Biologic and oral disease-modifying antirheumatic drug monotherapy in rheumatoid arthritis

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ABSTRACT

Clinical evidence demonstrates coadministration of tumour necrosis factor inhibitor (TNFi) agents and methotrexate (MTX) is more efficacious than administration of TNFi agents alone in patients with rheumatoid arthritis, leading to the perception that coadministration of MTX with all biologic agents or oral disease-modifying antirheumatic drugs is necessary for maximum efficacy. Real-life registry data reveal approximately one-third of patients taking biologic agents use them as monotherapy. Additionally, an analysis of healthcare claims data showed that when MTX was prescribed in conjunction with a biologic agent, as many as 58% of patients did not collect the MTX prescription. Given this discrepancy between perception and real life, we conducted a review of the peer-reviewed literature and rheumatology medical congress abstracts to determine whether data support biologic monotherapy as a treatment option for patients with rheumatoid arthritis. Our analysis suggests only for tocilizumab is there evidence that the efficacy of biologic monotherapy is comparable with combination therapy with MTX.

INTRODUCTION

Methotrexate (MTX), administered alone or with another conventional disease-modifying antirheumatic drug (DMARD), is the recommended first-line treatment for patients with rheumatoid arthritis (RA).1,2 MTX plus tumour necrosis factor inhibitor (TNFi) agents is the usual treatment for patients with RA with insufficient response to MTX/DMARDs (MTX-/DMARD-IR).3,4 TNFi agents plus MTX reduce disease activity, improve physical function and attenuate radiographic progression in MTX-/DMARD-IR patients.5-12 When administered with MTX, enhanced efficacy has been observed for TNFi agents infliximab, etanercept, adalimumab and golimumab.13-18 The efficacy reported with certolizumab in combination with MTX19-20 is higher than that reported in separate studies with certolizumab monotherapy.21 The non-TNFi agent rituximab, which targets CD20 B cells, may also be more effective when combined with MTX.22 Despite the efficacy of TNFi agents plus conventional DMARDs and the limited approval of biologics (etanercept, adalimumab, certolizumab, tocilizumab) as monotherapy, biologic monotherapy for managing RA is widespread in clinical practice.23-29 Review of the peer-reviewed published literature (2005–2012) and rheumatology medical congress abstracts (European League Against Rheumatism and American College of Rheumatology (ACR), 2009–2012) was conducted to determine potential reasons for, and evidence supporting, the use of biologics or oral DMARDs (tocafitnib) as monotherapy (box 1). References in retrieved articles were reviewed to identify trials in which biologics alone were administered. Additional search strategies to identify potential reasons for use of biologics as monotherapy were conducted.

MTX IN COMBINATION THERAPY

The enhanced efficacy of TNFi agents used in combination with MTX compared with TNFi monotherapy is supported by data from randomized controlled trials (RCTs). Patients treated with infliximab plus MTX had longer duration of response than those who received infliximab alone; 20% Paulus criteria were maintained for median 16.5 versus 2.6 weeks (p=0.006).31 In the PREMIER study, adalimumab in combination with MTX was superior to adalimumab monotherapy; 62% of patients achieved ACR50 response on combination therapy compared with 41% on monotherapy with significantly less radiographic progression (p<0.001, both comparisons).31 In the Trial of Etanercept and Methotrexate (ETAM) study, etanercept plus MTX was more effective than etanercept monotherapy; ACR20, 86% vs 75%; ACR50, 71% vs 54%; ACR70, 49% vs 27% and 28-joint Disease Activity Score (DAS28) remission, 42% vs 22% (p<0.01, all comparisons); there was also less radiographic progression (p<0.05).17 In the A Multicenter, Randomized, Double-Blind, Placebo-controlled Trial of Golimumab, a Fully Human Anti-TNFa Monoclonal Antibody, Administered Subcutaneously, in Subjects With Active Rheumatoid Arthritis Despite Methotrexate Therapy (GO-FORWARD) study, ACR20 response was achieved by 56% of patients receiving golimumab in combination with MTX, which was significantly higher than MTX monotherapy (33%, p<0.001), and 44% receiving golimumab alone, which was not significantly higher than MTX alone (p=0.059).16 ACR50 responses were reported in 58% of patients treated with certolizumab in combination with MTX, which was significantly higher than MTX monotherapy (33%, p<0.001), and 44% receiving golimumab alone, which was not significantly higher than MTX alone (p=0.059).16 ACR50 responses were reported in 58% of patients treated with certolizumab in combination with MTX, which was significantly higher than MTX monotherapy (33%, p<0.001), and 44% receiving golimumab alone, which was not significantly higher than MTX alone (p=0.059).16 ACR50 responses were reported in 58% of patients treated with certolizumab in combination with MTX, which was significantly higher than MTX monotherapy (33%, p<0.001), and 44% receiving golimumab alone, which was not significantly higher than MTX alone (p=0.059).16

