Comment on: 'EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update' by Gossec *et al*

We read with great interest the published paper by Gossec *et al*[1] which provided updated European League Against Rheumatism (EULAR) recommendations for pharmacological therapies for psoriatic arthritis (PsA). In this full-scale, evidence-based guideline, the authors proclaimed 6 overarching principles and 12 recommendations for PsA. Recently, the field of pharmacotherapy for PsA has progressed rapidly and is replete with competing clinical trials working on the efficacy of plenty of drugs. However, in light of some evidence on therapeutic efficacy still being scarce today, there are a few points in this study that are worth mentioning.

First, for PsA with relevant skin involvement, the authors recommended methotrexate (MTX) as the standard treatment superior to other conventional synthetic disease-modifying antirheumatic drugs (csDMARDs). However, the evidence on the efficacy of MTX remains limited to date.[2] Furthermore, the medication trends for psoriasis in Asia seemed to be quite different from the EULAR recommendations. In our previous population-based study in Taiwan, we found that ciclosporin (CsA) was more commonly used for patients with psoriatic diseases in the past decade.[3] Likewise, an epidemiological study from Korea reported higher use of CsA than MTX for patients with psoriasis, and the use of CsA showed a 32.2% increase during the period of 2006–2015. The preference of CsA over MTX may be explained by the nature of CsA, which allows for easier monitoring and management of adverse effects.[4] It is noteworthy that previous studies from Japan revealed improved quality of life for patients with psoriasis after low-dose and short-term use of CsA.[5 6] Although CsA might pose unwanted side effects, nephrotoxicity caused by short-term use of CsA has been investigated to be reversible. Moreover, for patients with psoriasis, higher dose of CsA as induction therapy and lower dose of CsA as maintenance therapy have been reported to be a feasible way to control and diminish symptoms. The laboratory abnormalities found during induction therapy have been documented to return to normal ranges during maintenance therapy.[7] Considering the insufficient evidence for MTX to be prior to other csDMARDs, we suggest that CsA should have a different weight on the discussion.

Second, the EULAR recommendations classified PsA into oligoarticular and polyarticular joint involvement. However, a previous study pointed out that the activity states of oligoarticular PsA cannot be accurately evaluated without assessing full 66/68 joint counts. The Disease Activity States of the PsA score, which is calculated by a comprehensive overview of the 66/68 joint counts, has been proven to have high validity for clinical endpoints of PsA.[8] As a result, to prevent misclassification and make treatment strategy for PsA more robust, thoroughly running through 66/68 joint counts to evaluate active PsA instead of simply accounting for the affected joint counts is recommended.

Third, the authors provided the concept of cautious tapering of biologic disease-modifying antirheumatic drugs (bDMARDs) to the smallest effective dose when patients have reached sustained remission. Nonetheless, the article did not provide a valid algorithm for tapering down bDMARDs. A Denmark clinical trial published in 2019 displayed a tapering guidance for bDMARDs meanwhile maintaining stable disease activity for PsA.[9] In our opinion, the EULAR recommendations should have an introduction on the tapering strategy in an effort to help alleviate the burden on patients with PsA.

Last but not least, the EULAR recommendations undoubtedly provided the most detailed and multifaceted guideline for the treatment of PsA. However, we think the therapeutic concerns for elderly patients with PsA deserve some attention. Based on a recently published study, there is obvious discrepancy in disease severity between late-onset and early-onset PsA.[10] To date, evidence on pharmacological approaches to elderly patients with PsA is still lacking. Therefore, further research is needed to underpin therapeutic precautions and modification on the treatment dosage for elderly patients with PsA.

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