Citation for published version (APA):
Tumour necrosis factor inhibitors versus combination intensive therapy with conventional disease modifying anti-rheumatic drugs in established rheumatoid arthritis: TACIT non-inferiority randomised controlled trial

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ABSTRACT

OBJECTIVE
To determine whether intensive combinations of synthetic disease modifying drugs can achieve similar clinical benefits at lower costs to high cost biologics such as tumour necrosis factor inhibitors in patients with active rheumatoid arthritis resistant to initial methotrexate and other synthetic disease modifying drugs.

DESIGN
Open label pragmatic randomised multicentre two arm non-inferiority trial over 12 months.

SETTING
24 rheumatology clinics in England.

PARTICIPANTS
Patients with rheumatoid arthritis who were eligible for treatment with tumour necrosis factor inhibitors according to current English guidance were randomised to either the tumour necrosis factor inhibitor strategy or the combined disease modifying drug strategy.

INTERVENTIONS
Biologic strategy: start tumour necrosis factor inhibitor; second biologic in six months for non-responders. Alternative strategy: start combination of disease modifying drugs; start tumour necrosis factor inhibitors after six months in non-responders.

MAIN OUTCOME MEASURE
Primary outcome: reduction in disability at 12 months measured with patient recorded health assessment questionnaire (range 0.00–3.00) with a 0.22 non-inferiority margin for combination treatment versus the biologic strategy. Secondary outcomes: quality of life, joint damage, disease activity, adverse events, and costs. Intention to treat analysis used multiple imputation methods for missing data.

RESULTS
432 patients were screened: 107 were randomised to tumour necrosis factor inhibitors and 101 started taking; 107 were randomised to the combined drug strategy and 104 started taking the drugs. Initial assessments were similar; 16 patients were lost to follow-up (seven with the tumour necrosis factor inhibitor strategy, nine with the combined drug strategy); 42 discontinued the intervention but were followed-up (19 and 23, respectively). The primary outcome showed mean falls in scores on the health assessment questionnaire of −0.30 with the tumour necrosis factor inhibitor strategy and −0.45 with the alternative combined drug strategy. The difference between groups in unadjusted linear regression analysis favoured the alternative strategy of combined drugs. The mean difference was −0.14, and the 95% confidence interval (−0.29 to 0.01) was below the prespecified non-inferiority boundary of 0.22. Improvements at 12 months in secondary outcomes, including quality of life and erosive progression, were similar with both strategies. Initial reductions in disease activity were greater with the biologic strategy, but these differences did not persist beyond six months. Remission was seen in 72 patients (44 with biologic strategy; 36 with alternative strategy); 28 patients had serious adverse events (18 and 10, respectively); six and 10 patients, respectively, stopped treatment because of toxicity. The alternative strategy reduced health and social care costs per patient by £3615 (€4930, $5585) for months 0–6 and £1930 for months 6–12.

CONCLUSIONS
In patients with active rheumatoid arthritis who meet English criteria for biologics an alternative strategy with combinations of intensive synthetic disease modifying drugs gives non-inferior outcomes to treatment with tumour necrosis factor inhibitors. Costs are reduced substantially.

TRIAL REGISTRATION
ISRCTN 37438295.

Introduction
Tumour necrosis factor inhibitors, the first biologics for rheumatoid arthritis, have changed specialist
management. Placebo controlled trials in patients with active rheumatoid arthritis defined their efficacy. Long term observational studies confirmed their relative safety. Economic modelling used placebo controlled trials to justify their use in patients with active rheumatoid arthritis who were resistant to methotrexate. European and North American expert groups provided international guidance on their use in rheumatoid arthritis. English guidance from the National Institute for Health and Care Excellence (NICE) recommends starting them in patients with persistent active rheumatoid arthritis that is resistant to methotrexate and one other synthetic disease modifying drug and continuing them as long as the patients maintain good responses.

Tumour necrosis factor inhibitors are expensive. By 2012 international spending exceeded £15bn (£20.5bn, $23bn) a year. Guidance for their use is driven by results of placebo controlled trials in rheumatoid arthritis sponsored by manufacturers. Few trials have compared them with active non-biological treatments, even though lower cost strategies, such as combinations of synthetic disease modifying drugs, are effective. England spends over £600 m (£820 m, $926 m) a year on tumour necrosis factor inhibitors, which has a substantial impact on the National Health Service’s budget. Healthcare commissioners would prefer lower cost alternatives provided patients were not disadvantaged.

