EXTENDED REPORT

Adding tocilizumab or switching to tocilizumab monotherapy in methotrexate inadequate responders: 24-week symptomatic and structural results of a 2-year randomised controlled strategy trial in rheumatoid arthritis (ACT-RAY)

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ABSTRACT

Objective In patients with active rheumatoid arthritis (RA) despite methotrexate, to compare the efficacy of adding tocilizumab to that of switching to tocilizumab monotherapy.

Methods Double-blind, 2-year study in which adults with active RA (DAS28 >4.4) despite methotrexate were randomly assigned either to continue methotrexate with the addition of tocilizumab (MTX+TCZ) 8 mg/kg every 4 weeks or switch to tocilizumab and placebo (TCZ+PBO). The primary endpoint was the DAS28–erythrocyte sedimentation rate (ESR) remission rate at week 24. Secondary objectives included other symptomatic outcomes, quality of life and progression of structural damage.

Results Of 556 randomly assigned patients, 512 (92%) completed 24 weeks. DAS28–ESR remission rates were 40.4% for TCZ+MTX and 34.8% for TCZ+PBO (p=0.19); American College of Rheumatology (ACR) 20/50/70/90 rates were 71.5%/45.5%/24.5%/5.8% (TCZ+MTX) and 70.3%/40.2%/25.4%/5.1% (TCZ+PBO); differences not significant. A significant difference between groups was seen for low DAS28 (61.7% vs 51.4%). Radiographic progression was small and not different between groups (Genant–Sharp score progression ≤ smallest detectable change in 91% (TCZ+MTX) and 87% (TCZ+PBO)). Rates per 100 patient-years of serious adverse events and serious infections were 21 and six, respectively, for TCZ+MTX and 18 and six, respectively, for TCZ+PBO.

Conclusion No clinically relevant superiority of the TCZ+MTX add-on strategy over the switch to tocilizumab monotherapy strategy was observed. The combination was more commonly associated with transaminase increases. Meaningful clinical and radiographic responses were achieved with both strategies, suggesting that tocilizumab monotherapy might be a valuable treatment strategy in suitable RA patients.

Persistent inflammation at the level of the joint (synovitis and osteitis) or the whole body (reflected in acute phase reactants) is among the most important predictors of subsequent structural deterioration.1 Inflammation is also responsible for symptoms such as pain, fatigue and disability that impair the patient’s quality of life.2 Structural deterioration can be evaluated over months using radiological scoring systems.3 Therefore, the short-term objective of RA treatment is to improve the patient’s condition by abrogating inflammation and by sustaining this, thereby achieving the longer term objective of stopping radiological progression.4

Methotrexate is considered the cornerstone of RA therapy to achieve this goal. When there is inadequate disease control with methotrexate alone, the current recommendation is to add a tumour necrosis factor blocker or another approved biological agent.4 However, as evidenced by registries of routine clinical practice treatment, approximately one third of RA patients are being treated with biological monotherapy, that is without concomitant methotrexate.5 6 There are many reasons for stopping methotrexate or initiating biological agents as a monotherapy. In daily practice, frequent methotrexate-induced gastrointestinal disorders (eg, nausea) have been reported as leading to poor patient compliance. Moreover, the use of methotrexate may lead to other safety issues such as haematological and hepatic adverse events. Such limitations explain why it is important to evaluate a switch strategy to biological monotherapy in addition to traditional add-on strategies (ie, the addition of a biological agent to methotrexate).

Tocilizumab, a humanised anti-human interleukin-6 receptor monoclonal antibody8 has proved its efficacy and safety in RA patients continuing to receive methotrexate9 10 and as biological monotherapy.11 The latter is supported by data from a head-to-head trial showing that tocilizumab was more efficacious than methotrexate in patients who had not failed previous treatment with methotrexate or biological agents.12 Because methotrexate is the current recommended first-line therapy, the question arises as to whether tocilizumab should...
be added to methotrexate (add-on strategy) or methotrexate could be stopped when commencing tocilizumab (switch strategy) in patients with inadequately controlled disease. The only data comparing the two strategies is from a phase II study with a small sample size and no structural outcome measures to indicate the superiority of the add-on strategy.\(^3\)

We therefore conducted a 2-year trial with the objective of assessing the efficacy and safety profile of either adding tocilizumab to methotrexate or switching methotrexate to tocilizumab monotherapy in patients with persistent active disease despite methotrexate therapy. Here, we report the first 24-week clinical and radiological data.

