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Letter to the Editor (matters arising)

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Comment on: A randomized placebo-controlled trial of methotrexate in psoriatic arthritis: reply

SIR, We thank Sathi and colleagues [1] for commenting on the inclusion criteria for the Methotrexate in Psoriatic Arthritis (MIPA) trial [2] and drawing further attention to outcome measures considered by Dougados in an accompanying editorial [3].

Would the findings in MIPA have been different if the Classification of Psoriatic Arthritis Study Group (CASPAR) criteria were used to identify patients with PsA? As MIPA started to enrol patients before the CASPAR criteria were published, this is a theoretical question. Unlike earlier criteria used in MIPA, CASPAR includes criteria about dactylitis and juxta-articular new bone formation, which increases specificity but reduces sensitivity. It is therefore likely the CASPAR criteria would exclude many patients with RA-like disease. Our exploratory analysis of PsA subtypes in MIPA (published as supplementary online material) suggested that such RA-like patients had larger improvements in joint counts with MTX than patients with oligoarthritis. Using the CASPAR criteria to select patients would be likely to minimize any further impact of MTX on joint counts.

Would the findings in MIPA have been different if we had used the absence of active joints as the primary outcome, as suggested by Dougados [3]? A brief additional exploratory analysis of patients with no swollen joints or no tender joints at 6 months in MIPA showed that similar numbers of patients achieved this state with either placebo or MTX. However, we agree it is useful to assess benefit in this way.

Dougados [3] suggested that most rheumatologists are convinced MTX benefits patients with active PsA. Their conviction almost certainly reflects the impact of regression to the mean, which ensures most patients with active PsA will improve after starting MTX. MIPA and the only other placebo-controlled trial of oral MTX in PsA [4] both show that MTX has no significant benefit on joint counts over and above such regression to the mean. As there are now highly effective treatments for PsA [5] we question whether it is appropriate to continue to treat active disease with MTX alone.

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Gabrielle H. Kingsley[1,2] and David L. Scott[1,3]

[1]*Department of Rheumatology, King's College London School of Medicine, King's College London,* [2]*Lewisham Healthcare NHS Trust, London and* [3]*Department of Rheumatology, King's College Hospital, London, UK.*
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Correspondence to: Gabrielle H. Kingsley, Department of Rheumatology, King's College London School of Medicine, King's College London, London SE5 9RJ, UK.

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