSpA)

These are divided into ungraded Good Practice Statements, recommendations for adults with suspected axSpA, adults with either active or inactive axSpA, adults with active axSpA, and adults with inactive axSpA. The PICO number for each statement appears in brackets after each statement. New PICOs (not present in the 2015 or 2019 guidelines) are indicated with an asterisk (*).

Good Practice Statements (ungraded)
Adults with axSpA and IBD should be co-managed with a gastroenterologist rather than management by a rheumatologist alone [3.3].*
Adults with active axSpA and active uveitis should be co-managed with an ophthalmologist rather than management by a rheumatologist alone [4.1].
Adults with active axSpA and active psoriasis should be co-managed with a dermatologist rather than managed by a rheumatologist alone [6.1].*
Adults with active axSpA without a response to two therapeutic agents should be re-evaluated for reasons for non-response before changing b/tsDMARDs [1.1].*
Adults with axSpA and kyphosis/ankylosis should wear a medical alert bracelet to alert first responders to "brittle" or fused spine and fracture risk [50.1].*

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
Recommendations for Evaluating Adults with SUSPECTED axSpA		
We **conditionally** recommend obtaining a dedicated anterior-posterior (AP) pelvis radiograph over a lumbar spine radiograph [67.5].*	Conditional	Very Low
We **conditionally** recommend ***against*** obtaining dedicated sacroiliac joint (SIJ) x-ray (anteroposterior, oblique views) over an AP pelvis x-ray [67.4].*	Conditional Against	Very Low
We **conditionally** recommend obtaining AP pelvis as the initial imaging test over spinal or SIJ MRI, or SIJ low-dose CT [67.6].	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend obtaining MRI SIJ without contrast [66.3].*	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend obtaining MRI SIJ without contrast over MRI lumbar spine to detect axSpA [66.5].*	Conditional	Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend obtaining SIJ MRI over SIJ low-dose (low radiation) CT [68.2].*	Conditional	Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend obtaining SIJ MRI over bone scan [68.5].*	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend obtaining SIJ low-dose (low radiation) CT [68.1].*	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend ***against*** obtaining PET scan over spinal or SIJ MRI [68.3].*	Conditional Against	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend ordering a specific MRI SIJ protocol over ordering a non-specific protocol to detect axSpA [66.6].*	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography undergoing MRI of the SIJ, we **conditionally** recommend ordering studies without gadolinium [66.9].*	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend having standardized MRI reporting over non-standardized reporting [66.8].*	Conditional	Very Low
In adults with non-diagnostic (non-definitive) plain radiography, we **conditionally** recommend having MRI interpreted by an individual experienced in detecting axSpA over a professional without specific experience in detecting axSpA [66.7].*	Conditional	Very Low