We evaluated this possibility by testing the hypothesis that a lower cost strategy of combinations of synthetic disease modifying drugs achieves outcomes that are not inferior and costs substantially less.

### Methods

#### Design

The TACIT (tumour necrosis factor inhibitors against combination intensive therapy) trial was an open label pragmatic randomised two arm non-inferiority trial carried out over 12 months in multiple centres.

<table>
<thead>
<tr>
<th>TREATMENT STRATEGIES</th>
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<tbody>
<tr>
<td><strong>Tumour necrosis factor inhibitor strategy</strong></td>
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<tr>
<td>This had two steps:</td>
</tr>
<tr>
<td>• Start one tumour necrosis factor inhibitor from adalimumab, etanercept, and infliximab. The choice depended on current local practice</td>
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<tr>
<td>• Switch to another tumour necrosis factor inhibitor after six months if fall in disease activity score for 28 joints was &lt;1.2</td>
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<tr>
<td>All patients also received methotrexate or another disease modifying drug. Patients taking more than one disease modifying drug before randomisation had this tapered to monotherapy. Patients taking oral prednisolone at entry continued as needed.</td>
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<td><strong>Disease modifying drug strategy</strong></td>
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<td>This had four steps:</td>
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<tr>
<td>• Maximise initial disease modifying drug treatment(s)</td>
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<tr>
<td>• Add second/third disease modifying drug</td>
</tr>
<tr>
<td>• Start fourth/fifth disease modifying drug</td>
</tr>
<tr>
<td>• Offer tumour necrosis factor inhibitors after six months if fall in disease activity score for 28 joints was &lt;1.2</td>
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</table>

Disease modifying drugs were given in combination and sequentially. Patients taking oral prednisolone at entry continued as needed; short term oral or intramuscular steroids were an option with this strategy.

### Participants

Patients were recruited from 24 rheumatology clinics in England. We included men and women aged over 18 with disease durations over 12 months who met the 1987 criteria for classification of rheumatoid arthritis and NICE criteria for starting biologics in England. The NICE criteria comprise disease activity score for 28 joints >5.1 twice over one month apart after treatment with methotrexate and one other disease modifying drug. We excluded patients who unable or unwilling to give informed consent, had not had successful results with or had contraindications to all combinations of disease modifying drugs (including possible pregnancy), had contraindications to tumour necrosis factor inhibitors, had serious inter-current illness, or were taking high dose corticosteroids (>10 mg prednisolone).

### Interventions

The trial compared two treatment strategies in patients who completed local screening procedures for treatment with tumour necrosis factor inhibitors, including tuberculosis screening. Safety monitoring followed national guidance. Treatment was guided by monthly changes in disease activity scores for 28 joints. The box outlines the tumour necrosis factor inhibitor strategy, which replicated NICE guidance when the trial started, and the combined disease modifying drug strategy. Treatments used as required at standard doses included non-opiate analgesics, non-steroidal anti-inflammatory drugs, folic acid (5 mg/week) with methotrexate, bone protection (such as alendronate and calcium/vitamin D) with glucocorticoids, and intra-articular steroids.

<table>
<thead>
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<th>Primary outcome</th>
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<tr>
<td>The primary outcome was the score on the health assessment questionnaire at 12 months. Scores were measured initially at baseline and at six and 12 months. Trials of disease modifying drugs and biologics have shown that this patient assessed outcome is sensitive to change. Its performance is equal to disease activity measures like joint counts. Changes in health assessment questionnaire scores influenced NICE’s decisions on biologics. It involves questions across eight domains: dressing and grooming, getting up, eating, walking, hygiene, reach, grip, and chores or activities. There are four possible answers: 0 = without any difficulty; 1 = with some difficulty; 2 = with much difficulty; and 3 = unable to do. The sum of the highest score per domain is divided by eight. The total score ranges from 0 to 3 (0 = best; 3 = worst) in 0.125 increments.</td>
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<table>
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<th>Secondary outcomes</th>
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<td>Every six months we assessed quality of life, erosive damage, and economics. Assessments comprised the EuroQol 5-dimension scale (EQ5D-3L), medical outcomes study short form 36 (SF36), and radiographs of the hands (including wrists) and feet. An experienced observer (DLS) who was blinded to treatment read the digitised radiographs using modified Larsen scores after the trial ended. Use of resources was recorded with a modified client service receipt inventory.</td>
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administered as self completed questionnaires retrospectively for the previous three month period. Costs (for 2010–11 in £) were assessed from a health and social care perspective and were multiplied by two to represent the six month period before each assessment.

