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EULAR definition of difficult-to-treat rheumatoid arthritis

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ABSTRACT

Background Despite treatment according to the current management recommendations, a significant proportion of patients with rheumatoid arthritis (RA) remain symptomatic. These patients can be considered to have ‘difficult-to-treat RA’. However, uniform terminology and an appropriate definition are lacking.

Objective The Task Force in charge of the “Development of EULAR recommendations for the comprehensive management of difficult-to-treat rheumatoid arthritis” aims to create recommendations for this underserved patient group. Herein, we present the definition of difficult-to-treat RA, as the first step.

Methods The Steering Committee drafted a definition with suggested terminology based on an international survey among rheumatologists. This was discussed and amended by the Task Force, including rheumatologists, nurses, health professionals and patients, at a face-to-face meeting until sufficient agreement was reached (assessed through voting).

Results The following three criteria were agreed by all Task Force members as mandatory elements of the definition of difficult-to-treat RA: (1) Treatment according to European League Against Rheumatism (EULAR) recommendation and failure of ≥2 biological disease-modifying antirheumatic drugs (DMARDs)/targeted synthetic DMARDs (with different mechanisms of action) after failing conventional synthetic DMARD therapy (unless contraindicated); (2) presence of at least one of the following: at least moderate disease activity; signs and/or symptoms suggestive of active disease; inability to taper glucocorticoid treatment; rapid radiographic progression; RA symptoms that are causing a reduction in quality of life; and (3) the management of signs and/or symptoms is perceived as problematic by the rheumatologist and/or the patient.

Conclusions The proposed EULAR definition for difficult-to-treat RA can be used in clinical practice, clinical trials and can form a basis for future research.

INTRODUCTION

European League Against Rheumatism (EULAR) recommendations provide valuable guidance to direct the management of rheumatoid arthritis (RA). The treat-to-target (T2T) strategy advises an agreed disease activity target, remission or at least low disease activity, that can in turn inform responsive treatment escalation.1–3 However, a number of patients remain symptomatic despite recommended treatment changes reflecting the complex interplay of disease and wider patient and clinical factors that leads to the increasingly recognised term of ‘difficult-to-treat RA’.4–7

A recent international survey of rheumatologists highlighted the perceived management problems and features in this patient category; the results of which confirmed the unmet need of this subpopulation of RA patients.8 The survey indicated that in addition to new drugs, new management approaches are also needed for the optimal treatment of these patients. Consequently, a EULAR Task Force was established to derive comprehensive recommendations addressing unmet needs in the management of difficult-to-treat (D2T) RA. Uniform terminology and a clear definition for this patient group are lacking. In the current literature, different terms are used to describe this subpopulation of RA patients, for example, severe, refractory, resistant to multiple drugs or treatments, established and difficult-to-treat.4–7. As an initial step in the development of the management recommendations for D2T RA, terminology and a definition of this complicated RA patient group was established by the Task Force, guided by the results of the survey.9

METHODS

Steering committee and task force

The Steering Committee of the Task Force included a convenor (GN), co-convenor (JMvL), two methodologists (PMJW and DvdH) a rheumatology postdoctoral fellow (MJvdH) and three fellows (NMTR, MK and AH). The Task Force comprises 32 individuals (including the Steering Committee members) of which 25 members were present at the first Task Force meeting, which took place in August 2018. Among the Task Force members, there were 26 rheumatologists (including two EMerging EULar
Network (EMEUNET) representatives, two patient partners, one health professional, one psychologist, one pharmacist and one occupational therapist. All rheumatologists are experienced in the treatment of RA, the majority with significant experience in clinical trials and a proportion in outcomes research. Numerous Task Force members have a leading role in organising and evaluating patient registries. All Task Force members declared their potential conflicts of interest before the start of the project.

Survey

An online survey was conducted among rheumatologists to identify characteristics of D2T RA; the survey was distributed by email via the authors’ networks and by EMEUNET. The survey consisted of nine questions, including two general questions ‘Where do you work? How many RA patients do you treat?’, and four multiple-choice and three open questions regarding the definition of D2T RA. Four hundred and ten respondents from 33 countries completed the survey between July 2017 and March 2018, 96% of the respondents were European.8

Development of terminology and definition for D2T RA

The Steering Committee created the first draft of the definition based on the results of the survey and on a scoping literature search that was performed to explore different definitions that currently have been used (by NMTR, MJHdH and PMJW, see, online supplemental material 1). The results of the survey, the proposed terminology and the draft definition were presented to the Task Force at the first Task Force meeting. The definition was divided into three parts: treatment failure history, characterisation of active/symptomatic disease and clinical perception.