**PATIENTS AND METHODS**

**Study design**

This report covers the planned analysis of the first 24 weeks (including the primary endpoint) of an on-going 2-year double-blind placebo controlled parallel-group clinical trial (NCT00810199, EudraCT no 2008-001847-20). The treatment allocation of individual patients remained blinded for patients, site personnel and the data analysis/interpretation team, except for the separate subgroup technically preparing the data.

The study was approved by the appropriate institutional review boards/ethics committees with written informed consent obtained from each patient before study participation. The study was conducted in full accordance with International Conference on Harmonisation/good clinical practice and the principles, laws and regulations of the countries in which the research was conducted.

**Patients**

Eligible patients had confirmed RA according to the 1987 American College of Rheumatology (ACR) criteria with active disease defined as disease activity score based on 28 joints–erythrocyte sedimentation rate (DAS28–ESR) greater than 4.4 at baseline and 4.0 or more at screening, and had been receiving methotrexate for at least 12 weeks, with a stable dose of at least 15 mg/week for 6 weeks or longer before starting study treatment. For inclusion, patients were also required to have bone damage with radiographic evidence of at least one joint with definite erosion attributable to RA as determined by a central reader. Major exclusion criteria included severe comorbidities, any previous use of biological agents as well as any conventional disease-modifying antirheumatic drug treatment other than methotrexate during the month (3 months for leflunomide) preceding the baseline visit (see supplementary data, available online only, for full inclusion and exclusion criteria).

**Study treatment**

Patients were randomly assigned either to the add-on or the switch strategy group (see supplementary data, available online only, for study design schematic). Randomisation was stratified by study site and baseline DAS28–ESR (≤ 5.0 or >5.0) using a minimisation algorithm. All patients received open-label tocilizumab 8 mg/kg intravenously every 4 weeks. Treatment with methotrexate/placebo was double-blind: all patients received identical capsules of either placebo (switch strategy arm) or methotrexate 2.5 mg (add-on strategy arm), with the number of capsules at study entry being consistent with pretreatment dosage. Tocilizumab and/or disease-modifying antirheumatic drug treatment was reduced or temporarily interrupted in patients with alanine aminotransferase or aspartate transaminase values greater than one to three times the upper limit of normal (ULN), and was discontinued for persistent increases greater than three times ULN.

**Concomitant RA treatments**

Oral corticosteroids (≤10 mg/day prednisone or equivalent) and non-steroidal anti-inflammatory drugs were permitted as long as doses had been stable for at least 25 of 28 days before the start of study treatment. Alterations in the non-steroidal anti-inflammatory drug dose were not recommended during the study, particularly during the first 24 weeks. The corticosteroid dose could not be changed during the first 24 weeks of the study.

**Collected patient data and assessments**

Data collected at baseline included demographics and disease characteristics such as RA disease duration. At baseline and every 4 weeks thereafter the following parameters were assessed: tender joint count, swollen joint count, health assessment questionnaire–disability index (HAQ–DI), patient’s global assessment, physician’s global assessment, C-reactive protein (CRP), ESR. Quality of life was assessed at baseline and at weeks 4, 8, 12 and 24 using the rheumatoid arthritis quality of life questionnaire (RAQoL). At each visit, patients were monitored for adverse events, vital signs and laboratory tests (eg, blood counts, transaminases, cholesterol). Radiographs of the hands/ wrists and feet were obtained at baseline and week 24. Each radiograph was assessed applying the Genant-modified Sharp scoring system (GSS) by two independent readers (Perceptive Informatics Medical Imaging Services, Berlin, Germany) who were blinded to treatment assignment, chronological order of radiographs and patient’s clinical status. The smallest detectable change (SDC) for GSS was computed based on the observed SD of difference between the x-ray readers,\(^3\) whereas three readers in total participated in the campaign. The SDC is the smallest change that can be attributed to something more than observed variability of reader differences.

**Statistical analysis**

The clinical superiority of the tocilizumab plus methotrexate combination treatment in the phase II CHARISMA study\(^3\) had an important influence on the statistical parts of the design.