Recommendations for Adults with ACTIVE OR INACTIVE axSpA		
General Approaches to axSpA Management		
We **conditionally** recommend counseling regarding axSpA risk in first-degree relatives [2.1].*	Conditional	Very Low
We **conditionally** recommend ***against*** counseling to test first-degree relatives with genetic tests [2.2].*	Conditional Against	Very Low
We **conditionally** recommend routine measurement using a standardized disease activity measure [9.1].	Conditional	Very Low
We **conditionally** recommend measuring specific disease activity outcomes for axSpA over non-disease-specific measures [9.2].*	Conditional	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **conditionally** recommend regular interval use and monitoring axSpA disease-specific measure (ASDAS or BASDAI) over other non-disease-specific measures. [65.2].*	Conditional	Very Low
We **conditionally** recommend regular interval use and monitoring of C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) over usual care without CRP or ESR monitoring [64.1].	Conditional	Very Low
In adults with AxSpA and unclear activity while on a b/tsDMARD, we **conditionally** recommend obtaining a spinal or SIJ MRI to assess activity [66.2].	Conditional	Very Low
We **conditionally** recommend group or individual self-management education [51.1].	Conditional	Low
We **conditionally** recommend counseling regarding achieving an optimal weight [59.1].*	Conditional	Very Low
We **conditionally** recommend counseling regarding maintaining an optimal weight [59.2].*	Conditional	Very Low
We **conditionally** recommend cardiovascular disease risk screening [55.3].*	Conditional	Very Low
We **conditionally** recommend ***against*** screening for cardiac conduction defects with electrocardiogram [55.1].	Conditional Against	Very Low
We **conditionally** recommend ***against*** screening for valvular heart disease with echocardiogram [55.2].	Conditional Against	Very Low
We **conditionally** recommend depression screening and management [57.1].*	Conditional	Very Low
We **conditionally** recommend counseling regarding intense physical labor [56.1].*	Conditional	Very Low
We **conditionally** recommend counseling for modifications related to driving [62.1].*	Conditional	Very Low
We **conditionally** recommend counseling regarding the dangers of contact sports over no such counseling, whether the disease is active [62.2] or inactive [62.3].*	Conditional	Very Low
We **conditionally** recommend ***against*** microbiome targeted therapy [61.1].*	Conditional Against	Low
We **conditionally** recommend ***against*** treatment with alternative medicine (e.g., naturopathic, homeopathic, ayurvedic) [63.1].*	Conditional Against	Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **conditionally** recommend acupuncture and massage therapy [63.2].*	Conditional	Low
In adults with axSpA with pain, we **conditionally** recommend ***against*** treatment with cannabinoids (THC and CBD) [63.3].*	Conditional Against	Very Low
Management of Uveitis, IBD, and Psoriasis in the Setting of axSpA		
We **strongly** recommend education regarding symptoms of uveitis [4.5].*	Strong	Very Low
In adults with axSpA without a known history of uveitis, we **strongly** recommend screening for uveitis with a medical history [2.5].*	Strong	Very Low
In adults with axSpA without symptoms suggestive of active uveitis, we **conditionally** recommend ***against*** screening by ophthalmologic exam [2.6].*	Conditional Against	Very Low
In adults with axSpA and a history of recurrent uveitis, we **conditionally** recommend prescription of topical glucocorticoids for prompt at-home use in the event of eye symptoms [4.2].	Conditional	Very Low
In adults with axSpA and a history of recurrent uveitis, we **conditionally** recommend use of certain biologics over other b/tsDMARDs [4.3].	Conditional	Very Low
In adults who develop recurrent uveitis while on TNFi monoclonal, we **conditionally** recommend continuing on TNFi and adding topicals/csDMARDs over switching the TNFi to a non-TNFi biologic [4.4].	Conditional	Very Low
In adults with axSpA without a known history of IBD, we **strongly** recommend screening for IBD with a medical history [2.7].*	Strong	Very Low
In adults with axSpA without a known history of IBD and without clinical findings suggestive of active IBD, we **conditionally** recommend ***against*** screening using fecal calprotectin [2.8].*	Conditional Against	Very Low
In adults with axSpA without a known history of IBD but with clinical findings suggestive of active IBD, we **strongly** recommend testing using fecal calprotectin [2.12].*	Strong	Very Low
In adults with active axSpA and inactive IBD, we **conditionally** recommend ***against*** use of continuous/scheduled NSAIDs [3.4].*	Conditional Against	Very Low
In adults with axSpA and IBD (active or inactive), we **conditionally** recommend use of certain NSAIDs over other NSAIDs [3.1].	Conditional	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In adults with axSpA and IBD, we **conditionally** recommend use of certain b/tsDMARDs over other b/tsDMARDs [3.2].	Conditional	Very Low
In adults with axSpA without a known history of psoriasis, we **conditionally** recommend evaluation for psoriasis [2.9].*	Conditional	Very Low
In adults with axSpA and active psoriasis, we **conditionally** recommend use of certain biologics or tsDMARDs over other b/tsDMARD [6.2].*	Conditional	Very Low
In adults who develop mild TNFi-induced psoriasis, we **conditionally** recommend continuing on TNFi and adding topicals/csDMARDs/phototherapy over switching the TNFi to a non-TNFi biologic or a different TNFi [6.4].*	Conditional	Very Low
Management of axSpA Complicated by Nociplastic Pain		
We **conditionally** recommend treatment with gabapentinoid agents [22.1].*	Conditional	Very Low
We **conditionally** recommend treatment with SSRI/SNRI agents [23.1].*	Conditional	Very Low
We **conditionally** recommend treatment with muscle relaxants [24.1].*	Conditional	Very Low
We **conditionally** recommend treatment with cognitive behavioral therapy [42.1].*	Conditional	Very Low
We **strongly** recommend ***against*** treatment with opioid analgesics [25.1].*	Strong Against	Very Low
Pharmacologic Management of Active and Inactive axSpA		
We **conditionally** recommend ***against*** favoring TNFi or IL17i (including IL17A/Fi) as a preferred treatment; the medication classes are considered equal [28.1].	Conditional Against	Low
We **conditionally** recommend treatment with TNFi over JAKi [28.2].	Conditional	Very Low
We **conditionally** recommend treatment with IL17i over JAKi [28.3].	Conditional	Very Low
In adults with axSpA on IV infusion of a biologic, we **conditionally** recommend rapid infusion over traditional rate of infusion [38.1].*	Conditional	Very Low
We **strongly** recommend ***against*** treatment with adrenocorticotropic hormone [27.1].*	Strong Against	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
Physical Therapy and Related Approaches for the Management of axSpA		
We **strongly** recommend physical therapy in adults with active axSpA [44.1].	Strong	Very Low to Moderate
We **conditionally** recommend physical therapy in adults with inactive axSpA [44.2].	Conditional	Very Low
We **conditionally** recommend active physical therapy interventions (supervised exercise) over passive physical therapy interventions (massage, ultrasound, heat) [45.1].	Conditional	Very Low to Low
We **conditionally** recommend unsupervised back exercises over no exercise [45.4].	Conditional	Very Low to Moderate
We **conditionally** recommend recreational exercises over no recreational exercise [45.5].*	Conditional	Very Low
We **conditionally** recommend stretching over nonspecific exercises [45.6].*	Conditional	Very Low
We **conditionally** recommend aquatic exercises over weight-bearing exercises [45.3].*	Conditional	Very Low
We **conditionally** recommend aquatic physical therapy interventions over land-based physical therapy interventions [45.2].	Conditional	Very Low
We **conditionally** recommend repeat physical therapy over a one-time course of therapy [44.4].*	Conditional	Very Low
We **conditionally** recommend aerobic exercises over nonspecific exercises [45.7].*	Conditional	Very Low to Low
We **conditionally** recommend yoga over nonspecific exercises [45.8].*	Conditional	Low
We **conditionally** recommend Tai Chi over nonspecific exercises [45.9].*	Conditional	Very Low to Low
We **conditionally** recommend TENS over no TENS [40.1].*	Conditional	Low
We **conditionally** recommend ***against*** radiofrequency ablation over no radiofrequency ablation [41.1].*	Conditional Against	Very Low to Low
We **conditionally** recommend ***against*** traction [46.1].*	Conditional Against	Very Low
We **strongly** recommend ***against*** spinal manipulation [47.1].	Strong Against	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
Surgical and Perioperative Management of axSpA		
In adults with cervical spine disease who will receive surgery that requires general anesthesia, we **strongly** recommend intubation counseling (advising anesthesiologist, informed consent of patient) [48.1].*	Strong	Very Low
In adults with advanced hip arthritis, we **conditionally** recommend total hip arthroplasty [49.1].	Conditional	Very Low
In adults with severe kyphosis, we **conditionally** recommend elective spinal osteotomy [49.2].	Conditional	Very Low
In adults who have undergone THA, we **conditionally** recommend celecoxib to prevent heterotopic ossification [49.3].*	Conditional	Very Low
In adults who have undergone THA, we **conditionally** recommend ***against*** local radiation to prevent heterotopic ossification [49.4].*	Conditional Against	Very Low
In adults who have undergone THA, we **conditionally** recommend ***against*** local radiation over celecoxib to prevent heterotopic ossification [49.5].*	Conditional Against	Very Low
Management of Bone Health in axSpA		
We **strongly** recommend fall evaluation and counseling [53.4].	Strong	Very Low
We **conditionally** recommend screening for low bone mass with DXA scanning [53.1].	Conditional	Very Low
We **conditionally** recommend screening for low bone mass with DXA scanning over screening with other modalities such as CT [53.2].*	Conditional	Very Low
We **conditionally** recommend ***against*** yearly screening for low bone mass with DXA scanning over screening every other year or every five years [53.3].*	Conditional Against	Very Low
In adults with osteoporosis, we **conditionally** recommend ***against*** routine measurement of bone turnover markers [53.5].*	Conditional Against	Very Low
In adults with syndesmophytes or spinal fusion, we **conditionally** recommend screening for low bone mass with DXA scan of the spine as well as the hips over DXA scan solely of the hip or other non-spine site [53.6].	Conditional	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In adults with osteoporosis, we **conditionally** recommend the addition of anabolic or antiresorptive therapies to b/tsDMARD over b/tsDMARD alone [54.1].*	Conditional	Very Low
In adults with osteoporosis who have failed or have a contraindication to antiresorptive agents, we **conditionally** recommend anabolic therapy over continuing antiresorptive therapy [54.2].*	Conditional	Very Low
Imaging in axSpA		
In adults with active axSpA on any treatment, we **conditionally** recommend ***against*** obtaining repeat spine radiographs at a scheduled interval (e.g., every two years) [67.1].	Conditional Against	Very Low
In adults with inactive axSpA on any treatment, we **conditionally** recommend ***against*** obtaining repeat spine radiographs at a scheduled interval (e.g., every two years) [67.2].	Conditional Against	Very Low
We **conditionally** recommend ***against*** obtaining repeat pelvis or lumbar radiographs at a scheduled interval (e.g., every two years) [67.3].*	Conditional Against	Very Low
In adults with axSpA of unclear activity while on a b/tsDMARD, we **strongly** recommend obtaining spinal or SIJ MRI to assess activity over PET scan [68.4].*	Strong	Very Low
In adults with axSpA of unclear activity while on a b/tsDMARD, we **conditionally** recommend obtaining spinal or SIJ MRI to assess activity over bone scan [68.6].*	Conditional	Very Low
Recommendations for Adults with ACTIVE axSpA		
We **conditionally** recommend ***against*** a treat-to-target strategy over a symptom-prompted treatment strategy [2.10].	Conditional Against	Low
We **conditionally** recommend a goal of low disease activity over other targets [2.11].*	Conditional	Low
Pharmacologic Management of Active axSpA–First-Line Therapies		
We **strongly** recommend use of NSAIDs [10.1].	Strong	Very Low to Moderate
In adults with active axSpA despite NSAID monotherapy, we **strongly** recommend ***against*** switching to combination NSAIDs over NSAID monotherapy [10.7].*	Strong Against	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **conditionally** recommend certain NSAIDs over other NSAIDs [10.3].	Conditional	Low
We **conditionally** recommend continuous NSAID treatment over on-demand NSAID treatment [10.4].	Conditional	Low to Moderate
We **conditionally** recommend use of NSAIDs as first-line therapy over b/tsDMARD [10.2].*	Conditional	Very Low to Moderate
For adults at high risk of poor outcomes (syndesmophytes present, high CRP), we **conditionally** recommend b/tsDMARDs as initial pharmacologic treatment over starting with NSAIDs as initial therapy [2.3].*	Conditional	Very Low
In adults with active axSpA despite NSAIDs, we **conditionally** recommend switching to a new NSAID over continuing the original NSAID [10.6].*	Conditional	Very Low
We **conditionally** recommend ***against*** use of systemic glucocorticoids [17.1].	Conditional Against	Very Low
In adults with axSpA and active sacroiliitis, we **conditionally** recommend treatment with intra-articular glucocorticoids [16.1].	Conditional	Very Low

