Dr. Charles-Schoeman and E. Bananis reply

To the Editor:

We thank Professor Boers for his interest[1] in our study[2] and are grateful for the opportunity to respond to his queries.

Our posthoc analysis investigated the effect of concomitant glucocorticoid (GC) use on clinical and radiographic outcomes in phase III studies of methotrexate (MTX)-naive patients receiving tofacitinib or MTX as monotherapy (ORAL Start), disease-modifying antirheumatic drug (DMARD)–inadequate responder (IR) patients receiving tofacitinib or placebo as monotherapy (ORAL Solo), and MTX-IR and DMARD-IR patients receiving tofacitinib or placebo in combination with background conventional synthetic DMARD (ORAL Sync, ORAL Standard, ORAL Scan, and ORAL Step).

We noted with interest that our findings for MTX with or without GC were similar to those previously published by Professor Boers in this journal[3]. In our analysis, radiographic progression data were reported only in ORAL Start (NCT01039688), a 24-month study of tofacitinib versus MTX in MTX-naive patients (n = 956). In this study, radiographic efficacy and rates of radiographic nonprogression in tofacitinib-treated patients were similar regardless of GC use; however, concomitant use of GC with MTX appeared to inhibit radiographic progression to a greater extent than MTX alone. Patients treated with MTX without GC had the highest least squares mean change from baseline in the van der Heijde modified total Sharp score (mTSS) through Month 24 among all the treatment groups; however, the 95% CI overlapped between the 2 MTX subgroups (MTX only vs MTX + GC).

In response to Professor Boers' query regarding the statistical tests used, these posthoc analyses were exploratory in nature and no formal statistical comparisons between the subgroups were performed; rather, the data were analyzed by descriptive statistics only and trends were reported. We can confirm that changes from baseline in mTSS were measured at months 6, 12, and 24, and that an overall assessment spanning the full 24-month period, inclusive of these 3 visits, was performed in the mixed-model separately for each subgroup.

We also wish to clarify that while 5 of the 6 phase III studies in this posthoc analysis included a placebo arm, patients receiving placebo blindly advanced to tofacitinib 5 or 10 mg BID at Month 3 or Month 6; therefore, no patients still took placebo at Month 24. It should also be noted that ORAL Start compared tofacitinib 5 mg or 10 mg BID versus MTX, and did not include a placebo arm.

CHRISTINA CHARLES-SCHOEMAN, MD, MS, Associate Professor of Medicine, University of California, Los Angeles, California; EUSTRATIOS BANANIS, PhD, Pfizer Inc., New York, New York, USA. Address correspondence to E. Bananis, 235 E. 42nd St., New York, New York 10017, USA. E-mail: stratis.bananis@pfizer.com. Dr. Charles-Schoeman received research grants from AbbVie, BMS, and Pfizer Inc., and consulting fees from Regeneron-Sanofi. E. Bananis is an employee and shareholder of Pfizer Inc. This work was funded by Pfizer Inc. Medical writing support, under the direction of the authors, was provided by Jennifer Higginson, PhD, of CMC Connect, a division of Complete Medical Communications Ltd., Glasgow, UK, and was funded by Pfizer Inc., in accordance with Good Publication Practice (GPP3) guidelines.

REFERENCES

1. Boers M. Effects of co-medication with glucocorticoids in biologics trials. J Rheumatol 2018;45:1605.
2. Charles-Schoeman C, van der Heijde D, Burmester GR, Nash P, Zerbini CAF, Connell CA, et al. Effect of glucocorticoids on the clinical and radiographic efficacy of tofacitinib in patients with rheumatoid arthritis: a posthoc analysis of data from 6 phase III studies. J Rheumatol 2018;45:177-87.
3. Boers M, Aletaha D, Mela CM, Baker DG, Smolen JS. Glucocorticoid effect on radiographic progression in placebo arms of rheumatoid arthritis biologics trials. J Rheumatol 2016; 43:1024-6.

J Rheumatol 2018;45:11; doi:10.3899/jrheum.180489