European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update

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Table 1 Updated EULAR recommendations for the management of PsA, with levels of evidence, grade of recommendations and level of agreement

	Overarching principles			Level of agreement (mean±SD)
A.	PsA is a heterogeneous and potentially severe disease, which may require multidisciplinary treatment			9.6±1.1
B.	Treatment of patients with PsA should aim at the best care and must be based on a shared decision between the patient and the rheumatologist, considering efficacy, safety and costs			9.2±1.7
C.	Rheumatologists are the specialists who should primarily care for the musculoskeletal manifestations of patients with PsA; in the presence of clinically significant skin involvement a rheumatologist and a dermatologist should collaborate in diagnosis and management			9.5±0.8
D.	The primary goal of treating patients with PsA is to maximise health-related quality of life, through control of symptoms, prevention of structural damage, normalisation of function and social participation; abrogation of inflammation is an important component to achieve these goals			9.6±1.0
E.	When managing patients with PsA, extra-articular manifestations, metabolic syndrome, cardiovascular disease and other comorbidities should be taken into account			9.5±1.0
	Recommendations	**Level of evidence**	**Grade of recommendation**	**Level of agreement (mean±SD**
1.	Treatment should be aimed at reaching the target of remission or, alternatively, minimal/low disease activity, by regular monitoring and appropriate adjustment of therapy	1b	A	9.6±0.9
2.	In patients with PsA, NSAIDs may be used to relieve musculoskeletal signs and symptoms	1b	A	9.6±0.8
3.	In patients with peripheral arthritis, particularly in those with many swollen joints, structural damage in the presence of inflammation, high ESR/CRP and/or clinically relevant extra-articular manifestations[a], csDMARDs should be considered[b] at an early stage[a], with methotrexate preferred in those with relevant skin involvement[b]	[a]: 3 [b]: 1b	B	9.4±0.8
4.	Local injections of glucocorticoids should be considered as adjunctive therapy in PsA[a]; systemic glucocorticoids may be used with caution at the lowest effective dose[b]	[a]: 3b [b]: 4	C	9.1±1.2
5.	In patients with peripheral arthritis and an inadequate response to at least one csDMARD, therapy with a bDMARD, usually a TNF inhibitor, should be commenced	1b	B	9.5±0.7
6.	In patients with peripheral arthritis and an inadequate response to at least one csDMARD, in whom TNF inhibitors are not appropriate, bDMARDs targeting IL12/23 or IL17 pathways may be considered	1b	B	9.1±1.1
7.	In patients with peripheral arthritis and an inadequate response to at least one csDMARD, in whom bDMARDs are not appropriate, a targeted synthetic DMARD such as a PDE4-inhibitor may be considered	1b	B	8.5±1.4
8.	In patients with active enthesitis and/or dactylitis and insufficient response to NSAIDs or local glucocorticoid injections, therapy with a bDMARD should be considered, which according to current practice is a TNF inhibitor	1b	B	9.1±1.2
9.	In patients with predominantly axial disease that is active and has insufficient response to NSAIDs, therapy with a bDMARD should be considered, which according to current practice is a TNF inhibitor	1b	B	9.6±0.6
10.	In patients who fail to respond adequately to a bDMARD, switching to another bDMARD should be considered, including switching between TNF inhibitors	1b	B	9.6±0.7

The level of evidence was determined for different parts of the recommendation (referred to as a and b) where necessary.
The level of agreement was computed as a 0–10 scale.
bDMARD, biological DMARD; CRP, C reactive protein; csDMARDs, conventional synthetic disease-modifying antirheumatic drugs, such as methotrexate, sulfasalazine or leflunomide; ESR, erythrocyte sedimentation rate; EULAR, European League Against Rheumatism; NSAIDs, non-steroidal anti-inflammatory drugs; PDE, phosphodiesterase; PsA, psoriatic arthritis; TNF, tumour necrosis factor.