Pharmacologic Management of Active axSpA–Second-Line Therapies		
We **strongly** recommend treatment with TNFi [13.1].	Strong	Moderate to High
We **strongly** recommend treatment with IL-17i [14.1].	Strong	Moderate to High
We **strongly** recommend treatment with JAKi (TOFA, UPA) [15.1].*	Strong	Moderate
We **conditionally** recommend ***against*** certain TNFi over other TNFi [13.2].	Conditional Against	Very Low to High
We **conditionally** recommend ***against*** certain IL-17i over other IL-17i [14.2].*	Conditional Against	Very Low
We **conditionally** recommend ***against*** certain JAKi over other JAKi [15.2].*	Conditional Against	Very Low
We **conditionally** recommend ***against*** treatment with csDMARD (methotrexate, sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, or apremilast) [12.1].	Conditional Against	Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **strongly** recommend ***against*** treatment with opioid analgesics over b/tsDMARDs [26.1].*	Strong Against	Very Low
We **conditionally** recommend ***against*** treatment with bisphosphonates (to treat axSpA) [20.1].*	Conditional Against	Low
We **conditionally** recommend ***against*** treatment with abatacept, rituximab, tocilizumab, sarilumab, belimumab, or anakinra [18.1].	Conditional Against	Low
We **strongly** recommend ***against*** treatment with IL-23i [19.1].*	Strong Against	Very Low
In adults with axSpA and active peripheral arthritis, we **conditionally** recommend intra-articular glucocorticoids [7.1].	Conditional	Very Low
In adults with axSpA and active peripheral arthritis, we **conditionally** recommend csDMARD/b/tsDMARDs [7.2].*	Conditional	Low to High
In adults with axSpA and active enthesitis, we **conditionally** recommend peri-entheseal glucocorticoid injections [7.3].	Conditional	Very Low
Pharmacologic Management of Active axSpA–Subsequent Therapies		
In adults with active axSpA despite treatment with the first b/tsDMARD used, we **conditionally** recommend switching to a different b/tsDMARD from the same class over adding a csDMARD [34.1].	Conditional	Low
In adults with active axSpA despite treatment with the first b/tsDMARD used, we **conditionally** recommend ***against*** switching to a different agent from the same class over switching to different class of b/tsDMARD [34.2].	Conditional Against	Low
In adults with active axSpA despite maximum FDA-approved dosing of bDMARD, we **conditionally** recommend dosing above the FDA approved maximum dose [36.2].*	Conditional	Very Low
In adults with treatment "refractory" axSpA, we **conditionally** recommend depression screening and management over no depression screening and management [58.1].*	Conditional	Very Low
In adults with active axSpA (manifest as axial disease) despite bDMARD/tsDMARD monotherapy, we **conditionally** recommend ***against*** co-treatment/combination with csDMARD [12.2].	Conditional Against	Very Low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In adults with active axSpA despite bDMARD/tsDMARD monotherapy, we **conditionally** recommend the use of dual therapy (bDMARD + tsDMARD or two bDMARDs) over bDMARD/tsDMARD monotherapy [31.1].*	Conditional	Very Low
In adults with axSpA and IBD in which either condition is active despite bDMARD or tsDMARD monotherapy, we **conditionally** recommend use of dual therapy (bDMARD + tsDMARD or two bDMARDs) over use of monotherapy [3.5].*	Conditional	Very Low
In adults with axSpA and psoriasis in which either condition is active despite bDMARD or tsDMARD monotherapy, we **conditionally** recommend use of dual therapy (bDMARD + tsDMARD or two bDMARDs or tsDMARD + either APREM or DEUCR) over use of monotherapy [6.3].*	Conditional	Very Low
In adults with active axSpA despite bDMARD, we **conditionally** recommend ***against*** management based on serum anti-drug antibody monitoring and/or serum medication concentrations [37.1].*	Conditional Against	Very Low
In adults with active axSpA because of withdrawal or discontinuation of b/tsDMARDs (due to a period of prolonged inactivity), we **conditionally** recommend restarting the same agent over switching to a different agent from the same class, or switching to a different agent from a different class of b/tsDMARD [35.1].*	Conditional	Very Low
In adults with axial PsA, we **conditionally** recommend ***against*** treatment with IL-23i [19.2].*	Conditional Against	Low

