Response to: 'Comment on: 'EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update' by Gossec et al' by Wei et al

Gossec, L.; Baraliakos, X.; McInnes, I.; Kerschbaumer, A.; Wit, M. de; Dougados, M.; ... ; Smolen, J.S.

Response to: 'Comment on: 'EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update' by Gossec *et al*' by Wei *et al*

We thank Wei *et al*[1] for their correspondence on the recently published European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis (PsA).[2] The authors of this correspondence raise some interesting points.

The first point relates to the role of cyclosporine A (CsA) in the treatment of patients with psoriatic disease. The authors mention that this drug is often used in Asia, in particular in skin psoriasis. They suggest that CsA could be proposed for PsA. While CsA is recommended for the management of skin psoriasis,[3] EULAR's systematic literature searches did not reveal a convincing efficacy in PsA based on two small randomised controlled trials[4 5]; indeed, even a randomised trial on the addition of CsA in patients who had an insufficient response to methotrexate failed to meet its primary endpoint.[6] Therefore, CsA is not put forward in the EULAR recommendations for the management of PsA,[2] and these recommendations do not deal with patients who only have psoriasis.

The second point of the authors' comments relates to the definition of oligoarticular disease and, more specifically, the necessity for a full 66/68 joint count. We fully support using the 66/68 joint counts in PsA, as studies have shown that more limited joint counts may miss significant proportions of inflammation.[7] The authors mentioned the Disease Activity in Psoriatic Arthritis (DAPSA) score, which is also recommended in the updated EULAR recommendations and, indeed, uses the 66/68 counts.[8]

Wei *et al* support the new recommendation for tapering of biological DMARDs in patients reaching sustained remission, but suggest that an algorithm or a tapering guidance would be useful.[1 2] Currently, given the lack of data on this subject, it is difficult to propose formal tapering strategies.[4] In the absence of any data for PsA, Wei *et al* may be referred to the EULAR RA management recommendations[9] for a potential orientation, given that in RA tapering schedules have been studied.[10] Tapering should be further investigated in PsA. The last point regards elderly patients and we agree with the authors that research is warranted on the management of elderly patients with PsA.

Laure Gossec ,[1,2] **Xenofon Baraliakos**,[3] **Iain McInnes**,[4] **Andreas Kerschbaumer** ,[5] **Maarten de Wit** ,[6] **Maxime Dougados**,[7] **Jette Primdahl** ,[8,9] **Désirée van der Heijde** ,[10] **Josef S Smolen**[11]

[1]Institut Pierre Louis d'Epidémiologie et de Santé Publique, INSERM, Sorbonne Universite, Paris, France
[2]APHP, Rheumatology Department, Hopital Universitaire Pitie Salpetriere, Paris, France
[3]Rheumazentrum Ruhrgebiet, Ruhr-Universität Bochum, Herne, Germany
[4]Institute of Infection, Immunity and Inflammation, University of Glasgow, Glasgow, UK
[5]Division of Rheumatology, Department of Medicine 3, and 2nd Department of Medicine, Medical University of Vienna, Hietzing Hospital, Vienna, Austria
[6]EULAR past Vice President representing People with Arthritis/Rheumatism in Europe (PARE), EULAR, Amsterdam, The Netherlands
[7]Medicine Faculty, Paris Descartes University, Paris, France
[8]Danish Hospital for Rheumatic Diseases, University Hospital of Southern Denmark, Sønderborg, Denmark
[9]Department of Regional Health Research, University of Southern Denmark, Odense, Denmark
[10]Rheumatology, Leiden University Medical Center, Leiden, The Netherlands
[11]Medical University of Vienna, Vienna, Austria

Correspondence to Professor Laure Gossec, Institut Pierre Louis d'Epidémiologie et de Santé Publique, INSERM, Sorbonne Universite, Paris 75005, France; laure.gossec@gmail.com

Handling editor David S Pisetsky

Contributors LG, XB and JSS drafted the text. The other authors reviewed the text and commented. All authors approved the final version of the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement A patient was involved in this response, as part of the steering committee of the recommendations

Patient consent for publication Not required.

Provenance and peer review Commissioned; internally peer reviewed.

To cite Gossec L, Baraliakos X, McInnes I, *et al*. *Ann Rheum Dis* 2022;**81**:e139.

Received 14 August 2020
Accepted 15 August 2020
Published Online First 1 September 2020

Linked

► http://dx.doi.org/10.1136/annrheumdis-2020-218385

Ann Rheum Dis 2022;**81**:e139. doi:10.1136/annrheumdis-2020-218456

ORCID iDs
Laure Gossec http://orcid.org/0000-0002-4528-310X
Andreas Kerschbaumer http://orcid.org/0000-0002-6685-8873
Maarten de Wit http://orcid.org/0000-0002-8428-6354
Jette Primdahl http://orcid.org/0000-0002-1049-4150
Désirée van der Heijde http://orcid.org/0000-0002-5781-158X

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