To assess the working hypothesis that the add-on strategy (ie, initiation of tocilizumab plus continuation of methotrexate) would be superior to the switch strategy (ie, initiation of tocilizumab and discontinuation of methotrexate), the primary outcome measure of the study was defined as the percentage of patients in remission according to DAS28–ESR (DAS28 <2.6) at week 24. A two-sided statistical test of no difference between the two treatment arms at the 5% significance level was used. Specifically for the primary endpoint, as well as for similar endpoints, a logistic regression model was employed including the stratification factors used at randomisation (site and baseline DAS28 ≤ 5.0 or >5.5) with a supportive Cochran–Mantel–Haenszel test stratified for the same parameters. Analysis of covariance models were used to compare continuous outcome measures.

Efficacy analyses were conducted in the intention-to-treat population (all randomly assigned and treated patients analysed in the arm they were randomly assigned to) with non-responder imputation for categorical variables (eg, DAS28 remission, ACR response), last observation carried forward until patient withdrawal for missing joint counts and no additional imputation of missing values.

The target sample size (255 patients per arm) was computed to provide 80% power to detect a 12.5% treatment effect
difference between an expected 42.5% DAS28 remission rate at week 24 in the add-on strategy arm versus 30% in the switch strategy arm. This difference (12.5%) was deemed to be clinically relevant by the study’s steering committee (see supplementary data, available online only).

The following additional endpoints were analysed in accordance with the European League Against Rheumatism (EULAR)/ACR collaborative recommendations for reporting RA disease activity in clinical trials:

(1) Other outcome measures at week 24 included mean changes in DAS28–ESR and in selected variables (eg, swollen joint count, tender joint count, ESR, CRP, HAQ–DI, RAQoL); percentage of patients who improved during the 24 weeks of the study according to ACR20/50/70/90, EULAR response and the percentage of patients with DAS28 ≤3.2 (low disease activity state). Remission as defined by the 2010 ACR–EULAR criteria (Boolean definition), simplified disease activity index ≤3.3 and clinical disease activity index ≤2.8 were analysed post hoc.

(2) To approach the concepts of onset of action and sustainability, changes over time of selected variables such as joint counts, CRP, pain and HAQ–DI were evaluated.

(3) The domain fatigue was evaluated using question 21 of the RAQoL questionnaire.

(4) Radiographic endpoints included changes from baseline in total GSS, erosion and joint space narrowing scores and the proportion of patients with no radiographic progression (progression defined as change in GSS >SDC or >0).

Safety endpoints included the incidence of adverse events (AE), serious AE, serious infections and specific laboratory abnormalities, which were analysed in the safety population (all treated patients with at least one post-dose assessment of safety, analysed according to the treatment received).

RESULTS
Patient flow and baseline characteristics
Figure 1 summarises the flow of patients. The predominant reason for screening failure (n=308) was the absence of radiological erosions (40% of screening failures). Five hundred and fifty-six patients were recruited, exceeding the target of 470 patients. This larger sample size increased the precision of the estimates.

Of the 556 randomly assigned patients, 512 (92%) completed the first 24 weeks of the trial. There were no clinically significant differences between the groups in the baseline characteristics except for a potentially relevant difference in GSS (table 1).

Clinical efficacy
The main efficacy results at week 24 are summarised in figure 2 and table 2 (also see supplementary data, available online only). Patients received mean weekly doses of methotrexate/placebo ranging from 15.2 to 15.9 mg/week and 15.8 to 16.3 mg/week.