Recommendations for Adults with INACTIVE axSpA		
In adults with asymptomatic axSpA at high risk of poor outcomes (syndesmophytes present, high CRP), we **conditionally** recommend pharmacologic therapy over no pharmacologic therapy [2.4].*	Conditional	Very Low
We **conditionally** recommend ***against*** continuous NSAID treatment over on-demand NSAID treatment [10.5].*	Conditional Against	Low to Moderate
In adults on an originator bDMARD, we **conditionally** recommend continuation of originator bDMARD over switching to its biosimilar bDMARD [29.1].	Conditional	Low to Moderate
In adults on treatment with a b/tsDMARD, we **strongly** recommend ***against*** discontinuations/withdrawing without tapering [32.1].	Strong Against	Moderate

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In adults with inactive axSpA on treatment with a b/tsDMARD, we **conditionally** recommend reducing frequency or dose (tapering) of the b/tsDMARD over maintaining the current frequency and dose [33.1].	Conditional	Low to Moderate
In adults on treatment with a b/tsDMARD and NSAIDs, we **conditionally** recommend ***against*** continuing treatment of both over treating with the b/tsDMARD alone [10.8].	Conditional Against	Very Low
In adults on treatment with a b/tsDMARD and a csDMARD, we **conditionally** recommend discontinuing the csDMARD over continuing treatment with both therapies [32.2].	Conditional	Very Low
In adults with clinically inactive axSpA, we **strongly** recommend ***against*** obtaining a spinal or MRI SIJ to confirm inactivity [66.1].	Strong Against	Very Low

Recommendations for Diagnosis and Treatment of Children and Adolescents with Axial Spondyloarthritis (axSpA)

Recommendations are divided into diagnosis, education and counseling, monitoring, and treatment considerations. The corresponding PICO number for each recommendation appears in brackets after each statement.

