Table 2

EULAR recommendations for the management of rheumatoid arthritis

1 Treatment with synthetic DMARDs should be started as soon as the diagnosis of RA is made
2 Treatment should be aimed at reaching a target of remission or low disease activity as soon as possible in every patient; as long as the target has not been reached, treatment should be adjusted by frequent (every 1-3 months) and strict monitoring
3 MTX should be part of the first treatment strategy in patients with active RA
4 When MTX contraindications (or intolerance) are present, the following DMARDs should be considered as part of the (first) treatment strategy: leflunomide, sulfasalazine or injectable gold
5 In DMARD naïve patients, irrespective of the addition of glucocorticoids (GCs), synthetic DMARD monotherapy rather than combination therapy of synthetic DMARDs may be applied
6 GCs added at low to moderately high doses to synthetic DMARD monotherapy (or combinations of synthetic DMARDs) provide benefit as initial short-term treatment, but should be tapered as rapidly as clinically feasible
7 If the treatment target is not achieved with the first DMARD strategy, addition of a biologic DMARD should be considered when poor prognostic factors are present; in the absence of poor prognostic factors, switching to another synthetic DMARD should be considered
8 In patients responding insufficiently to MTX and/or other synthetic DMARDs with or without GCs, biologic DMARDs should be started; current practice would be to start a TNF inhibitor (adalimumab, certolizumab, etanercept, golimumab, infliximab) which should be combined with MTX
9 Patients with RA for whom a first TNF inhibitor has failed, should receive another TNF inhibitor, abatacept, rituximab or tocilizumab
10 In cases of refractory severe RA or contraindications to biologic agents or the previously mentioned synthetic DMARDs, the following synthetic DMARDS might also be considered, as monotherapy or in combination with some of the above: azathioprine, ciclosporin A (or exceptionally, cyclophosphamide)
11 Intensive medication strategies should be considered in every patient, although patients with poor prognostic factors have more to gain
12 If a patient is in persistent remission after having tapered GCs, one can consider tapering biologic DMARDS, especially if this treatment is combined with a synthetic DMARD
13 In cases of sustained long-term remission, cautious titration of synthetic DMARD dose could be considered, as a shared decision between patient and doctor
14 DMARD naïve patients with poor prognostic markers might be considered for combination therapy of MTX plus a biologic agent
15 When adjusting treatment, factors apart from disease activity such as progression of structural damage, comorbidities and safety concerns should be taken into account

Adapted from Smolen JS, Landewé R, Breedveld FC et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs. *Ann Rheum Dis* 2010; 69:964-75