We assessed disease activity monthly by recording tender and swollen joint counts (28 joints), erythrocyte sedimentation rates, patients’ global assessments of disease activity (100 mm visual analogue scale), and the disease activity scores for 28 joints. Withdrawals from treatment or the trial were also recorded monthly together with details of drugs and adverse events.

An anonymised electronic data capture system collected clinical data except radiographs (www.medscinet.net).

Sample size calculation
Published data on 12 month changes in scores on the health assessment questionnaire in rheumatoid arthritis trials of tumour necrosis factor inhibitors (mean baseline score 1.7; reduction after treatment of 25%; standard deviation of change 0.4)10 and combination therapy with disease modifying drugs (mean baseline score 1.6; reduction after treatment of 31%; standard deviation of change 0.6)20 gave an average standard deviation for changes in health assessment questionnaire scores of 0.5.

The minimal clinically important change in scores on the health assessment questionnaire is 0.22.21 We based our sample size on testing the null hypothesis of a difference of >0.22 between the two treatments. With a (one sided) testing level of 5%, we needed a sample size of 176 to achieve 90% power. We recruited 214 patients to allow for patients not receiving treatment or dropping out when treatment had started.

Randomisation
Potentially eligible patients were screened and reasons for non-entry recorded. Consenting patients were randomised in blocks of four with allocation stratified by region. MedSciNet generated the allocation sequence; trial staff had no prior knowledge of the allocation sequence. There were variable delays between randomisation and baseline assessments because patients received combination disease modifying drugs and tumour necrosis factor inhibitors through routine NHS systems.

Blinding
The trial was unblinded because it used treatment specific algorithms with the adjustment of multiple drug doses. Patients assessed their own disability and quality of life. Radiographs were read blinded.

Statistical methods
Baseline characteristics were summarised by randomisation group as means and standard deviations (continuous normally distributed variables), medians and interquartile ranges (non-normally distributed variables), and frequencies and percentages (categorical variables).

Randomised patients who received treatment were assessed on an intention to treat basis. All participants had complete observations at baseline. Missing data at follow-up was imputed regardless of the reason(s) they was missing. For participants with missing outcomes, we used the baseline outcomes and other explanatory covariates (treatment group, sex, age, ethnicity, region, and disease duration) to impute the missing data, assuming unobserved measurements were missing at random (see appendix table A).

Linear regression evaluated 12 month outcomes. Univariate analyses were adjusted for region (design variable). Multivariable analyses were adjusted for sex, ethnicity, age, region, and duration of disease and baseline scores, which all influence disability. Generalised estimating equations with working correlations (auto-regressive with lag one) evaluated disease activity score for 28 joints and its components measured monthly. Treatment withdrawals and toxicities were compared with Fisher’s exact tests. These analyses compared treatment strategies ignoring subsequent treatment switches. In all analyses patients in the tumour necrosis factor inhibitor strategy were the reference group. Only the primary outcome was tested for non-inferiority. Other outcomes were compared for evidence of superiority of one or other treatment strategy.

Exploratory analyses examined good responders according to the European League Against Rheumatism (EULAR)22 with odds ratios and the development of remission based on disease activity scores for 28 joints23 with log rank tests on all observed data. No imputations were performed for these data. These analyses also examined differences between patients in the disease modifying drug strategy who stayed taking these drugs or switched to tumour necrosis factor inhibitors. Finally complete case analyses evaluated patients who followed the protocol and received 12 months’ treatment.

We also undertook a full economic evaluation, which will be reported separately.

Results

Patients and treatments
Participant flow and recruitment
Between September 2008 and December 2010, we screened 432 patients, randomised 214, and treated 205 (fig 1). Of these 205 treated patients, 147 (72%) completed 12 months of treatment; 16 (8%) were lost to follow-up; 42 (20%) discontinued the intervention and were followed-up; 16 (8%) stopped treatment because of toxicity (10 in combined drug strategy; six in tumour necrosis inhibitor factor strategy); five stopped (2%) because of disease progression (one and four, respectively); and 37 (18%) stopped for other reasons including patients’ decisions to stop treatment (21 and 16, respectively).

