

EULAR Recommendations 2013 Update

Management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs

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Principles

- A. Treatment of RA patients should aim at the best care and must be based on a shared decision between the patient and the rheumatologist
- B. Rheumatologists are the specialists who should primarily care for RA patients
- C. RA incurs high individual, societal and medical costs, all of which should be considered in its management by the treating rheumatologist

Recommendations

1. Therapy with DMARDs should be started as soon as the diagnosis of RA is made
2. Treatment should be aimed at reaching a target of remission or low disease activity in every patient
3. Monitoring should be frequent in active disease (every 1–3 months); if there is no improvement by at most 3 months after the start of treatment or the target has not been reached by 6 months, therapy should be adjusted
4. MTX should be part of the first treatment strategy in patients with active RA
5. In cases of MTX contraindications (or early intolerance), sulfasalazine or leflunomide should be considered as part of the (first) treatment strategy
6. In DMARD-naïve patients, irrespective of the addition of glucocorticoids, csDMARD monotherapy or combination therapy of csDMARDs should be used
7. Low-dose glucocorticoids should be considered as part of the initial treatment strategy (in combination with one or more csDMARDs) for up to 6 months, but should be tapered as rapidly as clinically feasible
8. If the treatment target is not achieved with the first DMARD strategy, in the absence of poor prognostic factors, change to another csDMARD strategy should be considered; when poor prognostic factors are present, addition of a bDMARD should be considered
9. In patients responding insufficiently to MTX and/or other csDMARD strategies, with or without glucocorticoids, bDMARDs (TNF inhibitors*, abatacept or tocilizumab, and, under certain circumstances, rituximab†) should be commenced with MTX
10. If a first bDMARD has failed, patients should be treated with another bDMARD; if a first TNF inhibitor therapy has failed, patients may receive another TNF inhibitor* or a biological agent with another mode of action
11. Tofacitinib may be considered after biological treatment has failed
12. If a patient is in persistent remission after having tapered glucocorticoids, one can consider tapering‡ bDMARDs§, especially if this treatment is combined with a csDMARD
13. In cases of sustained long-term remission, cautious reduction of the csDMARD dose could be considered, as a shared decision between patient and physician
14. When therapy needs to be adjusted, factors apart from disease activity, such as progression of structural damage, comorbidities and safety issues, should be taken into account

*TNF inhibitors: adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, biosimilars (as approved according to a thorough approval process, such as by EMA and/or FDA).

†The 'certain circumstances', which include history of lymphoma or a demyelinating disease, are detailed in the accompanying text.

‡Tapering is seen as either dose reduction or prolongation of intervals between applications.

§Most data are available for TNF inhibitors, but it is assumed that dose reduction or interval expansion is also pertinent to biological agents with another mode of action.

DMARD, disease-modifying antirheumatic drug; EMA, European Medical Agency; EULAR, European League against Rheumatism; FDA, Food and Drug Administration; MTX, methotrexate; RA, rheumatoid arthritis; TNF, tumour necrosis factor.