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
Diagnosis in Children and Adolescents with Suspected axSpA		
We **strongly** recommend obtaining an MRI of the sacroiliac joints without contrast over not obtaining an MRI to detect axSpA [66.3].	Strong	Very low
We **conditionally** recommend MRI of the sacroiliac joints over x-ray of the sacroiliac joints for diagnosis of juvenile axSpA [67.6].	Conditional	Very low
We **strongly** recommend obtaining SIJ MRI over SIJ low-dose (low radiation) CT [68.2].	Strong	Low
We **strongly** recommend obtaining MRI of the sacroiliac joints over bone scan [68.5].	Strong	Very low
We **strongly** recommend obtaining MRI of the sacroiliac joints without contrast over MRI of the lumbar spine to detect axSpA [66.5].	Strong	Low
We **conditionally** recommend use of a specific MRI protocol over a non-specific protocol to detect axSpA [66.6].	Conditional	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **conditionally** recommend standardized MRI reporting over non-standardized reporting [66.8].	Conditional	Very low
We **conditionally** recommend having MRI interpreted by an individual experienced in detecting axSpA over a professional without specific experience in detecting axSpA [66.7].	Conditional	Very low
We **conditionally** recommend ***against*** use of gadolinium [66.9]	Conditional Against	Very low
In children or adolescents with suspected axSpA undergoing plain radiography, we **conditionally** recommend obtaining dedicated AP pelvis radiograph over a lumbar spine radiograph [67.5].	Conditional	Very low
In children or adolescents with suspected axSpA undergoing plain radiography, we **conditionally** recommend a simple AP pelvis radiograph over a dedicated SIJ (Ferguson, oblique views) radiograph [67.4].	Conditional	Very low
In children and adolescents with enthesitis-related arthritis without axial symptoms, we **conditionally** recommend obtaining MRI of the sacroiliac joints to detect axSpA [66.5].	Conditional	Very low
Education and Counseling		
We **conditionally** recommend group or individual self-management education [51.1].	Conditional	Low
We **conditionally** recommend counseling regarding intense physical labor [56.1].	Conditional	Very low
We **conditionally** recommend counseling regarding contact sports [62.2, 62.3].	Conditional	Very low
We **conditionally** recommend counseling regarding axSpA risk in first-degree relatives [2.1].	Conditional	Very low
We **conditionally** recommend ***against*** counseling to test first-degree relatives with genetic tests [2.2].	Conditional Against	Very low
We **conditionally** recommend counseling regarding achieving or maintaining an optimal weight [59.1, 59.2].	Conditional	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
Monitoring		
We **conditionally** recommend measuring specific disease activity outcomes for axSpA over non-disease-specific measures [9.2].	Conditional	Very low
We **conditionally** recommend regular interval use and monitoring with the axSpA disease-specific measure (JSpADA) over other non-disease-specific measures [65.3].	Conditional	Very low
We **conditionally** recommend regular interval use and monitoring with JIA-specific measure (JADAS) over other non-disease-specific measures [65.4].	Conditional	Very low
We **conditionally** recommend regular interval use and monitoring of C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) over usual care without CRP or ESR monitoring [64.1].	Conditional	Very low
In children and adolescents with active axSpA despite bDMARD, we **conditionally** recommend ***against*** management based on serum anti-drug antibody monitoring and/or serum medication concentrations [37.1].	Conditional Against	Very low
We **conditionally** recommend a goal of low disease activity [2.11].	Conditional	Low
In children and adolescents with axSpA and unclear activity while on a b/tsDMARD, we **strongly** recommend obtaining a spinal or SIJ MRI to assess activity over not obtaining an MRI [66.2].	Strong	Very low
In children and adolescents with axSpA and unclear activity while on a b/tsDMARD, we **strongly** recommend obtaining MRI of the SIJ to assess activity over bone scan [68.6].	Strong	Very low
In children and adolescents with clinically inactive axSpA, we **conditionally** recommend ***against*** obtaining an MRI of the SIJ or spine to confirm inactivity [66.1].	Conditional Against	Very low
In children and adolescents with active axSpA on any treatment, we **strongly** recommend ***against*** obtaining repeat spine radiographs at a scheduled interval (e.g., every two years) [67.1].	Strong Against	Very low
In children and adolescents with inactive axSpA on any treatment, we **strongly** recommend ***against*** obtaining repeat spine radiographs at a scheduled interval (e.g., every two years) [67.2].	Strong Against	Very low
In children and adolescents with axSpA irrespective of disease activity, we **strongly** recommend ***against*** obtaining repeat pelvis radiographs at a scheduled interval (e.g., every two years) [67.3].	Strong Against	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
Initial Pharmacologic Treatment of Active Juvenile axSpA		
We **conditionally** recommend treatment with NSAIDs over no treatment with NSAIDs [10.1].	Conditional	Very low to moderate
We **conditionally** recommend treatment with NSAIDs over b/tsDMARDs as first-line therapy [10.2].	Conditional	Low to moderate
In children and adolescents with active axSpA at risk of poor outcomes, we **conditionally** recommend b/tsDMARDs as initial pharmacologic treatment over starting NSAIDs as initial therapy [2.3].	Conditional	Very low
We **conditionally** recommend COX-2 selective NSAIDs over non-selective NSAIDs [10.3].	Conditional	Low
We **conditionally** recommend continuous NSAID treatment over on-demand NSAID treatment [10.4].	Conditional	Low to moderate
In children and adolescents with active axSpA despite NSAIDs, we **conditionally** recommend switching to a new NSAID over continuing the original NSAID [10.6].	Conditional	Very low
In children and adolescents with active axSpA despite NSAID monotherapy, we **strongly** recommend ***against*** switching to combination NSAIDs over NSAID monotherapy [10.7].	Strong Against	Very low
We **conditionally** recommend treatment with intra-articular glucocorticoids over no use of intra-articular glucocorticoids [16.1].	Conditional	Very low
We **conditionally** recommend against the use of systemic glucocorticoids [17.1].	Conditional Against	Very low
We **strongly** recommend ***against*** treatment with adrenocorticotrophic hormone [27.1].	Strong Against	Very low
We **conditionally** recommend against treatment with csDMARD (methotrexate, sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, or apremilast) [12.1].	Conditional Against	Low
We **strongly** recommend treatment with TNFi [13.1].	Strong	Moderate to high
We **strongly** recommend treatment with IL-17i [14.1].	Strong	Moderate to high
We **conditionally** recommend treatment with JAKi [15.1].	Conditional	Moderate