Baseline data and numbers analysed
Demographic and disease assessments were similar in both groups of treated patients (Table 1). All treated patients were analysed.
groups favoured the disease modifying drug strategy. The figure follows the recommendations of Piaggio and colleagues.\textsuperscript{24} It shows unadjusted regression coefficients with 95% confidence intervals. The non-inferiority margin is shown for the scores on the primary outcome health assessment questionnaire. The mean difference was $-0.14$ and the 95% confidence interval ($-0.29$ to 0.01) was below the prespecified non-inferiority boundary of 0.22. There were no pre-defined non-inferiority margins for the secondary outcome measures. Adjustment for baseline and demographic variables did not change this conclusion (appendix table C).

**Secondary outcomes**

Both groups had improved quality of life, shown by increases in EQ5D-3L utility scores and SF-36 summary scores, and some erosive progression, shown by increases in Larsen scores. Difference between groups favoured the disease modifying drug strategy with EQ5D-3L scores, SF-36 physical component summary scores, and Larsen scores and the tumour necrosis factor inhibitor strategy with SF-36 mental component summary scores (fig 2). With all four outcomes, 95% confidence intervals of the differences between groups included zero. Adjustment for baseline and demographic variables did not change these conclusions (appendix table D). Fifty eight patients withdrew from study treatments; there was no difference between strategies (32 in disease modifying drug strategy v 26 in tumour necrosis factor strategy; Fisher's exact test $P=0.44$).

Baseline health and social care costs were similar in both groups. Compared with the tumour necrosis factor strategy, the disease modifying drug strategy reduced costs for months 0–6 by a mean of £3615 (95% confidence interval £4104 to £3182) and for months 6–12 by £1930 (£2599 to £1301).

Disease activity fell in both groups (fig 3). Initial falls were greater with the tumour necrosis factor inhibitor strategy, but with time the differences equalised. Over the whole 12 months the unadjusted difference between groups was 0.48 (95% confidence interval 0.17 to 0.79), favouring the tumour necrosis factor inhibitor strategy. The difference was predominantly because of changes in the erythrocyte sedimentation rate (appendix table E).

**Ancillary analyses**

**Switching treatments**

Patients in the disease modifying drug strategy who remaining taking disease modifying drugs ($n=58$) or switched to tumour necrosis factor inhibitors ($n=46$) had similar 12 month outcomes in all analyses. At six months the “switchers” had higher mean scores on the health assessment questionnaire (1.64 v 1.42) and disease activity scale for 28 joints (5.76 v 4.01).

**Exploratory analyses using all observed data**

Eighty patients had remissions (36 in disease modifying drug strategy, 44 in tumour necrosis factor inhibitor strategy) at any point in the trial. Only 30 patients (11 and 19, respectively) had sustained remissions. Time to first remission did not differ significantly between patients in the disease modifying drug strategy and in the tumour necrosis factor strategy. The difference was $-0.14$ and the 95% confidence interval ($-0.29$ to 0.01) was below the prespecified non-inferiority boundary of 0.22. There were no pre-defined non-inferiority margins for the secondary outcome measures. Adjustment for baseline and demographic variables did not change this conclusion (appendix table C).

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Table 1 | Baseline demographic and clinical characteristics of patients with rheumatoid arthritis randomised to treatment with combinations of disease modifying drugs or tumour necrosis factor inhibitors. Figures are means (SD) unless stated otherwise.

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>Combination disease modifying drugs strategy (n=104)</th>
<th>Tumour necrosis factor inhibitor strategy (n=101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>58 (13)</td>
<td>57 (11)</td>
</tr>
<tr>
<td>No (%) of women/men</td>
<td>73/31 (70/30)</td>
<td>79/22 (78/22)</td>
</tr>
<tr>
<td>No (%) by ethnic group:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>89 (86)</td>
<td>92 (91)</td>
</tr>
<tr>
<td>Black (African, Caribbean, other)</td>
<td>6 (6)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (9)</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Median (IQR) duration of disease (years)</td>
<td>4.4 (1.6–9.9)</td>
<td>5.9 (2.2–13.4)</td>
</tr>
<tr>
<td>Height (m)</td>
<td>1.64 (0.11)</td>
<td>1.66 (0.09)</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>78 (20)</td>
<td>81 (17)</td>
</tr>
<tr>
<td>Median (IQR) BMI</td>
<td>29 (24–33)</td>
<td>29 (25–32)</td>
</tr>
</tbody>
</table>

