

## Correspondence on 'Efficacy of a tight-control and treat-to-target strategy in axial spondyloarthritis: results of the open-label, pragmatic, cluster-randomised TICOSPA trial'

We have read with great interest the work of Anna Molto *et al* studying on comparing the benefits of TICOSPA (a tight control/treat-to-target strategy (TC/T2T) in axial spondyloarthritis (axSpA)) trial with those of usual care (UC).<sup>1</sup> They concluded that TC/T2T approach was not significantly superior to UC for the primary outcome, while it might be beneficial in axSpA and had a favourable outcome from a societal health economic perspective. However, we believe that some concerns should be discussed in this important study.

First of all, although the primary endpoint Assessment of SpondyloArthritis international Society Healthy Index (ASAS-HI) was not met due to relatively small sample size and treatment duration, the EQ5D of TC/T2T arm was significantly superior to UC ( $p=0.02$ ). We understand that ASAS-HI was a newly validated instrument to measure quality of life in ankylosing spondylitis. However, the selection of this tool as primary endpoint in patients with axSpA might not be suitable. On the other hand, EQ-5D is being widely used in a variety of clinical areas, including ankylosing spondylitis in many clinical studies.<sup>2-4</sup> The difference and sensitivity to detect changes between ASAS-HI and 5-level version of the EuroQol five dimensions (EQ-5D-5L) in axSpA should be also considered in this study.

Second, it is a pity that radiographic evaluation was not available in this study. We suggested that future T2T study in SpA should include Modified Stoke AS Spine Score (mSASSS) which is the most important treatment goal of axSpA by experts' consensus.<sup>5,6</sup> We also suggest that the study duration should be extended to at least 2 years to observe the benefit on mSASSS.<sup>5</sup>

Finally, the mean age of study population is 37.9, but mean disease duration is only 3.7. This is not reasonable because that average age of onset in axSpA should be 20–30.<sup>7</sup> We wonder that there might be measurement inaccuracy in the disease duration. The relative old age of study subjects might also lead to negative result.

In conclusion, although the primary endpoint was not met, we still see some benefits in the T2T strategy in axSpA in this study. We believe that more T2T studies in SpA should be done before drawing the conclusion. For future T2T studies in SpA, we recommend patient selection of younger age with larger sample size and longer study duration for at least 2 years.<sup>5</sup>

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