**Supplementary Material B**

For the sake of clarity, we do not present all details of the discussion around individual overarching principles or recommendations in the main body of the manuscript. To yet capture these details so they are not lost, particularly with respect to future update of these recommendations, these discussion points are presented here.

*Overarching principles*

C. *SpA and PsA are multifaceted systemic diseases; the management of musculoskeletal and extra-articular manifestations should be coordinated, as needed, between the rheumatologist and other specialists (such as dermatologists, gastroenterologists, ophthalmologists).*

Further points discussed: SpA and PsA are caused by a combination of genetic, environmental and lifestyle factors, of which some have not yet been identified and may differ among the disease manifestations; therefore, “multifaceted” was proposed to replace “complex”. Secondly, as a minor change, “as needed” was shifted to the centre from the beginning of the second part of this principle. There was also discussion on whether “extra-articular” should be replaced by “extra-musculoskeletal”, but the view prevailed that the phrase “extra-articular” has always been understood as inner organ rather than skeletal (i.e. joints and related structures) manifestations. Some task force members mentioned – also during the manuscript development process – that for them enthesitis was an articular feature; *sensu strictu* the entheses are not part of a joint, as exemplified by the Leeds Enthesitis Index,1 and are even considered as “enthesis organ”;2, 3 dactylitis, while often a pan-digital inflammation, is associated with tenosynovitis that may be occasionally present even in the absence of articular synovitis;4, 5 and axial involvement is usually separated from that of peripheral joints. However, clearly they are musculoskeletal symptoms of the disease. We will therefore refer to these as “non-articular musculoskeletal manifestations” for the sake of semantic consistency.

*Recommendations*

*1. The treatment target should be clinical remission/inactive disease of musculoskeletal (arthritis, dactylitis, enthesitis, axial disease) and extra-articular manifestations.*

Further points discussed: Listing these features does not imply that rheumatologists must focus on the treatment of extra-articular (i.e. organ) manifestations, as these may be managed by other specialists, in line with overarching principle C. Further, as also mentioned in 2012, “remission” and “inactive disease” were seen as synonymous, since given overarching principle E, abrogation of inflammation is important and means reversing disease activity. Importantly, this recommendation addresses a general theme and not any particular measure or score; these are dealt with in subsequent items.

*2. The treatment target should be individualised based on the current clinical manifestations of the disease; the treatment modality should be considered when defining the time required to reach the target.*

Further points discussed: There is currently still no evidence in terms of respective strategic trials that individualisation of the treatment target on the basis of clinical manifestations has any advantage; however, this was assumed by the task force, since for example significant skin involvement in addition to joint involvement may elicit a different drug strategy than arthritis with just little cutaneous manifestations or major skin disease with low arthritic activity.6, 7 The focus on the individual was more highlighted in the 2014 update of the T2T recommendations for RA by moving the respective recommendation upward, from item 9 to item 5.8 Moreover, real life data from the Norwegian DMARD registry have shown that discordance between patient’s and physician’s evaluations of disease activity may reduce likelihood of achieving remission both in RA and PsA.9

*3. Clinical remission/inactive disease is defined as the absence of clinical and laboratory evidence of significant disease activity.*

Further points discussed: One may be concerned if a patient had high CRP in the absence of clinical activity.10 An additional discussion point related to the term “significant”. However, it was agreed in the deliberations that the presence of one residual tender and/or swollen joint or minimal residual axial pain should not preclude a patient viewed as being in remission. Similar judgement should apply to enthesitis and psoriasis. Finally, the previous version used the term “inflammatory disease activity”, but since disease activity is always “inflammatory” in the current context and inflammation was already addressed in the overarching principles, it was decided by simple majority vote to delete this adjective.

*4. Low/minimal disease activity may be an alternative treatment target.*

Additional discussion points: While the TICOPA trial showed better clinical, functional and quality of life outcomes when targeting MDA compared with a non-steered approach, radiographic changes, an important separate outcome, were not different between treatment groups.11 This may be a consequence of the design in which both groups received active therapy in early disease, but it cannot be excluded that a T2T approach may not be superior to routine care for important endpoints.

**Reference List**

 1. Healy PJ, Helliwell PS. Measuring clinical enthesitis in psoriatic arthritis: assessment of existing measures and development of an instrument specific to psoriatic arthritis. Arthritis Rheum 2008;59:686-691.

 2. McGonagle D, Tan AL. The enthesis in psoriatic arthritis. Clin Exp Rheumatol 2015;33(5 Suppl 93):S36-S39.

 3. Benjamin M, McGonagle D. The enthesis organ concept and its relevance to the spondyloarthropathies. Adv Exp Med Biol 2009;649:57-70.

 4. Olivieri I, Barozzi L, Favaro L et al. Dactylitis in patients with seronegative spondylarthropathy. Assessment by ultrasonography and magnetic resonance imaging. Arthritis Rheum 1996;39(9):1524-1528.

 5. Tan AL, Fukuba E, Halliday NA, Tanner SF, Emery P, McGonagle D. High-resolution MRI assessment of dactylitis in psoriatic arthritis shows flexor tendon pulley and sheath-related enthesitis. Ann Rheum Dis 2015;74(1):185-189.

 6. Coates LC, Kavanaugh A, Mease PJ et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. Arthritis Rheumatol 2016;68(5):1060-1071.

 7. Gossec L, Smolen JS, Ramiro S et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. Ann Rheum Dis 2016;75(3):499-510.

 8. Smolen JS, Breedveld FC, Burmester GR et al. Treating rheumatoid arthritis to target: 2014 update of the recommendations of an international task force. Ann Rheum Dis 2016;75(1):3-15.

 9. Michelsen B, Kristianslund EK, Hammer HB et al. Discordance between tender and swollen joint count as well as patient's and evaluator's global assessment may reduce likelihood of remission in patients with rheumatoid arthritis and psoriatic arthritis: data from the prospective multicentre NOR-DMARD study. Ann Rheum Dis 2016;76(4):708-711.

 10. Poddubnyy D, Haibel H, Listing J et al. Baseline radiographic damage, elevated acute-phase reactant levels, and cigarette smoking status predict spinal radiographic progression in early axial spondylarthritis. Arthritis Rheum 2012;64(5):1388-1398.

 11. Coates LC, Moverley AR, McParland L et al. Effect of tight control of inflammation in early psoriatic arthritis (TICOPA): a UK multicentre, open-label, randomised controlled trial. Lancet 2015;386(10012):2489-2498.