Clinical variables

| Disease activity score for 28 joints | 6.2 (0.9) | 6.3 (0.8) |
| Tender joint count                | 16 (7)    | 18 (7)    |
| Swollen joint count               | 11 (6)    | 11 (7)    |
| ESR (mm in first hour)            | 33 (26)   | 30 (23)   |
| Patient global visual analogue score (mm) | 68 (20) | 68 (21) |
| Health assessment questionnaire score | 1.8 (0.6) | 1.9 (0.7) |
| Larsen score                      | 45 (42)   | 38 (39)   |
| EQ5D score                        | 0.39 (0.31) | 0.35 (0.31) |
| SF-36 physical component summary score | 28 (7) | 27 (7) |
| SF-36 mental component summary score | 43 (12) | 41 (12) |

Previous disease modifying drug treatments (No of patients)

| Methotrexate                     | 98        | 97       |
| Sulfasalazine                    | 68        | 56       |
| Leflunomide                      | 27        | 29       |
| Other                            | 48        | 49       |
| Three previous treatments        | 33        | 29       |
| Combination drugs at screening   | 38        | 39       |
| Prednisolone at screening (mean daily dose) | 16 (4 mg) | 8 (4 mg) |

Harms

Adverse events (Table 2) were common: 28 patients had serious adverse events (18 with the tumour necrosis factor inhibitor strategy; 10 with the disease modifying drugs strategy; Fisher’s exact test P=0.11). One patient in the tumour necrosis factor strategy died from pneumonia and multiple organ failure. Sixteen patients (six and 10, respectively) stopped treatment because of toxicity (Fisher’s exact test P=0.44). Overall there were 1100 adverse events; more occurred with the disease modifying drug strategy (635 vs 465). Infections that involved several body systems occurred in 54 patients in the tumour necrosis factor strategy and 30 patients in the disease modifying drug strategy.

Discussion

Interpretation

In patients with rheumatoid arthritis, our strategy of treatment with synthetic disease modifying drugs achieved non-inferior outcomes to the NICE approved strategy of treatment with tumour necrosis factor inhibitor over 12 months. It also cost substantially less. Our primary outcome—the score on the health assessment questionnaire—fell in both groups, indicating reduced disability at the trial endpoint. The difference between groups favoured the disease modifying drug strategy, with 95% confidence intervals.
within the prespecified boundary of non-inferiority. Both strategies improved quality of life similarly and resulted in minimal erosive progression. The tumour necrosis factor inhibitor strategy cost an additional £5545 less in patients who were treated with the combined drug strategy. These reduced costs were associated with reduced scores on the health assessment questionnaire, which have immediate economic benefits.

Our trial had several limitations. Firstly, many eligible patients did not participate, mainly because they did not consent. Although non-consenting patients could have responded differently to participants, participation levels replicated other English grant funded trials in rheumatoid arthritis and recent tumour necrosis factor inhibitors trials. Non-participation is likely to reflect patients’ concerns about all intensive treatments and our cautiously worded patient information sheet.

Secondly, disease modifying drugs regimens varied because standardisation was impossible in this context. Thirdly, few trials in rheumatoid arthritis use the health assessment questionnaire as their primary outcome measure. It was relevant in our trial because it measures changes important to patients, is sensitive to improvements with all tested treatments, and helps NICE to determine treatment benefits. Scores on the health assessment questionnaire change less in those with late rheumatoid arthritis, but both groups had clinically important improvements, and the durations of disease in our patients were comparable with those in pivotal biologic trials. Although minimally important differences in scores might be less than 0.22 in routine practice, this lower difference would not change our conclusions.

Fourthly, our trial was un-blinded because blinding is impractical when many different treatments are used. The primary outcome, however, was self completed by patients and not directly influenced by clinicians. Fifthly, our trial lasted only 12 months because when it was designed longer delays in assessing biologic treatments raised ethical concerns.

Finally, the effects of withdrawal and switching treatments need careful consideration. Only a few patients (16/205, 8%) were lost to follow-up and required the imputation of missing data. As the complete case analysis gave similar findings to the intention to treat analysis, it seems unlikely that withdrawals influenced our conclusions. Comparable numbers of patients withdrew from both trial arms, suggesting withdrawals were unlikely to be economic modelling studies are needed to show whether this approach has any enduring benefits.

Tumour necrosis factor inhibitors have many advantages. Their innovative nature, rapid effects, and ease of use attract patients and clinicians. Their defined mechanism of action contrasts with the uncertainties about the molecular effects of drugs like methotrexate. Combinations of lower cost synthetic disease modifying drugs, however, are relevant for advanced health economies and might be even more relevant in health economies where biologics are unaffordable.