To cite: Emery P, Sebba A, Huizinga TWJ. Ann Rheum Dis 2013;72:1897–1904. doi:10.1136/annrheumdis-2013-203485.
MTX may independently reduce inflammatory activity after 6 months.42 Alternatives to initiating DMARD monotherapy include step-up, parallel, or step-down regimens.43 The most effective regimen is unknown and may be different for different patients.

**Box 1 Search terms and strategies for identifying clinical studies that support the use of biologic monotherapy in patients with rheumatoid arthritis**

Search strategies:

- Evidence supporting the use of biologics as monotherapy: [drug name] AND [rheumatoid arthritis] AND [monotherapies OR monotherapy].
- Reasons for using biologics as monotherapy: [DMARD] OR [methotrexate] AND [intoleran*] AND [management] AND [rheumatoid arthritis].

Drug names: tocolizumab, infliximab, etanercept, adalimumab, anakinra, abatacept, rituximab, certolizumab, golimumab, tofacitinib

Search limits: PubMed, 2005–2012; Congress (EULAR and ACR) abstracts, 2009–2011; phase 3/4 studies and comparator studies only; English language. Monotherapy studies that included background methotrexate were excluded.

A CR, American College of Rheumatology; DMARD, disease-modifying antirheumatic drug; EULAR, European League Against Rheumatism.

Direct and indirect effects potentially account for the enhanced efficacy of TNFi agents coadministered with MTX. MTX may independently reduce inflammation and radiographic progression.4–8 MTX also may increase the bioavailability of TNFi agents (infliximab30 31 and adalimumab,32 though no dose adjustments are required). Infliximab can induce formation of anti-infliximab antibodies that may lower circulating infliximab levels33 and reduce clinical effect. However, MTX coadministration can promote immune tolerance and increase circulating infliximab levels, prolonging therapeutic effect.13 A meta-analysis of 17 prospective cohort studies showed that development of antidrug antibodies to adalimumab and infliximab reduced the therapeutic response rates by up to 68%; this was attenuated with concomitant MTX or other immunosuppressive agents (azathioprine, mercaptopurine).34 Compared with MTX, patients receiving no DMARD, lefunomide or sulphasalazine were more likely to discontinue their first TNFi.24

Clinical response to infliximab is related to its trough levels. Pharmacokinetic analysis of RA patients treated with infliximab plus MTX showed good and moderate responders maintained trough serum concentrations ≥1 μg/mL through 14 weeks of treatment, whereas poor responders had undetectable trough concentrations.35 Increasing MTX or corticosteroid dose improved therapeutic response in poor responders after an initial response, although trough serum concentrations of infliximab remained below the detectable limit.

Autoantibodies, including antinuclear antibodies (28–100%) and antibodies to double-stranded DNA (0–78%), are detected in patients receiving TNFi agents, particularly infliximab.36 Increased autoantibody formation correlates with lack of response to infliximab37 suggesting immunologic abnormalities influence efficacy. Addition of an immunosuppressant, such as MTX, may reduce the risk of autoantibody development.36 However, concomitant MTX did not suppress autoantibody development in two small studies,38 39 and the effect of autoantibody formation on efficacy of TNFIs is yet to be confirmed.

Patients taking TNFi agents who discontinue concomitant MTX experience reduced efficacy and shorter responses. A long-term study in Japan comparing the efficacy of continuation versus discontinuation of MTX when initiating etanercept in MTX-IR patients showed continuation resulted in better clinical and radiographic outcomes at weeks 52 and 104 than discontinuation.40 41 Data from a Dutch registry showed discontinuation of DMARDs was not associated with increased disease activity after 6 months.42

**CHARACTERISATION OF RA PATIENTS NOT TAKING MTX**

Data from biologic registries23–28 44 and US claims databases29 45 indicate approximately 30% of patients taking biologics use them as monotherapy. However, this does not capture patients who fill prescriptions but do not take some or all of the medication.

