Response to: 'Depression and anxiety associate with less remission after 1 year in rheumatoid arthritis' by Boer *et al*

We thank Boer *et al* for their interesting report[1] validating our findings of depression and anxiety as strong negative predictors of remission in rheumatoid arthritis (RA).[2]

Depression and anxiety are frequent disorders among patients with inflammatory arthritides,[3 4] and emphasis on these conditions may be important in a treat-to-target strategy, not only in the shared decision-making of a treatment target between patient and rheumatologist, but also in the decision of type of treatment target. That is, as baseline depression and anxiety are found to be associated with more subjectively weighted measures, but not acute phase reactants and swollen joint count during follow-up,[1 2] alternative (composite) measures of disease activity as well as target values should be considered, in accordance with recommendation number 5 in the treat-to-target recommendations.[5]

Boer *et al* used Disease Activity Score 44 remission, and we used Disease Activity Score 28, Simplified Disease Activity Index, Clinical Disease Activity Index, American College of Rheumatology/European League Against Rheumatism Boolean and modified Disease Activity index for PSoriatic Arthritis remission (patients with psoriatic arthritis were also included in our study), with similar findings of baseline depression and anxiety as strong negative predictors of remission. Subjective weighted measures (patients' global assessment, tender joint count, pain) are included in all these composite scores and may cause misinterpretation of RA disease activity also due to impaired pain perception[6] in patients with depression and anxiety.

We fully agree with Boer *et al* that depression and anxiety may influence important treatment decisions in RA and that it is of importance to take this into consideration to prevent increased medical costs as well as patient burden due to unnecessarily intensified treatment regimens.

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