

# ACR remission criteria and response criteria

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## ABSTRACT

As additional DMARDs have been added to the armamentarium of rheumatologists over the last 60 years, the approach to the treatment of rheumatoid arthritis has changed. Many clinical studies now are geared toward evaluating the concept of eradicating inflammation as a method to seek the elusive goal of sustained remission in RA. One of the first descriptions of remission in "RA" was by Short *et al* in 1948, when he documented the natural progression of the disease. Since that time, various criteria have been developed to define RA remission utilizing clinical, radiographic, and laboratory measures. The most stringent of criteria is the American College of Rheumatology Remission Criteria, developed in 1980, which consists of clinical symptoms and signs of inflammation including fatigue, joint pain, morning stiffness, joint tenderness, joint swelling, and erythrocyte sedimentation rate (ESR). Several reports have compared ACR remission criteria to Disease Activity Score (DAS) values to identify equivalent DAS remission values, and these have been extrapolated to modified versions of the DAS, the Simple Disease Activity Index (SDAI), and Clinical Disease Activity Index (CDAI). The ACR remission criteria and the response measures were not designed for use as the target or goal for the clinical management of individual RA patients in routine clinical practice. Nevertheless, rheumatologists yearn for the eradication of inflammation in all RA patients, and attaining remission may be achievable in the future.

## Introduction

Despite the significant advances in disease-modifying therapy and clinical trial methodology, it is unusual for a physician to have the pleasure of telling a patient with rheumatoid arthritis (RA) that his or her unrelenting disease is in remission. As seen with disease activity measures, "remission" in RA is

difficult to define precisely with a single disease activity measure. Clinical remission is defined as an absence of joint inflammation and extraarticular disease activity (1) and is now being considered a target for RA therapy. The approach to the treatment of RA has changed over the past 60 years as additional disease-modifying antirheumatic drugs (DMARDs) with good efficacy and toxicity profiles have been added to the armamentarium of rheumatologists. Many studies now are geared toward evaluating the concept of eradicating inflammation as close as possible to symptom onset, as a method to seek the elusive goal of remission in RA.

One of the first descriptions of remission in RA was by Short *et al*. (2, 3), in which he illustrated the natural history of the disease over a 24-year period. In 1948, Short and Bauer described a series of 300 RA patients (above the age of 12) admitted to Massachusetts General Hospital between 1930 and 1936. Approximately 38 patients with peripheral arthritis were found to have rheumatoid spondylitis, but were included in the cohort, while patients with a clearly erroneous diagnosis were excluded. Patients' hospital stay was usually 3 to 4 weeks and included the following therapeutic interventions: rest, analgesics, exercises, heat application to joints, diet with supplementary vitamins, fever therapy, blood transfusions, treatment of infections, and orthopedic procedures. Of the 293 patients, 38 patients with more severe disease required readmission. Patients were seen in clinic at least once or twice a year, however some patients were seen at irregular intervals. During the 12 to 18 years of observation, 56 patients died of "causes unrelated to the arthritis". Short *et al*. classified patients as being in RA remission "if the disease was inactive, the patients were asymptomatic and examination of the joints was negative except for residual deformity". Patients were assessed in 1937,

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**David M. Reid, Colin G. Miller**



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