Patients not taking MTX are those who never initiate MTX—MTX is contraindicated or declined—and those who initiate MTX but subsequently discontinue (figure 1). Among patients who never initiate treatment with MTX are those with contraindications to MTX such as patients who are pregnant or breastfeeding, are heavy alcohol users, have alcohol-induced or other chronic liver diseases or have immunodeficiency or pre-existing blood dyscrasias, known hypersensitivity to MTX or lung disease.46 The ACR recommends MTX not be used in the presence of clinically important RA-associated pneumonitis or interstitial lung disease of unknown cause, or in patients with active bacterial, active tuberculosis or life-threatening fungal or active herpes zoster infection.5 Additionally, some patients may decline MTX because of the advice to abstain from alcohol consumption; the combination is associated with increased risk for hepatotoxicity.46

Patients or physicians may discontinue treatment for a number of reasons. Gastrointestinal, hepatic, dermatologic and neurologic adverse events (AE), as well as cytopenia and MTX-induced pneumonitis, have been reported with MTX and sometimes cause discontinuation. Even in tightly controlled clinical studies, 5–15% of patients taking MTX discontinued treatment because of AEs.3 5 7 8 14 17 22 Despite the well-established benefits of MTX for the treatment of RA, including favourable drug survival rates53 and cost-effectiveness,54 data from observational studies representing real-life clinical practice indicate MTX discontinuation rates attributed to AEs range from 10% to 77% after 3–12.7 years’ treatment.51 53–60 Risk factors for MTX-associated AEs include renal dysfunction, liver disease, active infectious disease and excessive alcohol consumption.49 52 61 Renal insufficiency is a major risk factor, because
lower creatinine clearance rate is associated with reduced MTX clearance, increasing the risk for MTX-related AEs.52

Patients who initiate and subsequently discontinue MTX include those who do not inform their rheumatologists. In an online survey of 1500 patients, 45% admitted to being less than forthright with their rheumatologists.62 Some patients might be reluctant to admit discontinuation because of minor AEs or unwillingness to abstain from alcohol, but it appears this subgroup exists. Analysis of 6744 patient records from Canadian private and public drug plans showed that, among patients on their first biologic for >6 months, 45% did not purchase a DMARD and 58% did not purchase MTX; 41% of patients taking a biologic for >24 months did not purchase a DMARD (54% for MTX). Independent patient and physician surveys indicated half the patients did not take MTX but continued their prescribed biologic regularly. By contrast, physician surveys indicated a DMARD was prescribed with a biologic for 80–90% of patients.63

Another analysis of 1652 patient records from Canadian private and public drug plans (2009–2010) demonstrated a biologic monotherapy prescribing rate of 12%; however, 29% of patients (43% of those prescribed MTX) did not obtain their logic monotherapy prescription included the patient's previous biologic experience and the rheumatologist's perceptions and reality of the medications patients are taking.

**THERAPEUTIC STRATEGIES IN PATIENTS DISCONTINUING OR NOT INITIATING MTX**

Patients without a contraindication for MTX who decline its use, and those considering discontinuation, may benefit from counselling and education. Patients can be encouraged to use MTX if the potential for progressive joint damage and loss of efficacy with discontinuation or non-compliance is explained. Several approaches may improve MTX tolerability. Regular monitoring for signs of hepatic, renal or haematological AEs is advised.50 55 Dose adjustment or interruption with reinstatement at a lower dose may be considered if hepatotoxicity is evident.50

Switching from oral to intramuscular or subcutaneous (SC) MTX may benefit patients with poor adherence or gastrointestinal AEs.65–70 A retrospective study of 191 patients in the UK who switched from oral to SC MTX (2003–2011) showed among 53 patients who switched because of intolerance, 40 (75.5%) subsequently tolerated parenteral therapy.70 Another RCT comparing oral and SC MTX found no difference in tolerability, though SC administration demonstrated better clinical efficacy at the same dosage.71 An alternative strategy for improving MTX tolerability is twice-weekly dosing, which increases the bioavailability of MTX above once-weekly dosing;72 a preliminary study, however, did not demonstrate an efficacy advantage over once-weekly dosing.69 73 Potential adjunctive therapies to mitigate AEs include folate supplementation, which reduces MTX-associated hepatic AEs,50 74 and antiemetics, which suppress MTX-induced nausea and vomiting.75

