Author's response to reviews

Title: The Rheumatoid Arthritis Treat-To-Target Trial: A Cluster Randomized Trial Within the Corrona Rheumatology Network

Authors:

Leslie R Harrold (leslie.harrold@umassmed.edu)
George W Reed (Greed@corrona.org)
Timothy Harrington (tharrington@corrona.org)
Christine J Barr (cbarr@corrona.org)
Katherine C Saunders (ksaunders@corrona.org)
Allan Gibofsky (GibofskyA@HSS.EDU)
Jeffrey D Greenberg (jeffrey.greenberg@nyumc.org)
Ani John (john.ani@gene.com)
Jenny Davenport (davenport.jenny@gene.com)
Joel M Kremer (jkremer@joint-docs.com)

Version: 3 Date: 4 November 2014

Author's response to reviews: see over
October 31, 2014

MS:1038411308971308—The Rheumatoid Arthritis Treat-To-Target Trial: A Cluster Randomized Trial Within the Corrona Rheumatology Network

Dear BMC Editorial Office,

On behalf of my co-authors, I would like to thank the reviewers for taking the time to provide additional feedback on our submission. We have made revisions to the manuscript in response to the reviewer’s comments and we are now submitting a revised version, taking these comments/remarks into account. Below, we have provided a point-by-point response to address each query and provide detailed descriptions of how the manuscript has been modified. Please note the page and line numbers listed below correspond to the locations of each revision in the tracked changes version of the manuscript, which we have attached as a supplementary file for the editors. We feel that we have adequately answered all of the concerns and we hope that you will consider now this revised manuscript as suitable for publication.

Thank you again, and we look forward to hearing from you.

Kind Regards,

Leslie Harrold, MD, MPH

---

Editor’s Comments:

1.) Please update your ethics statement to include the full name of the ethics committee that approved your study in the main manuscript.

We have revised on the manuscript on Page 8, Lines 4-6 to include the full name of the ethics committee that approved of the study.

Reviewer 1: Raimon Sanmarti, MD, PhD

Reviewer’s Report: No additional comments

Reviewer 2: Burkhard Leeb, MD, PhD

Reviewer’s Report: Major compulsory revision.

General Comments:

- Are sufficient details provided to allow replication of the work or comparison with related analyses: if not, what is missing? Yes
Specific Comments:

1.) Will the study design adequately test the hypothesis? I’m really not sure, because the authors explicitly state that their interest is far more the level of the treating physician than the patient, given their randomization process. However, I’m not sure whether it is of importance that the physician feels well with the treatment instead of the patient. This reflects the predominantly paternalistic approach of the T2T initiative, which ultimately claims that the physicians knows better than the patients how the patient feels. Rheumatoid Arthritis treatment is far more than achieving a number. This is also particularly expressed by the choice of an 28 joint count containing composite index, which does not really meet the needs of daily practice.

Response: We wholeheartedly agree with the reviewer that it is very possible that patients may not buy into the T2T treatment paradigm. The T2T treatment paradigm was developed by an international group of rheumatologists and is being advocated as best practice (Smolen, et al. Annals of the Rheumatic Diseases 2010, 69(4):631-637). However, there is no understanding as to whether this approach is feasible in clinical practice—particularly in the United States—which is the point of our study. To our knowledge, no other research group has attempted this type of investigation in the United States. We agree that patients and providers may not be able to follow the T2T approach. It is possible that patients have different priorities and may not deem the benefits of the T2T approach worth the risks as well as inconveniences. For that reason, we will be assessing adherence to the T2T protocol to see whether this care approach is feasible. We have revised the manuscript on Page 13, Lines 18-20 to clarify that we will examine patient and provider adherence to the treatment protocol, as this is an important measure of feasibility of this care approach in clinical practice.

2.) Which advantages may be derived from the knowledge whether physicians keep to the T2T approach?

Response: Currently there is broad international support for the T2T approach. We believe it to be vitally important to assess whether this treatment paradigm is feasible in clinical practice, including whether patients and providers will adhere to the treatment regimen and whether this approach is associated with improved outcomes in real-world settings.

3.) And, what is an instrument good for in daily routine if one third of the patients are misleadingly assessed? I would be very much in favor of such an investigation if PROs, and thereby the patients, are applied as decisive measures.

Response: While our primary endpoint for the analyses is the CDAI (a validated instrument that is recommended by the American College of Rheumatology for routine assessment of disease activity in clinical practice), we will be evaluating other measures of disease activity as secondary analyses, including patient-reported outcomes (based on the RAPID3), and DAS28-ESR. This has been added to Page 12, Lines 13-16 of the manuscript.