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EDITORIAL

Remission makes its way to rheumatology

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Abstract

Remission was a rare event, even in the most advanced rheumatology clinics, until recent times. However, in the early 1990s, it was chosen as the treatment goal and the primary outcome measure for the Finnish Rheumatoid Arthritis Combination Therapy (FIN-RACo) trial, which can be considered the beginning of remission's way to rheumatology. In addition to remission in patients with rheumatoid arthritis, remission in patients with psoriatic arthritis is now being studied, although remission criteria for psoriatic arthritis have yet to be defined. Better treatment results with more active treatment strategies and availability of biologic agents motivate rheumatologists to monitor their patients as part of usual rheumatology care.

Remission was once an unusual phenomenon in rheumatology, despite references to disease-modifying antirheumatic drugs (DMARDs) as 'remission-inducing'. In the previous issue of *Arthritis Research & Therapy*, the study by Saber and colleagues [1] provides further evidence of remission as a reachable goal in a usual rheumatology clinic. The authors report a DAS28 (disease activity score using 28 joint counts) remission rate of 58% in psoriatic arthritis patients who were treated with anti-tumor necrosis factor therapy for 12 months.

Remission started its eventful and ambitious journey in the 1990s in patients with rheumatoid arthritis (RA). It was defined as the treatment goal and the primary outcome measure in the Finnish Rheumatoid Arthritis Combination Therapy (FIN-RACo) trial [2] in 1993, 6 years before the first biologic agent became available. Nonetheless, the results of the FIN-RACo trial were amazing: 42% of those who received a combination of conventional DMARDs were in remission 2 years after baseline, entirely without signs and symptoms of RA, and 68% met the DAS28 remission criteria [3]. The findings indicated that a strategy of 'tight control' appeared to be more important than a specific agent in the control of RA.

Subsequent studies confirmed the importance of a 'tight control' strategy directed to 'treat to target' according to a quantitative goal. The TICORA (Tight Control of Rheumatoid Arthritis) trial reported a remission rate of 65% using conventional DMARDs. In the CIMESTRA (Cyclosporine, Methotrexate, Steroid in Rheumatoid Arthritis) trial, remission rates were 59% and 54% for DAS28 remission and 41% and 35% for American College of Rheumatology (ACR) remission at 2 years in the combination and monotherapy arms, respectively [4]. In the BeSt (*Behandelstrategieën voor Reumatoide Artritis*) study of treatment strategies for RA, 38% to 46% of patients in the four arms were in remission at the end of intervention [5].

At this time, remission rates for RA in usual clinical care are higher than in the past [6], though primarily in North America and Western Europe [7]. Similarly, the clinical status of RA patients who are treated actively in rheumatology clinics has improved substantially compared with previous decades [8,9].

A single 'gold standard' measure is not available for disease activity in RA or other inflammatory joint diseases, and simple criteria for defining remission must include multiple measures. Preliminary remission criteria for RA were proposed by a committee of the American Rheumatism Association (now the ACR) in 1981 [10]. According to these criteria, remission is present if five of the following conditions are met: absence of morning stiffness, fatigue, joint pain, tenderness, and swelling and presence of normal erythrocyte sedimentation rate. However, these criteria are too stringent and are not based on real-world data; for example, mild pain is common in the population over age 50, and 85% would not meet ACR remission criteria [11]. The use of less stringent definitions of remission such as remission according to DAS28 has opened rheumatology for the concept of remission in a large number of patients [12], as shown by Saber and colleagues [1] in patients with psoriatic arthritis.

Psoriatic arthritis is a multifaceted disease. Global remission should involve the absence of peripheral

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arthritis, spondylitis, enthesitis, dactylitis, and skin disease. Fifty-eight percent, a high percentage for DAS28 remission [1], may be an overestimate compared with a real remission rate. However, no consensus about remission in psoriatic arthritis exists, and various criteria have been used to define remission [13], just as various criteria were used to define remission in RA [7]. In both diseases, remission has been defined as the treatment target [13,14].

Routine quantitative monitoring of rheumatology patients has been advocated for almost 3 decades. However, it appears that only the availability of biologic agents can direct rheumatologists' interest into routine monitoring of patients' pain, functional status, and disease activity. The patients of Saber and colleagues [1] were assessed every 3 months for disease activity and patient-reported outcomes. Remission is an achievable goal in rheumatology at this time, and routine monitoring of patients may make its way to rheumatology after a three-decade-long journey.

Finally, there is nothing new under the sun: The Health Assessment Questionnaire (HAQ) is the best predictor of the future [15] (in this case, remission). This observation by Saber and colleagues [1] confirms what many reports have been showing for the past 20 years: HAQ is the best predictor of mortality, work disability, functional status, and even joint replacements and health care costs.

Abbreviations

ACR, American College of Rheumatology; DAS28, disease activity score using 28 joint counts; DMARD, disease-modifying antirheumatic drug; FIN-RACo, Finnish Rheumatoid Arthritis Combination Therapy; HAQ, Health Assessment Questionnaire; RA, rheumatoid arthritis.

Competing interests

The authors declare that they have no competing interests.

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