Switching to another conventional DMARD may be an option in MTX-intolerant patients receiving combination therapy. Registry data and case series indicate rituximab plus leflunomide is a viable alternative to rituximab plus MTX, with potentially better tolerability.76 77 By contrast, a high incidence of AEs has been reported with infliximab plus leflunomide.78 Tocilizumab and abatacept, in combination with some non-MTX DMARDs, demonstrated good tolerability.79 80 Several TNFi agents are effective as monotherapy, and biologic monotherapy is currently prescribed in patients who are, for one reason or another, not going to use MTX. However, the efficacy of these agents is generally enhanced by concurrent MTX administration.13–17

**BIOLOGIC AND ORAL DMARD MONOTHERAPY**

A summary of biologic and oral DMARDs approved for RA is shown in table 1. The TNFi agents etanercept, adalimumab and certolizumab pegol are approved as monotherapy for patients with RA in the USA and Europe,81–86 whereas, infliximab and golimumab are approved only with MTX.87–90 Among non-TNFi agents, only tocilizumab is licenced for use as monotherapy in the USA and Europe.91 92 Tofacitinib anakinra and abatacept are approved as monotherapy only in the USA.93–96 Rituximab is approved only with MTX in the USA and Europe.97 98 Two recent analyses of the CORRONA registry showed the likelihood of starting biologic monotherapy was consistently increased if it was approved for use as monotherapy;44 99 Other factors that increased the likelihood of a biologic monotherapy prescription included the patient’s previous biologic experience and the rheumatologist’s prescribing patterns.

For use as monotherapy, a biologic or oral DMARD should be superior to placebo; be at least comparable to MTX/DMARDs and the agent plus MTX/DMARDs in reducing clinical signs, symptoms and radiographic progression; and have an acceptable safety and tolerability profile. Further, duration of efficacy, which is a major concern among rheumatologists familiar with the TNFi combination paradigm, should not be compromised. Trials of biologic and oral DMARD monotherapy that meet these criteria are summarised in table 2.

### Table 1 Biologic and oral DMARDs approved for the treatment of patients with rheumatoid arthritis

| Agent      | Mechanism of action | Location          | Regimen                          |
|------------|---------------------|-------------------|----------------------------------|
| Etanercept | TNFi                | USA and Europe    | Monotherapy                     |
| Adalimumab | TNFi                | USA and Europe    | Monotherapy                     |
| Infliximab | TNFi                | USA and Europe    | In combination with MTX only    |
| Certolizumab pegol | TNFi | USA and Europe | Monotherapy                     |
| Golimumab | TNFi                | USA and Europe    | In combination with MTX only    |
| Tocilizumab | IL-6 receptor inhibitor | USA and Europe | Monotherapy                     |
| Anakinra | IL-1 receptor inhibitor | USA             | Monotherapy                     |
| Abatacept | Inhibitor of T-cell activation (costimulation modulator) | USA             | Monotherapy                     |
| Rituximab | Anti-CD20           | USA and Europe    | In combination with a DMARD only|
| Tofacitinib | JAK inhibitor       | USA              | Monotherapy                     |

**DMARD, disease-modifying antirheumatic drug; IL, interleukin; JAK, Janus kinase; MTX, methotrexate; TNFi, tumour necrosis factor inhibitor.**

Emery P, et al. *Ann Rheum Dis* 2013;72:1897–1904. doi:10.1136/annrheumdis-2013-203485
Monotherapy with different adalimumab regimens was better than placebo in DMARD-IR patients. Adalimumab monotherapy was associated with similar clinical but more favourable radiological outcomes than MTX alone. Patients with low disease activity at the end of the randomised phase of the study maintained low disease activity and had minimal radiographic progression after 6 years of adalimumab monotherapy.

Etanercept monotherapy results have been inconsistent. Compared with sulphasalazine monotherapy, etanercept alone, or with sulphasalazine, resulted in significant improvements in disease activity. In the ERA trial, etanercept monotherapy had clinical and radiological advantages over MTX sustained for 24 months in MTX-naive patients. In the TEMPO study, which included patients with disease durations averaging 6 years, some indices of disease activity and radiographic progression showed greater improvement with etanercept than with MTX. However, the combination was more effective than either agent alone.

Etanercept plus MTX was also more effective than etanercept monotherapy in the Japanese Efficacy and Safety of Etanercept on Active Rheumatoid Arthritis (RA) Despite Methotrexate (MTX) Therapy in Japan (JESMR) study. By contrast, in the open-label ADORÉ study, clinical improvements (at 16 weeks) were similar with etanercept monotherapy or etanercept plus MTX.

