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## Letter to the Editor

### Remission and stringent treatment goals in psoriatic arthritis: Doctors' opinion is not enough



#### ARTICLE INFO

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Remarkable discrepancy exists between evaluation of disease activity by physicians and patients in psoriatic arthritis (PsA). In a recent study, it was found that about one-third of patients in an acceptable clinical situation judged by rheumatologists did not show the minimal disease activity (MDA) criteria [1]. It resulted clear from this study that patients felt to be in an acceptable disease state who did not meet the MDA criteria had higher levels of disease activity and this was associated with a significant impact on several PsA domains [1]. Therefore, achievement of stringent therapeutic goals is the current basis of the treat to target (T2T) approach as this is related to better outcomes [2].

We aimed to analyse the degree of agreement between remission judged by rheumatologists and treatment targets (MDA/VLDA) in patients with PsA treated with biological and non-biological systemic therapies in routine clinical practice. For this purpose, a subanalysis of the MAAPs (Spanish acronym for minimal activity in psoriatic arthritis) study was done [3]. Main study characteristics are shown in Table 1. When patients fulfilled 7/7 of MDA criteria, they were considered in very low disease activity (VLDA). In order to determine the degree of agreement between MDA/VLDA and disease remission defined by rheumatologists, the kappa ( $\kappa$ ) concordance index was used.

Of the 227 patients included, 133 (58.6%) achieved the MDA criteria and 26 (11.5%) were in VLDA. Seventy-seven patients (33.9%) were judged in joint remission. The agreement between joint remission and both treatment targets was discrete; MDA,  $\kappa$ : 0.39 (95%CI: 0.28–0.49),  $P < 0.0001$ , and VLDA,  $\kappa$ : 0.25 (95%CI: 0.14–0.37),  $P < 0.0001$ . One-hundred and forty five patients (63.9%) were judged as skin remission (including skin and nails). The agreement between cutaneous remission and both targets was insignificant; MDA,  $\kappa$ : 0.18 (95%CI: 0.05–0.31),  $P = 0.007$ , and VLDA,  $\kappa$ : 0.09 (95%CI: 0.03–0.20),  $P = 0.0072$ .

There was poor agreement between remission according to physicians' opinion and treatment objectives (MDA/VLDA) in PsA patients treated with systemic therapies in routine practice in Spain. In van Mens study, around one-third of their patients would have been considered for escalation of therapy if following a T2T

regime using MDA [1,2]. This points to a worrying reality in the management of patients with PsA in daily practice, since many rheumatologists would not estimate an escalation of treatment in patients who would surely benefit from it.

Some confounding factors (such as fibromyalgia) can lead to an overestimation of the PROs (pain, HAQ, patient's global disease activity assessment) and this way infraestimate the clinical usefulness of PsA composite indices [4]. In our study more than 75% of patients who achieved MDA met the pain VAS  $\leq 15$  criterion, whereas a global disease activity VAS score  $\leq 20$  was achieved by only 43% of them. These results indicate that there are important aspects that the patient attributes to his/her illness (for example, fatigue), which, however, are not adequately captured by the different PsA composite indices.

The achievement of well-defined treatment objectives is associated with better outcomes [2,5]. Therefore, recommendations proposed by EULAR to achieve treatment goals in timely manner should be incorporated into the routine management of these patients [6]. The therapeutic management of PsA has seen major changes over the last few years, as illustrated by the recent updates of the GRAPPA and EULAR recommendations. These changes were driven by new studies establishing important benefits from early management and tight control of disease activity. The concepts underlying the treatment of PsA must be reappraised in the light of these new data [7].

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#### Disclosure of interest

The author declares that he has no competing interest.

All patients provided their informed written consent. In accordance with the Spanish recommendations, the study was approved by the Clinical Research Ethics Committee of La Fe Hospital [(ref number: FPNT-07-14-EO (C))] and was conducted in accordance with the principles contained in the Declaration of Helsinki for studies in humans. Data were collected between May 2014 and February 2015 at the single visit of the study.

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**Table 1**  
Main characteristics and results of the MAAPs study.

	Totaln(227)	MDAn(133)	No MDAn(94)	P-values
Male, n (%)	123 (54.2)	82 (61.7)	41 (43.6)	< 0.05
Age, mean (SD), year	53.2 (12.4)	53.5 (13.3)	52.8 (10.9)	NS
Smoker, n (%)	41 (18.1)	19 (14.3)	22 (23.4)	NS
Comorbidities, n (%)				
Dyslipemia	69 (30.4)	44 (33.1)	25 (26.6)	NS
HBP	62 (27.3)	35 (26.3)	27 (28.7)	NS
Obesity	48 (21.1)	32 (24.1)	16 (17.0)	NS
DM	23 (10.1)	15 (11.3)	8 (8.5)	NS
PsA characteristics				
PsA clinical pattern, n (%)				NS
Axial	8 (3.5)	3 (2.3)	5 (5.3)	
Peripheral	189 (83.3)	113 (85.0)	76 (80.9)	
Mixed	30 (13.2)	17 (12.8)	13 (13.8)	
Familial history, n (%)				
Psoriasis	112 (49.3)	64 (48.1)	48 (51.1)	NS
PsA	28 (12.3)	10 (7.5)	18 (19.1)	< 0.05
Ankylosing spondylitis	2 (0.9)	2 (1.5)	0 (0.0)	NS
PsA duration, mean (SD), years.	9.6 (7.7)	9.80 (8.1)	9.38 (7.3)	NS
Skin symptoms duration, mean (SD), years.	22.1 (14.7)	20.6 (14.3)	24.2 (15.1)	NS
Articular symptoms duration, mean (SD), years.	12.1 (9.3)	11.8 (8.8)	12.7 (9.9)	NS
PsA status at study visit				
Radiologic findings				
Erosions in hands, n (%)	83 (36.6)	41 (30.8)	42 (44.7)	< 0.05
Joint in hands with erosion, mean (SD)	4.3 (4.2)	4.9 (4.5)	3.7 (3.9)	NS
Erosions in feet, n (%)	67 (29.5)	38 (28.6)	29 (30.9)	NS
Joint in feet with erosion, mean (SD)	3.7 (3.4)	3.9 (3.3)	3.5 (3.7)	NS
PsAID, mean (SD)	4.9 (4.5)	3.3 (3.1)	7.1 (5.2)	< 0.001
PASI, mean (SD)	1.6 (3.8)	0.9 (1.6)	2.8 (5.7)	< 0.05
BASDAI*, mean (SD)	2.8 (2.4)	2.0 (1.8)	3.6 (2.5)	< 0.001
HAQ, mean (SD)	0.8 (0.6)	0.3 (0.5)	0.5 (0.6)	< 0.001

MDA; Minimal disease activity; SD: Standard deviation; HBP: High blood pressure; DM: Diabetes mellitus; PsA: Psoriatic arthritis; PASI: Psoriasis Area and Severity Index; BASDAI: Bath Ankylosing Spondylitis Disease Activity Index; HAQ: Health Assessment Questionnaire; PsAID: Psoriatic Arthritis Impact of Disease.

\* Performed only in subjects with axial disease.

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