Correspondence on 'Five-year treat-to-target outcomes after methotrexate induction therapy with or without other csDMARDs and temporary glucocorticoids for rheumatoid arthritis in the CareRA trial'

The 5-year follow-up data of the Care-RA cohort are interesting.[1] However, a few points merit consideration and clarification.

Findings in the high-risk group reaffirm the fact that upfront combination disease-modifying antirheumatic drugs (DMARDs) are not needed even in patients of rheumatoid arthritis (RA) with poor prognostic factors, provided a treat-to-target strategy is followed. However, we wish to draw attention to the low-risk group which compared initial methotrexate (MTX) monotherapy to MTX+prednisolone bridging (COBRA-Slim). The results in the low-risk group seem counterintuitive to previous landmark trials (including the BeSt and the TEAR) that found long-term outcomes to be essentially determined by treating-to-target, with the intensity of initial treatment only guiding the rapidity of response achieved.[2 3] However, in the CareRA-plus, the initial difference in disease activity between MTX monotherapy vs MTX+prednisolone bridging (COBRA-Slim) in the low-risk group persisted for up to 5 years—this could reignite interest in the concept of 'a time-limited window of opportunity' in early RA.[4]

However, it must be stressed that any conclusions in the low-risk group should be guarded, as the numbers included in this group (n=49 at the start of this long-term extension study; 38 by the end of follow-up at 5 years) were too few to draw any reliable conclusions. Unfortunately, there was no MTX monotherapy arm in the high-risk group which had more patients, and thus could have better answered the question whether addition of bridging glucocorticoids to initial MTX monotherapy improves long-term outcomes in early RA, when followed by a tight step-up approach to treatment target.

Considering the little incremental response in any treatment arm after the first year, more details regarding the treatment escalation strategies followed after the protocol-specified two step escalation (step 1 and step 2) would be insightful. We would be interested in knowing the treatment changes (switches or additions) after the protocolised first year till year 5 (in the ~50% of patients who required such changes) and the final treatment patients were taking at the end of 5 years.

Nevertheless, the authors must be congratulated for their study which has reaffirmed the fact that excellent results are possible with conventional synthetic DMARDs+prednisolone in a majority of cases and biological DMARDs are required in only a minority of patients (one-fourth) with RA.

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