Golimumab is not approved for monotherapy. However, studies suggest the efficacy of intravenous golimumab monotherapy is comparable to that of MTX; golimumab plus MTX, however, was more effective than MTX alone.

Certolizumab pegol monotherapy demonstrated superiority to placebo in the FAST4WARD study and was similar to concomitant DMARD treatment in the REALISTIC study, regardless of previous TNFi use.

Monotherapy with non-TNFi biologics, except for tocilizumab, has not been investigated extensively. In a study involving 214 patients, abatacept monotherapy resulted in a dose-dependent increase in ACR20 response compared with placebo after approximately 3 months of treatment. In the ARRIVE study, TNFi-IR patients taking abatacept monotherapy experienced similar efficacy to patients taking abatacept plus DMARDs. Rituximab monotherapy yielded an ACR50 response rate higher than, but not statistically significantly different from, MTX. Anakinra monotherapy demonstrated increased efficacy compared with placebo, but response rates were modest.

Tocilizumab has the largest database on monotherapy and has demonstrated greater efficacy than MTX or other DMARDs, including salazosulphapyridine, bucillamine, mizoribine and D-penicillamine, in lowering disease activity and reducing radiographic progression. Results from Actemra versus Methotrexate double-Blind Investigative Trial In mONotherapy (AMBITION) and Study of Active controlled TOcilizumab monotherapy for Rheumatoid arthritis patients with Inadequate response to methotrexate (SATORI) demonstrated higher ACR20, ACR50 and ACR70 response rates with tocilizumab than MTX. Furthermore, patients from AMBITION maintained DAS28 and clinical disease activity index low-disease activity and remission thresholds during long-term tocilizumab monotherapy.

Tocilizumab monotherapy was more efficacious than non-biologic DMARDs at slowing joint damage in the Study of Active controlled Monotherapy Used for Rheumatoid Arthritis, an IL-6 inhibitor (SAMURAI) study, even in patients at high risk for structural damage. Contrary to findings with TNFi agents, add-on (tocilizumab plus MTX) therapy was not superior to tocilizumab monotherapy in MTX-IR patients in the ACT-RAY study; ACR responses, swollen and tender joint counts, DAS28 change from baseline, DAS28 ≤ 3.2 and Genant-modified Total Sharp Score were not significantly different between tocilizumab plus MTX and tocilizumab monotherapy (p>0.05), though proportions of patients achieving DAS28 < 2.6 and patients without radiographic progression were significantly higher with tocilizumab plus MTX (p<0.05).

These differences in efficacy are unlikely due to immunogenicity because the proportions of patients with neutralising antidrug antibodies were similar between monotherapy (4.4%) and combination therapy (3.7%).

In the ACT-SURE and ACT-STAR, which were real-world-type safety studies in patients with active RA despite receiving biologics or DMARDs, comparable improvements in clinical signs and symptoms were observed in patients receiving tocilizumab monotherapy or tocilizumab plus DMARDs, although precise reasons for not receiving DMARDs are unknown. Long-term data from the Safety and Efficacy of Tocilizumab, an anti-IL-6 receptor monoclonal antibody, in Monotherapy, in Patients With Rheumatoid Arthritis (STREAM) study showed tocilizumab monotherapy is not associated with clinically relevant decline in efficacy over time; ACR response rates and improvements in DAS28 were sustained over 5 years of tocilizumab monotherapy.

In the ADalimumab ACTemrA (ADACTA) trial, which directly compared tocilizumab and adalimumab monotherapy in patients who were MTX-intolerant or unable to continue MTX therapy, tocilizumab was superior to adalimumab in reducing signs and symptoms of RA. The AE profile of tocilizumab was consistent with previous findings and comparable with that of adalimumab.

Several additional reports support the efficacy of tocilizumab monotherapy. A systematic review of 10 clinical trials demonstrated tocilizumab monotherapy yielded significantly higher ACR20, ACR50 and ACR70 response rates than MTX. Additionally, a meta-analysis of six Japanese clinical studies and their five uncontrolled long-term extensions confirmed high rates of ACR20 (91.3%), ACR50 (73.0%) and ACR70 (51.3%) responses and DAS remission (59.7%) were maintained with tocilizumab monotherapy for 5 years. Finally, a network meta-analysis involving indirect comparison of clinical trials

