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

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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.

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