Sustained remission in RA is thought of as a target that is achievable: it is associated with better clinical outcomes, less long term disability, better patient-related outcome measures and less radiographic damage [1, 2]. Recent recommendations have suggested that achieving and maintaining remission is now the goal of treatment in RA [3].

The literature has many examples of the complexities of obtaining sustained remission and has concluded that using different criteria yielded different results. One such example is a recent sub-analysis of a trial of IL-6 inhibition using tociluzimab [4], which showed that patients in DAS28-ESR and DAS28-CRP remission would not satisfy other remission criteria. These data were on carefully selected patients with active disease who might not represent the real world.

To determine the feasibility of remission in routine clinical practice, a larger cohort of real world patients needs to be examined, and in this issue of Rheumatology a large Swedish study aimed to address that by examining the epidemiology of remission in RA using different criteria [5]. The study also wanted to look at sustained remission, which was defined as remission lasting >6 months. Further analysis on the predictors of remission was also performed.

Einarsson et al. [5] examined the Swedish quality database (SRR), which is a large registry of patients with RA in whom disease characteristics and duration of disease are recorded [6]. The SRR was established in the mid 1990s and has more than 40,832 patients with RA included within its ranks from 56 units. Data are collected at entry and at 3, 6 and 12 months, and then annually; information on confounders including body mass index, smoking, ethnicity and radiologic damage are not readily available in SRR. It does not cover every patient with RA in Sweden, but is thought to be a representation of 75–83% of all Swedish patients with a clinical diagnosis of RA. Unfortunately, exact details of the intensity of the treatment used in the cohort and what the treatment entailed, including proportions on methotrexate and biologics, was not detailed in this manuscript but appears to be commensurate with published observational cohorts [6].

Remission was examined in different ways: DAS28-ESR <2.6, clinical disease activity index (CDAI) <2.8, simplified disease activity index (SDAI) <3.3, ACR/EULAR Boolean (i.e. tender joint count ≤1 and swollen joint count ≤1 and CRP ≤10 mg/l and patient global assessment ≤10 on a visual analogue scale 0–100 scale) and fulfilling the sustained remission (SR) criteria, that is, remission on at least two consecutive occasions for at least 6 months.

Patients were stratified into early and established RA; predictors of remission were early disease, male gender, low disability and ACPA positivity, but surprisingly not variables like swollen joint count. Early diagnosis was associated with achieving SR as well as the absence of ACPA. SR was twice as likely using the DAS28 criteria vs CDAI, SDAI or Boolean criteria. It took some patients up to 15 years to achieve remission. In all, 41.9% reached DAS28 SR at some time point during follow-up, which seems quite high. The proportions of patients reaching CDAI, SDAI and ACR remission were 22.2, 21.3 and 17.5%, respectively. One year after symptom onset 16.4, 6.5, 6.0 and 4.6% were in sustained DAS28, CDAI, SDAI and ACR remission, respectively. The prevalence peaked after 5 years for all criteria. One year after symptom onset 21.3% of early RA patients were in sustained DAS28 remission compared with 9.8% of patients with established RA, and this difference was significant for at least 10 years of follow up. It took an average of 3.3 years to achieve SR.

The data appear robust and agree with data from other cohorts [7], but would this capture patients in sustained remission for 6 months in the year after the first year? If a patient has a flare in the year between visits, this would not be recorded after the first year of follow-up. Additionally, patients with longer duration of disease have also been excluded and remission rates in this population cannot be estimated from these data.

The lack of predictive value of swollen joint count is quite unusual as this has associated with severity in other cohorts [8, 9], but this could indicate that there are more unmeasured confounders and measuring the 28 joints in these scores does not capture the true measure of inflammation in disease.

The affirmation that treating disease early also increases the chances of remission in real life would also be a lesson for our community and encourage us as a community to seek ways in which to reduce delays in referral to specialist care.

The definition of any measures of remission mentioned so far does not include all the joints that could be involved in RA and excludes joints including those below the knee, and would therefore be an underestimate of true remission. There are also issues with registries that should be taken into account, including whether they can be applied...
universally as healthcare can differ from country to country [10]. True remission is therefore quite a rare and difficult to achieve undertaking. The concerns and issues with this low remission rate include us not being able to combat the entirety of the disease but only to ameliorate it; this might discourage the average rheumatologist from aiming for remission in all their patients. It could also lead to collusion between the patient and the treating clinician to allow residual inflammation when drug escalation would be beneficial. What is needed to overcome these issues is a measure that is achievable and is correlated with a good outcome.

Nonetheless, the take-home message for the working rheumatologist is that remission is possible and SR is possible, but only for a subset of patients, and no more than half of our patients will achieve it with the best of intentions. Remission as a target is a noble objective that we should all aspire to but we should not chastise our practice if we do not achieve it, as more and more evidence suggests that we should consider it the ideal but not the norm. Other more achievable measures of how to achieve good disease control are needed and then we would be able to benchmark and compare practice. Until then we will always aspire to a target that we can achieve less than half the time.

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