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **conditionally** recommend ***against*** favoring TNFi or IL-17i as a preferred initial bDMARD treatment [28.1].	Conditional Against	Low
We **conditionally** recommend ***against*** favoring any certain TNFi as the preferred choice over other TNFi [13.2].	Conditional Against	Very low to high
We **conditionally** recommend ***against*** favoring any certain IL-17i as the preferred choice over other IL-17i [28.1].	Conditional Against	Very low
We **conditionally** recommend ***against*** favoring any certain JAKi as the preferred choice over other JAKi [15.2].	Conditional Against	Very low
We **conditionally** recommend TNFi over JAKi [28.2].	Conditional	Very low
We **conditionally** recommend IL-17i over JAKi [28.3].	Conditional	Very low
We **conditionally** recommend ***against*** treatment with abatacept, rituximab, belimumab, tocilizumab, sarulimab, or IL-1 inhibition [18.1].	Conditional Against	Low
We **conditionally** recommend ***against*** treatment with IL-23i [19.1].	Conditional Against	Very low
We **conditionally** recommend ***against*** treatment with bisphosphonates [20.1].	Conditional Against	Low
In children and adolescents with axSpA receiving IV biologic therapy, we **conditionally** recommend a rapid infusion over a traditional infusion rate for ongoing infusions [38.1].	Conditional	Very low
We **strongly** recommend ***against*** treatment with opioid analgesics over b/tsDMARDs [26.1].	Strong Against	Very low
We **strongly** recommend ***against*** cannabinoids (THC and CBD) over no treatment with cannabinoids [63.3].	Strong Against	Very low

Ongoing Symptoms Despite Initial Pharmacologic Therapy		
In children and adolescents with active axSpA despite treatment with the first b/tsDMARD used, we **conditionally** recommend switching to a different class of b/tsDMARD over switching to a different agent from the same class [34.2].	Conditional	Low
In children and adolescents with active axSpA despite b/tsDMARD monotherapy, we **conditionally** recommend ***against*** co-treatment/combination with csDMARD [12.2].	Conditional Against	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In children and adolescents with active axSpA despite treatment with the first b/tsDMARD used, we **conditionally** recommend switching to a different b/tsDMARD over adding a csDMARD [34.1].	Conditional	Low
In children and adolescents with active axSpA despite maximum FDA-approved dosing of bDMARD, we **conditionally** recommend dosing above the FDA approved maximum dose over continuing on the FDA-approved maximum dose [36.2].	Conditional	Very low
In children and adolescents with active axSpA without a response to two or more therapeutic agents from different classes, the rheumatologist should re-evaluate the reason for non-response (e.g., reconsider diagnosis, treatment adherence, central pain, etc.) prior to a trial of another b/tsDMARD [1.1; GPS].	Good Practice Statement	Not graded
In children and adolescents with active axSpA despite bDMARD/tsDMARD montherapy, we **conditionally** recommend the use of dual therapy (bDMARD + tsDMARD or two bDMARDs) over bDMARD/tsDMARD monotherapy [31.1].	Conditional	Very low
We **conditionally** recommend depression screening and management over no depression screening and management [57.1].	Conditional	Very low
In children and adolescents with treatment "refractory" axSpA, we **conditionally** recommend depression screening and management over no depression screening and management [58.1].	Conditional	Very low