Agreement process

After the presentation of the draft terminology and definition, the general concepts were discussed and amended. Thereafter, the detailed wording was discussed and amended until consensus was reached. A voting process was conducted for each item of the terminology and definition. In case no consensus was reached among the present Task Force members, the preferred version was selected by voting. Twenty-one Task Force members were present during this discussion and voting process. After the meeting, two versions of the definition were distributed among all Task Force members to select the final version.

RESULTS

Terminology

At the first Task Force meeting, based on a scoping literature search and the suggestions of the Task Force members a variety of potential terms to describe this patient population were presented, including severe, refractory, multidrug/treatment resistant and complex RA. None of these terms was deemed to cover the wide range of possible clinical scenarios which may be relevant for this patient population. Since ‘difficult-to-treat’ is a widely accepted term in several fields including pulmonology, psychiatry and cardiology9–13 this terminology was finally proposed by the Steering Committee and unanimously endorsed by the Task Force (21/21 agreed by voting).

Definition

Thereafter, we sought to create a definition of D2T RA based on the results of the previously mentioned international survey8 and expert opinions. The Task Force agreed that both articular and extra-articular components should be considered and agreed to include the following criteria in the definition: (1) treatment failure history; (2) characterisation of active/symptomatic disease; and (3) clinical perception. All three criteria need to be present to confirm the state of D2T RA.

Criterion #1: treatment failure history

In the survey, 48% of the respondents selected ‘≥2 conventional synthetic disease-modifying antirheumatic drugs (csDMARDs) AND ≥2 biological (b)DMARDs or targeted synthetic (ts) DMARDs with different mode of action’ for the number and type of antirheumatic drugs that should have failed before a patient can be considered to have D2T RA. The Steering Committee initially proposed to include treatment duration in the definition ‘Treatment according to the current standard of care/EULAR recommendations for ≥1 year’. This was chosen so that D2T RA patients are in phase III of the current RA management recommendations, in which no recommendation is given other than to switch to another b/tsDMARD.1 However, inclusion of a certain time period in the definition was not supported by all Task Force members (primarily in order to provide flexibility) and the Task Force voted against referral to a treatment duration period for the definition of D2T RA (19/21 agreed, 2 abstained).

All Task Force members agreed to include the number of DMARDs previously failed in the definition and to create the definition consistent with the current EULAR RA management recommendations. ‘Failure of at least two b/tsDMARDs with different mode of action’ was selected by the majority of the respondents of the survey.8 Although according to the current EULAR recommendations’ no prioritisation for switching mechanism of action versus cycling is stated, it was decided that before being classified as D2T RA, a patient should at least have failed two b/tsDMARDs with different mechanisms of action. Consequently, it was decided to select this cut-off by the Task Force. With this cut-off, patients had to have completed phase III of the recommendations at least once (ie, they may also have been treated with multiple bDMARDs of a single class (eg, several tumour necrosis factor inhibitors) and also have failed another b/tsDMARD). Finally, all members agreed to select the following proposal: “Treatment according to EULAR recommendation and failure of ≥2 b/tsDMARDs with different mechanisms of action after failing csDMARD therapy (unless contraindicated)” (21/21 agreed). This also indicates that if csDMARD treatment is contraindicated, failure of ≥2 b/tsDMARDs with different mechanisms of action is sufficient.

Socioeconomic factors may limit the access to expensive DMARDS (eg, in low income countries), therefore (with the agreement of all Task Force members) we have added to the first criterion: ‘unless restricted by access to treatment due to socio-economic factors’.

Criterion #2: characterisation of active/symptomatic disease

Fifty per cent of the respondents of the international survey selected “disease activity score assessing 28 joints using erythrocyte sedimentation rate (DAS28-ESR)>3.2 OR presence of signs suggestive of active inflammatory disease activity with a DAS28-ESR≤3.2” as a characteristic of D2T RA. Additionally, 95% of the respondents of the international survey suggested to include the inability to taper glucocorticoids (GCs) in the criteria of D2T.1 Therefore, the Steering Committee proposed the following characterisation of active/symptomatic disease: ‘Presence of active disease defined as ≥1 of: (1) DAS28-ESR>3.2; (2) Presence of signs suggestive of active RA; and/or (3) Inability to taper oral glucocorticoids (below 7.5 mg/day prednisone or
The management of signs and/or symptoms is perceived as problematic by the rheumatologist and/or the patient. There were some concerns that this criterion might be too subjective, especially for research. However, the focus of the recommendations should be on the clinical implications, which supports to include this criterion. All Task Force members agreed unanimously on this (21/21 agreed).

