

## Treat to target in PsA should focus on clinical measures. Response to: 'DAPSA versus cDAPSA: do we need to use CRP?' by Gonçalves *et al*

We read with great interest, the work of Gonçalves *et al*<sup>1</sup> submitted in response to our article,<sup>2</sup> comparing potential treatment targets for patients with psoriatic arthritis in real world data. Our study showed considerable overlap between these targets, whether or not they included a laboratory measure of inflammation such as a C reactive protein (CRP). We concluded that 'Inclusion of laboratory markers seems unnecessary'.

This Brazilian study also used data from a real-life clinic cohort rather than a randomised controlled trial setting but only compared the two versions of the disease activity in PsA (DAPSA), with or without a CRP. This sort of observational clinical data is invaluable to address choice of targets for clinical practice, where a wide variety of patients are included rather than a highly selected trial population. They found a high correlation between the DAPSA and the clinical (c)DAPSA as in our data.

Gonçalves *et al* found that 17 of 50 (34%) patients in remission or low-disease activity had a raised CRP. This is higher than in our data where only 22 of 195 (11%) in cDAPSA low disease activity (LDA) and 18/162 (11%) of those in the minimal disease activity (MDA) criteria had a CRP above the upper limit of normal. Reassuringly in our data the patients achieving the targets, but with a persistently raised CRP did not show any differences in clinical or patient-reported outcomes.

As clinicians, we recognise the issues obtaining recent CRP results from all patients, and agree with Gonçalves *et al* that focusing on clinical measures of disease activity is ideal, utilising both physician assessment and patient-reported outcomes. Although CRP may be useful in some circumstances, we agree with these data that it does not offer a significant advantage above clinical assessment for most patients.

The only significant difference shown in our analysis was that measuring aspects of disease beyond the peripheral arthritis, such as psoriasis and enthesitis that are included in the MDA criteria does identify residual disease in other domains. A concern with both the DAPSA and cDAPSA is that as they focus on the peripheral arthritis, disease activity in enthesitis, skin and other domains may remain. Our data highlighted that exclusion of a skin domain can result in residual psoriasis that has a proven impact on quality of life.<sup>2</sup> Other data published subsequently have confirmed this assessment with high levels of residual disease in DAPSA low-disease activity or remission compared with the MDA criteria.<sup>3,4</sup> We agree with Gonçalves *et al* that the clinical measures, without CRP, are sufficient but believe that this should be using the MDA criteria to include assessment of

enthesitis and psoriasis. This will ensure that quality of life is maximised in routine clinical practice.

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