Table 1  Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>TCZ + MTX (N=277)</th>
<th>TCZ + PBO (N=276)</th>
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<tbody>
<tr>
<td>Women, n (%)</td>
<td>227 (81.9)</td>
<td>217 (78.6)</td>
</tr>
<tr>
<td>Age (years), mean (SD)</td>
<td>53.0 (13.4)</td>
<td>53.6 (11.9)</td>
</tr>
<tr>
<td>Patients aged ≥65 years, n (%)</td>
<td>53 (19.1)</td>
<td>52 (18.8)</td>
</tr>
<tr>
<td>BMI, kg/m², mean (SD)</td>
<td>26.3 (5.20)</td>
<td>26.5 (5.14)</td>
</tr>
<tr>
<td>Duration of RA, years, mean (SD)</td>
<td>8.2 (8.0)</td>
<td>8.3 (8.4)</td>
</tr>
<tr>
<td>Categorical duration of RA in years, n (%):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2</td>
<td>51 (18.4)</td>
<td>66 (23.9)</td>
</tr>
<tr>
<td>≥2 to &lt;5</td>
<td>76 (27.4)</td>
<td>68 (24.6)</td>
</tr>
<tr>
<td>≥6 to &lt;10</td>
<td>66 (23.8)</td>
<td>63 (22.8)</td>
</tr>
<tr>
<td>≥10</td>
<td>84 (30.3)</td>
<td>79 (28.6)</td>
</tr>
<tr>
<td>Swollen joint count, mean (SD)</td>
<td>14.4 (8.9)</td>
<td>15.3 (10.2)</td>
</tr>
<tr>
<td>Tender joint count, mean (SD)</td>
<td>25.8 (13.9)</td>
<td>26.6 (15.2)</td>
</tr>
<tr>
<td>DAS28–ESR, mean (SD)</td>
<td>6.33 (0.98)</td>
<td>6.36 (1.00)</td>
</tr>
<tr>
<td>HAQ–DI, mean (SD)</td>
<td>1.46 (0.66)</td>
<td>1.48 (0.60)</td>
</tr>
<tr>
<td>HAQ–DI &lt;0.5, n (%)</td>
<td>17 (6.2)</td>
<td>14 (5.2)</td>
</tr>
<tr>
<td>Genant-modified Sharp score, mean (SD)</td>
<td>30.4 (31.8)</td>
<td>37.1 (40.5)</td>
</tr>
<tr>
<td>Methotrexate dose, mg/week, mean (SD)</td>
<td>16.0 (4.4)</td>
<td>16.2 (4.1)</td>
</tr>
<tr>
<td>Methotrexate dose, mg/week, median</td>
<td>15.0</td>
<td>15.0</td>
</tr>
<tr>
<td>No of previous DMARD (including methotrexate before study entry), mean (SD)</td>
<td>1.9 (1.1)</td>
<td>1.9 (1.0)</td>
</tr>
<tr>
<td>Oral steroid use, n (%)</td>
<td>136 (49.1)</td>
<td>135 (48.9)</td>
</tr>
<tr>
<td>Folic acid use, n (%)</td>
<td>215 (77.6)</td>
<td>224 (81.2)</td>
</tr>
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</table>

BMI, body mass index; DMARD, disease-modifying antirheumatic drug; DAS28–ESR, disease activity score based on 28 joints–erythrocyte sedimentation rate; HAQ–DI, health assessment questionnaire–disability index; MTX, methotrexate; PBO, placebo; RA, rheumatoid arthritis; TCZ, tocilizumab.
for the tocilizumab plus methotrexate and tocilizumab plus placebo groups, respectively. Both treatment strategies showed a highly relevant clinical treatment effect. The study did not demonstrate a statistically significant difference between the two groups in DAS28–ESR remission rates (primary endpoint). The actual absolute difference between groups (5.65%, 95% CI –2.41% to 15.71%, p=0.19) was much smaller than what had been considered clinically relevant a priori (12.5%). For other endpoints, the differences between the treatment groups at week 24 were mostly not statistically significant and/or small, but with a numerical trend towards superiority of the add-on strategy. The difference between groups in the proportion of

Figure 2  Binary composite indices and radiographic results at week 24 (intent-to-treat population). (A) Patients achieving remission (DAS28 <2.6), (B) low disease activity (DAS28 ≤3.2), (C) good or moderate European League Against Rheumatism responses, (D) ACR responses, (E) patients (%) with no radiographic progression in total GSS, and (F) cumulative distribution of change from baseline in total GSS. Dashed lines indicate smallest detectable change with data falling between these lines representing no change. ACR, American College of Rheumatology; DAS28, disease activity score based on 28 joints; GSS, Genant-modified Sharp Score; MTX, methotrexate; NS, not significant; PBO, placebo; TCZ, tocilizumab.
patients achieving low disease activity (DAS28–ESR <3.2) was 10.3% (p=0.029).

Fatigue, as assessed by the proportion of patients answering ‘yes’ to question 21 of the RAQoL questionnaire (‘I feel tired whatever I do’) affected 75.6% and 73.3% of patients at baseline (add-on vs switch, respectively, p=0.79) and 51.9% and 50.0% at week 24 (p=0.68). Clinical parameters and CRP improved rapidly in both groups (figure 3A–D). For these variables a sustained or continuously increasing effect size was observed in both treatment groups through the first 24 weeks of the study.