**Order**

Most Task Force members agreed to start the definition with the treatment failure history criterion instead of the characterisation of active/symptomatic disease. However, the group noted that starting with signs of active disease might be better focused on the patients’ needs. Therefore, with the agreement of all Task Force members, it was decided to vote on the order of the two criteria, by which all Task Force members supported the first version of the definition (agreed 31/31 (AH, who joined the Task Force later, did not vote), box 1).

**DISCUSSION**

The treatment of the heterogeneous patient population that comprises D2T RA is often a clinical challenge for which practical management recommendations are needed. Several factors may complicate the management of these patients. Such factors include persistent inflammatory activity due to resistance of disease to DMARDs, limited drug options due to adverse drug reactions and/or comorbidities that preclude the use of DMARDs or treatment non-adherence. On the other hand, concomitant

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**Criterion #3: clinical perception**

As a final criterion, the Steering Committee suggested to include ‘The disease is perceived as problematic by the rheumatologist and/or the patient’. This suggests that only clinical scenarios which are judged as problematic (eg, apparently ineffective treatment) are referred to as D2T RA. Since the definition is only applicable to patients in which a management problem is present, it was agreed to adapt the definition accordingly: ‘The management of signs and/or symptoms is perceived as problematic by the rheumatologist and/or the patient’. There were some concerns that this criterion might be too subjective, especially for research. However, the focus of the recommendations should be on the clinical implications, which supports to include this criterion. All Task Force members agreed unanimously on this (21/21 agreed).

**Box 1 EULAR definition of difficult-to-treat RA**

1. Treatment according to European League Against Rheumatism recommendation and failure of ≥2 b/tsDMARDs (with different mechanisms of action) after failing csDMARD therapy (unless contraindicated).

2. Signs suggestive of active/progressive disease, defined as ≥1 of:
   a. At least moderate disease activity (according to validated composite measures including joint counts, for example, DAS28-ESR > 3.2 or clinical disease activity index (CDAI) > 10) (21/21 agreed).
   b. Signs (including acute phase reactants and imaging) and/or symptoms suggestive of active disease (joint related or other).
   c. Inability to taper glucocorticoid treatment (below 7.5 mg/day prednisone or equivalent).
   d. Rapid radiographic progression (with or without signs of active disease).
   e. Well-controlled disease according to above standards, but still having RA symptoms that are causing a reduction in quality of life.

3. The management of signs and/or symptoms is perceived as problematic by the rheumatologist and/or the patient.

All three criteria need to be present in D2T RA.

* Unless restricted by access to treatment due to socioeconomic factors.
†If csDMARD treatment is contraindicated, failure of ≥2 b/tsDMARDs with different mechanisms of action is sufficient.
‡Rapid radiographic progression: change in van der Heijde-modified Sharp score ≥5 points at 1 year.
syndromes or diseases, such as fibromyalgia, osteoarthritis and psychosocial factors associated with poor coping, can result in non-inflammatory symptoms (eg, pain) that can mimic inflammatory activity and therewith contribute to D2T RA. Currently, D2T RA EULAR management recommendations are under development, aiming to cover all inflammatory and non-inflammatory factors underlying D2T RA. These will include both pharmacological and non-pharmacological treatment options and will be complementary to the existing RA recommendations. As an essential initial step in the development of recommendations for D2T RA, the Task Force provided terminology and a definition of D2T RA.

The term ‘difficult-to-treat’ was selected because it was deemed to best capture the possible clinical scenarios. A definition of D2T RA, consisting of three criteria was agreed on by consensus by a multidisciplinary group of experts including patient representatives: (1) treatment failure history; (2) characterisation of active/symptomatic disease; and (3) clinical perception. These elements were selected based on the results of the survey.

The second criterion has five subelements, reflecting all potential clinically meaningful indicators of active/symptomatic disease. In this definition, in accordance with recent recommendations, the term ‘moderate disease activity according to validated composite measures including joint counts’ was used. However, these indices might not always include the affected joints (eg, feet) or other signs of disease activity. The ‘Signs (including acute phase reactants and imaging) and/or symptoms suggestive of active disease (joint related or other)’ item covers all potentially affected joints, as well as extra-articular manifestations.

The acceptable GC dose for chronic use remains a matter of discussion, although there is a significant group of RA patients that is treated with GCs long-term. Current EULAR RA recommendations suggest to consider using GCs, when initiating or managing the treatment of D2T RA, Task Force for chronic use. The EULAR Task Force in charge of recommending the treatment of D2T RA has been adequately captured by the currently proposed definition.

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Contributors GN wrote the first draft of the manuscript, with the help from DvdH, NMTR, PMJW, IBM and JMvL. All authors participated in the work of the Task Force and provided coauthorship to the manuscript. All authors read and approved the final manuscript.

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