

Response to: 'Evidence for treating rheumatoid arthritis to target: results of a systematic literature search update' by Goswami *et al*

We thank the authors of the letter¹ for their comments on our systematic literature review (SLR)² that aimed to compare a target-oriented approach with routine management in the treatment of rheumatoid arthritis to allow an update of the treat-to-target (T2T) recommendations.³ In addition to clinical, functional and structural changes as endpoints, comorbidities, cardiovascular risk, work productivity and education as well as patient self-assessment were investigated as outcomes in our SLR. Furthermore, our SLR aimed to update the literature review conducted by Schoels *et al*,⁴ which was performed in 2009. Therefore, we included studies published from 2009 to 2014.

We did not explicitly look into cost-effectiveness of biologic disease modifying antirheumatic drugs. The T2T activity is generic in nature. Therefore, it does not relate to any particular drug or class of therapies and thus also not to costs. T2T can and, in our view, should be implemented irrespective of the accessibility of certain agents. It should be borne in mind, that using a T2T strategy one can see very similar results with methotrexate (MTX) plus glucocorticoids as can be seen with a biological plus glucocorticoids.⁵ Also, reinstatement of a disease modifying antirheumatic drug that has failed may, at times, be successful because the modalities of application or the responsiveness of a given patient may have changed.⁶

The application of specific drugs and/or their sequence is a topic for management recommendations, as has already been done by European League Against Rheumatism (EULAR),⁷ and is not addressed by the T2T task force. Rather, the focus of our updated literature search was to describe the results of studies that addressed specific populations and endpoints, such as comorbidities, cardiovascular risk, work productivity, education and self-assessment, or patients with long-standing disease. To this end, it was important to decide, when a strategy aiming at a specific target is useful and recommendable and when it may have limitations. We believe that the updated version of the recommendations provides this information.

We agree with the authors of the letter¹ that it would be an important topic for further research to investigate cost-effectiveness in different regions of the world and also to take into account factors specific to certain countries/regions. Indeed, an approach to define environmental factors relevant to different regions of the world has been provided by the WHO in the International Classification of Functioning, Disability and Health.⁸ We also agree that national and international organisations should engage themselves with these topics in health services research. However, this is beyond the scope of the generic question addressed in our activity, namely if T2T is useful and where it may have its limitations. Of note, in many discussions, the aspect of costs is used to defend why T2T cannot be implemented in certain regions or countries, and this is exactly what is contrary to the intention of the recommendations and the

search underlying them. T2T can be implemented everywhere and used in accordance with the possibilities available locally at any point in time for the benefit of the patients. Adhering to T2T will always improve the patients' outcome, even if the target may not be achievable in all of them.

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