Generalisability
The patients in our trial had diverse ethnicities and deprivation levels and were seen in routine practice settings in geographically dispersed centres in England. We focused on patient centred outcomes, which are crucial for people with arthritis. Levels of disease activity replicated levels in national and international registers before and during treatment.

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influenced by the treatment strategies. Overall withdrawal rates were similar to those in comparable rheumatoid arthritis strategy trials involving biologics and disease modifying drugs.\textsuperscript{40–42} The frequencies with which patients discontinued tumour necrosis factor inhibitors were comparable with UK national registry data of routine practice results.\textsuperscript{44} The evidence suggests withdrawals in our trial were unlikely to have influenced our main conclusions.

**Overall evidence**

In early rheumatoid arthritis three head-to-head trials have shown that combinations of disease modifying drugs achieve similar benefits to tumour necrosis factor inhibitors.\textsuperscript{40–42} RACAT, the only other trial in established active rheumatoid arthritis,\textsuperscript{43} showed that triple therapy (methotrexate, sulfasalazine, and hydroxychloroquine) achieved similar benefits to etanercept plus methotrexate in incomplete methotrexate responders treated for 12 months. Our trial and RACAT had comparable results, despite differences in patients and trial design. They highlight the role of head-to-head trials against effective conventional comparators to evaluate expensive treatments.\textsuperscript{45} Although toxicity remains a potential concern with combined disease modifying drugs because single trials like ours cannot fully assess risks, such combinations have been used for many years without evidence of major toxicity.\textsuperscript{46–48} The current trial questions the status quo of use of biologics in patients with active rheumatoid arthritis in whom methotrexate does not achieve the required response. In these patients the clinical and economic evidence from our trial supports preferentially starting combinations of synthetic disease modifying drugs. We also believe that modernising biologic treatment regimens for rheumatoid arthritis requires more strategy trials. Increasing efficacy is important, and optimising cost effectiveness is crucial. Options include giving biologics to patients with rheumatoid arthritis who are likely to respond to specific agents,\textsuperscript{46–48} discontinuing biologics when patients do not fully respond, and tapering treatment when patients achieve sustained remissions.\textsuperscript{48}

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We are grateful for the many colleagues and collaborators who contributed to the TACIT trial.

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**Data monitoring and ethics committee:** Deborah Symmons, Peter Taylor, Caroline Doré.

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**Contributions:** DLS was chief investigator and grant holder and designed the study, developed the protocol, led the trial, searched literature, produced figures, interpreted data, and was responsible for writing paper and associated reports. FJ wrote the statistical analysis plan, undertook the main data analysis, produced tables for publication, and wrote the statistical section. VF was senior trial statistician and co-applicant on the grant, advised on the statistical analysis plan, reviewed all the data produced for the trial, and critically reviewed all statistical analyses. AGO’K was additional trial statistician and independently imputed trial data for intention to treat analysis and checked all trial outcome analyses. DW was co-applicant on the grant and helped design study, was a major recruiter to the trial, and provided a critical review of the results and final paper. CK was a major recruiter to the trial and served on the trial steering committee and provided a critical review of the results and final paper. FB was a major recruiter to the trial and provided a critical review of the results and final paper. PM was independent chair of the trial steering committee and was responsible for oversight of the trial, provided substantial ongoing independent advice to the grant holders and funders, and provided a critical review of the results and the final paper. MH analysed all the economic data for the trial. AP was a grant-holder, devised the economic aspects of the trial, oversaw the economic analysis, wrote the economic report of the final paper, and critically reviewed the economic aspects of the final paper. CHK was deputy chief investigator and grant-holder and supported the chief investigator in the design of the study, the ongoing conduct of the trial, data interpretation, and the content of the final paper and associated reports. DLS is guarantor.

**Funding:** This project was funded by the National Institute for Health Research Health Technology Assessment (NIHR HTA) programme (project No 06/303/84). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HTA programme, NIHR, NHS, or the Department of Health. The NIHR had no role in trial design, data collection, and analysis or preparing this publication.

**Competing interests:** All authors have completed the ICME uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

**Ethical approval:** This study was approved by University College London Hospital research ethics committee (MREC Ref 07/0Q505/57), and all patients gave written informed consent.

**Transparency declaration:** The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

**Data sharing:** Anonymised patient level data and a technical and statistical appendix will be available from the corresponding author for inclusion in meta-analyses and other relevant similar academic endeavours.
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Appendix: Supplementary tables A-E