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**Table 2** Studies investigating monotherapy of TNFi and non TNFi agents for the treatment of rheumatoid arthritis

| TNFi agents       | Monotherapy superior to placebo | Monotherapy at least comparable to MTX/DMARDs | Monotherapy at least comparable to the agent plus MTX/DMARDs |
|-------------------|----------------------------------|-----------------------------------------------|-------------------------------------------------|
| Adalimumab        | ✓100                             | ✓14                                           | ×14 15 101                                      |
| Etanercept        | ×3                               | ×17 102 103 104                               | ×102 107                                       |
| Golimumab         | ×128 129                         | ×16 108 109                                   | ×16                                            |
| Certolizumab      | ×21 110                          | NR                                            | NR                                             |
| Non-TNFi agents   |                                  |                                               |                                                |
| Abatacept         | ×111                             | NR                                            | ×112                                           |
| Rituximab         | ×22                              | ×4                                           | ×114 115 117 125 130                          |
| Anakinra          | ×113                             | NR                                            | 79 119 120 122 131                            |
| Tocilizumab       | ×117                             | ×114 115 117 125 130                        | ×132                                           |
| Tofacitinib       | ×118                             | ×114 115 117 125 130                        | ×132                                           |

DMARD, disease-modifying antirheumatic drug; MTX, methotrexate; NR, not reported; TNFi, tumour necrosis factor inhibitor.
showed tocilizumab plus MTX had ACR responses comparable to other biologics plus MTX. When used as monotherapy, tocilizumab was likely to show better efficacy than TNFi monotherapy and comparable efficacy to tocilizumab plus MTX.18

SUMMARY: PHYSICIAN’S PERSPECTIVE

Concurrent use of MTX and a biologic is generally the standard-of-care in patients with RA who continue with disease activity despite MTX. Many patients, however, do not take MTX concomitantly as prescribed. Strategies exist to mitigate MTX-associated AEs; however, a substantial proportion of patients should not or do not take MTX.

Rheumatologists may recognize biologic monotherapy is sometimes necessary when treating patients with RA and comorbidities or patients who consume alcohol. Although consensus is lacking on biologics as monotherapy, accumulating data can inform rheumatologist decision making to treat such patients optimally.

Although we use the generic term ‘biologics’, these medications have different mechanisms of action that might affect the need for combination with MTX for improved efficacy. It is, therefore, not surprising that biologics appear to differ substantially with respect to the degree of benefit when administered as monotherapy.

Tocilizumab monotherapy has greater efficacy than MTX or other conventional DMARDs in lowering disease activity and reducing radiographic progression and has stable safety and tolerability profiles.114 115 116 117 118 119 120 121 Tocilizumab monotherapy also demonstrated superiority over adalimumab monotherapy in reducing signs and symptoms of RA in patients who were MTX-intolerant, or in whom MTX was considered ineffective or inappropriate.124

That monotherapy with any biologic is absolutely equivalent to a biologic coadministered with MTX is not a proven notion. Data shed light on how to deal with this treatment issue; treating without MTX appears to be safe and effective when necessary. However, in the subpopulation of patients not taking, or unable or unwilling to take, MTX, in whom treatment is required, TNFi agents might not be the first choice of monotherapy given the evidence they are less effective as monotherapy than as combination therapy with MTX.

Correction notice This article has been corrected since it was published Online First. The names of the studies AMBITION, SATORI, SAMSURAI and STREAM have been amended; Table 1 has been updated and the following sentence amended to read: When used as monotherapy, tocilizumab was likely to show better efficacy than TNFi monotherapy and comparable efficacy to tocilizumab plus MTX.18

Acknowledgements The authors wish to acknowledge Maribeth Bogush, PhD, and Sara Duggan, PhD, who provided writing services on behalf of F Hoffmann-La Roche Ltd.

Contributors All authors fulfilled the following criteria: (1) conception and design, acquisition of data OR analysis and interpretation of data, (2) drafting the manuscript OR revising it critically for important intellectual content, and (3) final approval of version to be submitted for publication.

Funding Funding for manuscript preparation was provided by F. Hoffmann-La Roche Ltd. This study was sponsored by Roche.

Competing interests PE: Consulting and speaker’s fees from Pfizer, Merck, Abbott, UCB, Roche and Bristol-Myers Squibb; AS: Advisor and speakers bureau fees from Roche. TWJH: Grants from the European Union and the Arthritis Foundation; lecture and consultancy fees (shared with the Department of Rheumatology) from Merck, UCB, Roche and Bristol-Myers Squibb, Biotech AG, Pfizer, Novartis, Roche, Sanofi-Aventis, Abbott, Crescendo Bioscience, Nycomed, Boehringer, Takeda and Eli Lilly.

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