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The controversy of using PGA to define remission in RA

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We read with interest the commentary by van Tuyl and Boers (van Tuyl, L. H. D. & Boers, M. Remission — keeping the patient experience front and centre. Nat. Rev. Rheumatol. 13, 573–574 (2017))1 referring to our paper on the role of patient global assessment (PGA) in the definition of remission in rheumatoid arthritis (RA)2. However, we cannot agree with their interpretation that by suggesting to remove the PGA from the ACR/EULAR remission definition we are "calling for a paradigm change that limits the responsibility of the rheumatologist to prescribing immunosuppressive therapy," or that our proposal is "taking away the incentive to improve RA care by removing the patient's perspective from the remission criteria."1

Nothing could be further from the interpretation we made of our own data and from our proposals. What we actually proposed is that the management of RA should be guided by two separate targets: a measure of inflammatory activity (physician's perspective) and a measure of disease impact (patient's perspective).

We advocate that 3v-remission (defined as swollen and tender 28-joint counts and C-reactive protein in mg/dl all ≤1) is the most appropriate target for immunosuppressive therapy given that PGA has been shown to have no more than a weak correlation with disease activity, and is at least as much linked to personality and emotional aspects, which are not amenable to change by immunosuppressive therapy.

Achieving 3v-remission is a decisive step towards achieving good patient outcomes but does not guarantee the total abrogation of disease impact. In fact, the percentage of patients with RA who are missing remission solely because of a high PGA score is greater than the percentage who achieve full remission2,3. To further assist such patients, physicians ought to consider adjuvant interventions instead of reinforced immunosuppression.

For these reasons, a measure of disease impact should be part of the recommended treatment targets in RA management. This measure should be examined separately from inflammatory activity

and include more analytical measures than PGA, in order to guide efforts to alleviate impact beyond what is achieved through control of inflammation. We suggest that the Rheumatoid Arthritis Impact of Disease (RAID) score, using its seven domains as separate items, is ideally suited for this purpose. The RAID score was developed in close cooperation with patients from various countries4.

Our views were summarized in the abstract: “PGA mainly reflects fatigue, pain, function, and psychological domains, which are inadequate to define the target for immunosuppressive therapy. This consideration suggests that clinical practice should be guided by two separate remission targets: inflammation (3v-remission) and disease impact.”2

In summary, we do not propose to “limit the responsibility of the rheumatologist to prescribing immunosuppressive therapy”1, but rather we want to highlight the rheumatologist´s and multidisciplinary team's responsibility to assess and manage disease impact. The appropriateness of these proposals will be further scrutinized by clarifying whether high PGA in patients otherwise in remission is associated with subclinical inflammation and whether full remission is a better predictor than 3v-remission (without PGA) of a long-term good radiological outcome5. Both investigations are underway.

Contributions

R.J.O.F. and J.A.P.S researched data for the article and wrote the article. R.J.O.F., C.D., M.N., L.X., M.W., L.G. and J.A.P.S. made substantial contributions to discussion of its content and reviewed and/or edited the manuscript before submission.

Competing interests

The authors declare no competing financial interests.

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