Evaluation and Management of Disease Features Associated with Juvenile axSpA		
Peripheral Arthritis and Enthesitis		
In children and adolescents with axSpA and active peripheral arthritis, we **strongly** recommend b/cs/tsDMARDs over no use of b/cs/tsDMARDs [7.2].	Strong	Low to High
In children and adolescents with axSpA and active peripheral arthritis, we **conditionally** recommend intra-articular glucocorticoids over no use of local glucocorticoid [7.1].	Conditional	Very low
In children and adolescents with axSpA and active enthesitis, we **conditionally** recommend ***against*** peri-entheseal glucocorticoid injections [7.3].	Conditional Against	Very low
In children and adolescents with axSpA and peripheral arthritis, we **conditionally** recommend topical NSAIDs as adjunctive therapy over no use of topical NSAIDs [8.1].	Conditional	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In children and adolescents with axSpA and enthesitis, we **conditionally** recommend topical NSAIDs as adjunctive therapy over no use of topical NSAIDs [8.2].	Conditional	Very low
Uveitis		
Children and adolescents with axSpA and uveitis should be co-managed with an ophthalmologist [4.1; GPS].	Good Practice Statement	Not graded
We **strongly** recommend education regarding signs/symptoms of uveitis [4.5].	Strong	Very low
In HLA-B27-negative children and adolescents with axSpA without symptoms of active uveitis, we **strongly** recommend screening by ophthalmic exam over no screening by ophthalmologic exam [5.2].	Strong	Very low
In HLA-B27-positive children and adolescents with axSpA without symptoms of active uveitis, we **conditionally** recommend screening by ophthalmic exam over no screening by ophthalmic exam [5.1].	Conditional	Very low
In children and adolescents with axSpA and a history of recurrent uveitis, we **conditionally** recommend prescription of topical glucocorticoid for prompt at-home use in the event of eye symptoms over no at-home use [4.2].	Conditional	Very low
In children and adolescents with axSpA and a history of recurrent uveitis or complications from acute anterior uveitis, we **conditionally** recommend treatment with csDMARDs/tsDMARDs/bDMARD/ glucocorticoids over no treatment [5.3].	Conditional	Very low
In children and adolescents with axSpA and a history of recurrent or chronic uveitis, we **conditionally** recommend TNFi monoclonal antibodies over other b/tsDMARDs [4.3].	Conditional	Very low
In children and adolescents with axSpA who develop recurrent or chronic uveitis while on TNFi monoclonal antibodies, we **conditionally** recommend continuing on TNFi and adding topicals/csDMARDs over switching the TNFi to a non-TNFi biologic [4.4].	Conditional	Very low
Psoriasis		
Children and adolescents with active axSpA and psoriasis should be co-managed with a dermatologist [6.1; GPS].	Good Practice Statement	Not graded
In children and adolescents with axSpA without a known history of psoriasis, we **conditionally** recommend screening for psoriasis [2.9].	Conditional	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In children and adolescents with axSpA and active psoriasis, we **conditionally** recommend use of IL-17i over other b/tsDMARDs [6.2].	Conditional	Very low
In children and adolescents with axSpA and psoriasis, we **conditionally** recommend against treatment with IL-23i [19.2].	Conditional Against	Low
In children and adolescents with axSpA who develop TNFi-induced psoriasis, we **conditionally** recommend continuing on TNFi and adding topicals/csDMARDs/phototherapy over switching the TNFi to a non-TNFi biologic or a different TNFi [6.4].	Conditional	Very low
In children and adolescents with axSpA and psoriasis in which either condition is active despite bDMARD or tsDMARD monotherapy, we **conditionally** recommend use of dual therapy (bDMARD + tsDMARD or two bDMARDs or two tsDMARDs [JAKi + apremilast]) over use of monotherapy [6.3].	Conditional	Very low
Inflammatory bowel disease		
Children and adolescents with active axSpA and IBD should be co-managed with a gastroenterologist [3.3; GPS].	Good Practice Statement	Not graded
In children and adolescents with axSpA without a known history of IBD, we **strongly** recommend screening for IBD over no screening [2.7].	Strong	Very low
In children and adolescents with axSpA without a known history of IBD and without clinical findings suggestive of active IBD, we **conditionally** recommend ***against*** screening using fecal calprotectin [2.8].	Conditional Against	Very low
In children and adolescents with axSpA without a known history of IBD but with clinical findings suggestive of active IBD, we **conditionally** recommend screening using fecal calprotectin [2.12].	Conditional	Very low
In children and adolescents with active axSpA and inactive IBD, we **conditionally** recommend ***against*** use of continuous/scheduled NSAIDs over no use of NSAIDs [3.4].	Conditional Against	Very low
In children and adolescents with active axSpA and IBD (active or inactive), we **conditionally** recommend COX-II selective NSAIDs over non-selective NSAIDs [3.1].	Conditional	Very low
In children and adolescents with axSpA and IBD (active or inactive), we **strongly** recommend use of JAKi and monoclonal antibodies against TNF over other b/tsbDMARDs [3.2].	Strong	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In children and adolescents with axSpA and IBD in which either condition is active despite bDMARD or tsDMARD monotherapy, we **conditionally** recommend use of dual therapy (bDMARD + tsDMARD or two bDMARDs) over use of monotherapy [3.5].	Conditional	Very low
Nociplastic Pain		
We **conditionally** recommend ***against*** treatment with gabapentinoids over no treatment [22.1].	Conditional Against	Very low
We **strongly** recommend ***against*** treatment with SSRI/SSNI agents over no treatment [23.1].	Strong Against	Very low
We **strongly** recommend ***against*** treatment with muscle relaxants over no treatment [24.1].	Strong Against	Very low
We **strongly** recommend ***against*** treatment with opioids over no treatment [25.1].	Strong Against	Very low
We **conditionally** recommend treatment with cognitive behavioral therapy over no treatment [42.1].	Conditional	Very low
We **conditionally** recommend counseling regarding sleep hygiene over no counseling [43.1].	Conditional	Very low
We **conditionally** recommend physical therapy over no treatment with physical therapy [44.3].	Conditional	Very low