Progression of structural damage
There were no statistically significant intergroup differences in any of the evaluated continuous outcome measures (table 2, figure 3E). The SDC from baseline in GSS was 1.5, indicating a high agreement of the readings, therefore allowing for the detection of changes from baseline less than −1.5 and greater than 1.5. Radiographic progression was defined in two ways: any change in GSS greater than zero or greater than SDC. Based on the second definition the proportion of patients with no radiographic progression was 87.3% and 90.6% (GSS ≤SDC) in the tocilizumab plus placebo and tocilizumab plus methotrexate groups, respectively, and was generally very low in those patients who still had progressive structural damage. The changes from baseline in total GSS at week 24 were distributed similarly in the two groups (figure 2F).

Safety
A safety overview is presented in table 3. Overall rates per 100 patient-years of AE and serious AE were similar between groups. A total of 17 patients (6.1%) in the tocilizumab plus methotrexate group and 16 patients (5.8%) in the tocilizumab plus placebo group experienced serious AE, the most common of which were infections (seven events in each group) and cardiac disorders (three and four events in the two groups, respectively). There was a total of three deaths in the first 24 weeks and a fourth patient died from an AE that started within the first 24 weeks (two each in either group). The causes of death in these four patients were: sepsis; septic shock preceded by scrotal abscess, skin necrosis, acute renal failure and congestive heart failure; myocardial infarction; and sepsis with meningitis. AE-related discontinuations and dose modifications occurred in 28.8% of tocilizumab and in 19.2% and 0.4% (tocilizumab plus placebo) of patients, respectively, indicating a trend towards lower rates of liver enzyme elevations with tocilizumab monotherapy. As seen in previous studies with tocilizumab and also with other anti-inflammatory treatments, mean total cholesterol levels increased from 93.1 and 92.7 mg/dl at baseline to 102.4 and 103.5 mg/dl at week 24 in the tocilizumab plus methotrexate and tocilizumab plus placebo groups, respectively.

DISCUSSION
This study evaluated two different tocilizumab-based treatment strategies in patients with active RA and suggests that a clinically relevant effect with arrest of structural progression is observed at 24 weeks with both treatment strategies in the majority of patients. The study did not succeed at demonstrating that add-on strategy efficacy (combination therapy of tocilizumab plus methotrexate) was superior to the switch strategy (monotherapy tocilizumab plus placebo), although there were numerically small and not clinically meaningful differences in the primary and some secondary efficacy endpoints in favour of combination therapy. No differences were observed in safety, the exception being that the add-on strategy resulted in a numerically higher percentage of patients who had transaminase level increases compared with the switch strategy.
This is the first study comparing the efficacy and safety of tocilizumab in combination with methotrexate and as monotherapy in inadequate responders to methotrexate with a sufficient sample size to address this question prospectively. The primary outcome measure (DAS28–ESR remission rate at 24 weeks) did not differ significantly between the two strategies. With the exception of the proportion of patients with low disease activity (DAS28–ESR <3.2) at 24 weeks, the secondary efficacy analyses supported the primary endpoint by not showing a between-group statistically significant difference. This interpretation is also supported by the changes over time in individual parameters (figure 2). Looking at the overall picture across different endpoints and time points there was a trend towards slightly higher responses with the add-on strategy (e.g. 5.6% difference in DAS28 remission and 3.3% difference in patients with no radiological progression greater than SDC). Looking at the effect sizes and the fact that most of the differences are not statistically significant the trend in favour of the add-on strategy is considered clinically not meaningful.

As the study did not succeed at demonstrating the superiority of the add-on versus the switch strategy, we discuss here factors that could potentially have biased the study outcome, before

Figure 3 Changes from baseline in selected American College of Rheumatology core set variables over time (intent-to-treat population). (A) Mean change from baseline for swollen joint counts, (B) tender joint counts, (C) patient’s global assessment of pain, (D) HAQ–DI, (E) ESR and (F) CRP. CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; HAQ–DI, health assessment questionnaire–disability index; MTX methotrexate; TCZ, tocilizumab; VAS, visual analogue scale.
rej ecting the cl ini ca l study hy pothesis. The study was po wered to det ect a 12.5% di f f erence in DAS28–ESR rem is sion rates at week 24 between the two ar ms, which is the mini mum di f f erence that the sci ent if ic steerin g com mi ttee con sidered to be cl ini ca lly meanin gful. This cho ice was suppo rted by CHARISMA, a pha se II do se-fi ndi ng study, which indi cated that com bi nation ther apy of toc iliz umab with meth ot rexa te might be supe ri or to mono ther apy (eg, DAS28 rem is sion at week 16 ac hieved by 34% of com bi na tion ther apy and 17% of mon o ther apy pa tients).13,14 Bas ed on the num ber of pa tients actu ally ran domly as signed and the ob served rem is sion rate in the toc iliz umab plus placebo arm the study was factually able to det ect a di f f erence of approxi mately 11% be tween the two strate gies and as such had ade quate dis cri mi na tive po wer for a re lev ant treat ment di f f erence. The pa tients were se lected based on the es tab lished de fini tion of RA and their ba se line char ac ter is tic es were in con cor dance with ear li er studies with toc iliz umab or oth er bi o logi cal agents, and were well bal an ced be tween the treat ment ar ms. The only no t able excep tion was ba se line GSS, which showed more ad vanced struc tu ral dam age in the switch group.