Non-Pharmaceutical Therapy		
In children and adolescents with active axSpA, we **conditionally** recommend physical therapy (PT) [44.1].	Conditional	Very low to moderate
In children and adolescents with inactive axSpA, we **conditionally** recommend physical therapy over no treatment with PT [44.2].	Conditional	Very low
We **conditionally** recommend repeat PT over a one-time course of therapy [44.4].	Conditional	Very low
In children and adolescents with active axSpA, we **conditionally** recommend active PT interventions (supervised exercise) over passive PT interventions (massage, ultrasound, heat) [45.1].	Conditional	Very low to low
In children and adolescents with active axSpA, we **conditionally** recommend aquatic PT interventions over land-based PT interventions [45.2].	Conditional	Very low

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
We **conditionally** recommend aquatic exercises over weight-bearing exercises [45.3].	Conditional	Very low
We **conditionally** recommend unsupervised back exercises over no exercise [45.4].	Conditional	Very low to Moderate
We **conditionally** recommend recreational exercises over no recreational exercise [45.5].	Conditional	Very low
We **conditionally** recommend aerobic exercises over non-specific exercises [45.7].	Conditional	Very low to low
We **conditionally** recommend stretching over non-specific exercises [45.6].	Conditional	Very low
We **conditionally** recommend yoga over non-specific exercises [45.8].	Conditional	Low
We **conditionally** recommend TENS over no TENS [40.1].	Conditional	Low
We **strongly** recommend ***against*** spinal manipulation [47.1].	Strong Against	Very low
We **conditionally** recommend ***against*** microbiome-targeted therapy [61.1].	Conditional Against	Low
We **conditionally** recommend complementary/integrative medicine modalities such as acupuncture and massage therapy over no treatment by these modalities [63.2].	Conditional	Low
We **conditionally** recommend ***against*** naturopathic, homeopathic, and ayurvedic medicine [63.1].	Conditional Against	Low
Inactive Juvenile axSpA		
In children and adolescents with inactive axSpA on an originator bDMARD, we **conditionally** recommend continuation of originator bDMARD over switching to a biosimilar bDMARD [29.1].	Conditional	Low to moderate
In children and adolescents with inactive axSpA on treatment with a b/tsDMARD and NSAIDs, we **conditionally** recommend continuation of the b/tsDMARD alone over treatment with both therapies [10.8].	Conditional	Very low
In children and adolescents with inactive axSpA on treatment with a b/tsDMARD and NSAIDs, we **conditionally** recommend on-demand NSAID treatment over continuous NSAID treatment [10.5].	Conditional	Low to moderate

RECOMMENDATION STATEMENT	STRENGTH	LEVEL OF EVIDENCE
In children and adolescents with inactive axSpA on a treatment with a b/tsDMARD and a csDMARD, we **conditionally** recommend discontinuation of the csDMARD [32.2].	Conditional	Very low
In children and adolescents with inactive axSpA on treatment with a b/tsDMARD, we **conditionally** recommend ***against*** abrupt discontinuation of the ts/bDMARD [32.1].	Conditional Against	Moderate
In children and adolescents with inactive axSpA on a b/tsDMARD, we **conditionally** recommend reducing frequency or dose (tapering) of the b/tsDMARD over maintaining the current frequency and dose [33.1].	Conditional	Low to moderate
In children and adolescents with active axSpA because of withdrawal or discontinuation of b/tsDMARDs (due to a period of prolonged inactivity), we **conditionally** recommend restarting the same agent over switching to a different agent from the same class or switching to a different agent from a different class of ts/bDMARD [35.1].	Conditional	Very low

Abbreviations: AP = anterior posterior (radiograph); **axSpA** = axial spondyloarthritis; **COX** = cyclooxygenase; **DMARD** = disease-modifying anti-rheumatic drug (**bDMARD** = biologic, **csDMARD** = conventional synthetic, **tsDMARD** = targeted synthetic); **GPS** = Good Practice Statement; **IBD** = inflammatory bowel disease; **IL** = interleukin; **JADAS** = juvenile arthritis disease activity scale; **JAKi** = janus activating kinase inhibitor; **JSPADA** = juvenile spondyloarthritis disease activity index; **MRI** = magnetic resonance imaging; **NSAID** = nonsteroidal anti-inflammatory drugs; **PICO** = population, intervention, comparison, outcome; **PT** = physical therapy; **SIJ** = sacroiliac joints; **TENS** = transcutaneous electrical stimulation; **TNFi** = tumor necrosis factor inhibitor.

GPS=Good Practice Statement

Conditionally Recommend

Strongly Recommend

Conditionally Recommend Against

Strongly Recommend Against

This summary was approved by the ACR Board of Directors on May 31, 2026. These recommendations are included in full manuscripts, which will be submitted for publication in *Arthritis & Rheumatology* and *Arthritis Care & Research*.