The do ses of both me tho trexa te/placebo and toc iliz umab were in line with ap proved la be ls. Fur ther more, the me tho trexa te/placebo do ses were simi lar be tween trial ar ms (table 1) and con sistent with pre vi ous cl ini cal trials evalu at ing com bi na tion meth ot rexa te plus bi o logi cal agent ther apy15–20 as well as with com monly pre sc ripted meth ot rexa te do ses in clini cal practice.21–23 How ever, me tho trexa te/placebo do ses were lo wer than in so me cur rent recom men dations for the op ti mi sa tion of meth ot re xa te.24,25

In the ab sen ce of an y meth o do lo gi cal bias that could have artifi cially re duced the di f f erence in ef fi cacy be tween the two ar ms, we con clude that the an s er to the quest ion as ked in the study ‘Is the add-on strategy supe rior to the switch to mono ther apy strat egy?’ is ‘no’ so that one could sug gest that both strate gies pro vide a similar ben efit in terms of clini cal and struc tu ral out comes.

Sa fe ty out com es were simi lar in the two ar ms, ex cept for a nu merically higher rate of in creased trans ami nase lev els with the add-on strategy. Over all, the inci dence of ev ents such as se rious AE, se rious infections and dis con tin uations was simi lar be tween the add-on and switch strate gies, con sistent with pre vious toc iliz umab stud ies.

The da ta ob served in this study sug gest that toc iliz umab mono ther apy may be a va lu able treat ment strat egy for cer tain RA pa tients re quiring bio logi cal agen ts. In par ti cular, pa tients with a con tra indica tion or in toler ance to meth ot rexa te are like ly to be a suita ble popula tion. Fur ther con fi rmation of these da ta is re quired, in clus ing through the lon ger term ob servation of the pa tients re cruited for this study as well as ad di tional studies in other pa tient sets in clud ing the eva lu a tion in daily pr ac tice via re gis tries.

Contributors MD, KK, PPT, PGC, EMS, GS, CB and TWJH de signed the study and ana ly sed and in ter preted the data. MD, TS, PPT, PGC, EMS, GS, HA, FNS, AH and TWJH al ong with oth er inves ti gators were in vol ved in gen erat ing the data at their cli nical re se arch sites. All au thors were in vol ved in writ ing the man u script and ap proved it.

Funding The ACT-RAY study was funded by F Hoff man-La Roche Ltd, Basel, Swit zer land (Roche). Roche was in vol ved in de vel op ing the study de sign, in the ana ly sis and inter pret ation of the data, in the writ ing of the re port, and in the de cision to sub mit the pa per for pub li ca tion, through Roche em ployees, con tract ors and fund ing of third par ty sup port such as con tract re search or gan is a tions. All these ac tivi ties hap pened in close col labora tion with the ex ternal mem bers of the sci ent ific steerin g com mi ttee.

Com pet ing in terests MD has par ti pated in sym po sium and ad vis ory boards or ga nised by Roche and re ceived con sulting fees and his de part ment has re ceived re search grants from Roche for con duct ing clin ical tri als and/or clin ical epi de mi o lo gi cal studies. KK is an em ployee of F Hoff man-La Roche. TS re ceived con sulting fees and re search grants from Roche. PPT’s de part ment has re ceived Roche funds as grants and con sulting fees or ho norarium. PPT is an em ployee of and has stock/stock op tions for G ai o Smith Ki line. PGC has re ceived re search grants from Centocor Inc and Roche and has been a spea ker for Astra Zeneca, Biob erica, Bristol-My sers Squibb, Centocor Inc, Merck Philip Hen es, Novarits Pharma ce utical Cor poration, Pfizer and Roche. EMS has re ceived con sulting fees and been an ed uca tional lec turer for Abbott Im mu no lo gy, Roche MSD, Pfizer and UCB. GS re ceived consul ting fees from Roche. FNS has con sulted for Pfizer, UCB, Abbott and Roche and has been a spea ker for Roche, Pfizer, Abbott and MSD, and his de part ment has re ceived re search grants from Roche, Pfizer and Abbott. AH has no com peting in terests to re port. CB is a con tract or of F Hoff man-La Roche. TWJH has re ceived con sulting fees and has been a spea ker for Abbott Im mu no lo gy, Axis Shield Di agnostics, Bioc at Biog enc, Bristol-My sers Squibb, Crescendo Bi o scien ce, Roche, No varits Pharm ace uticals, Schering-Plough, UCB and Wyeth-Pfi zer.

Ethics ap proval The study was ap proved by the ap pro pri ate in stitutional re view boards/ethics com mittees.

Pa tient con sent O btained.

Provenance and peer re view Not com missioned; ex te rnally peer re viewed.

Table 3 Overview of adverse events, deaths, and liver enzyme elevations* until week 24

<table>
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<tr>
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<th>TCZ+MTX</th>
<th>TCZ+PBO</th>
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<tbody>
<tr>
<td>N=277</td>
<td>N=276</td>
<td></td>
</tr>
<tr>
<td>Total tocilizumab exposure (PY)</td>
<td>118.31</td>
<td>116.40</td>
</tr>
<tr>
<td>AE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total patients with ≥1 AE, % (n)</td>
<td>70.0% (194)</td>
<td>72.5% (200)</td>
</tr>
<tr>
<td>Total no of AE</td>
<td>581</td>
<td>544</td>
</tr>
<tr>
<td>Rate of AE (per 100 PY)</td>
<td>491</td>
<td>467</td>
</tr>
<tr>
<td>Serious AE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total patients with ≥1 serious AE, % (n)</td>
<td>6.1% (17)</td>
<td>5.8% (16)</td>
</tr>
<tr>
<td>Total no of serious AE</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Rate of serious AE (per 100 PY)</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Serious infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total patients with ≥1 serious infections, % (n)</td>
<td>2.2% (6)</td>
<td>2.2% (6)</td>
</tr>
<tr>
<td>Total no of infections</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Rate of serious infections (per 100 PY)</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total no of deaths</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>ALT elevations, % (n)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;ULN–1.5 x ULN</td>
<td>N=244</td>
<td>N=243</td>
</tr>
<tr>
<td>&gt;1.5–3 x ULN</td>
<td>25.8% (63)</td>
<td>16.5% (40)</td>
</tr>
<tr>
<td>&gt;3–5 x ULN</td>
<td>15.2% (37)</td>
<td>9.9% (24)</td>
</tr>
<tr>
<td>&gt;5 x ULN</td>
<td>5.3% (14)</td>
<td>0.8% (12)</td>
</tr>
<tr>
<td>AST elevations, % (n)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;ULN–1.5 x ULN</td>
<td>N=257</td>
<td>N=250</td>
</tr>
<tr>
<td>&gt;1.5–3 x ULN</td>
<td>21.8% (56)</td>
<td>14.8% (37)</td>
</tr>
<tr>
<td>&gt;3–5 x ULN</td>
<td>10.5% (27)</td>
<td>4.0% (10)</td>
</tr>
<tr>
<td>&gt;5 x ULN</td>
<td>1.9% (5)</td>
<td>0.4% (1)</td>
</tr>
<tr>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td></td>
</tr>
</tbody>
</table>

*Cumulative incidences weeks 1–24, excluding patients with elevations at baseline.

Data including non-fasting samples.

An additional patient in this group had an adverse event leading to death but died only after the 24-week cut-off.

Number of patients with a normal baseline and the highest value in the first 24 weeks within the indicated range. ULN=55 U/l for ALT and 40 U/l for AST.

Number of patients with normal value at baseline.

AE, adverse event; ALT, alanine aminotransferase (glutamate pyruvate transaminase); AST, aspartate aminotransferase (glutamate oxaloacetate transaminase); MTX, methotrexate; PBO, placebo; PY, patient years; TCZ, tocilizumab; ULN, upper limit of normal.

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