Attachment I:

EULAR recommendations (2010) for the management of RA; Differences between participating rheumatologists and rheumatologists that stopped or were lost to follow-up during the study.

	Participants (n=72)		Drop outs/LF* (n=50)	
	Always	(Some)times /Never	Always	(Some)times /Never
Are you aware of the recommendations? N (%)	72 (100)	-	50 (100)	-
Are you following the recommendations? N (%)	58 (81)	14 (19)	38 (76)	12 (24)
1. Treatment with synthetic DMARDs should be started as soon as the diagnosis of RA is made	70 (99)	1 (1)	48 (96)	2 (4)
2. Treatment should be aimed at reaching a target of remission or low disease activity as soon as possible in every patient; as long as the target has not been reached, treatment should be adjusted by frequent (every 1–3 months) and strict monitoring.	64 (90)	7 (10)	47 (94)	3 (6)
3. MTX should be part of the first treatment strategy in patients with active RA	69 (97)	2 (3)	47 (94)	3 (6)
4. When MTX contraindications (or intolerance) are present, the following DMARDs should be considered as part of the (first) treatment strategy: leflunomide, SSZ or injectable gold.	59 (83)	12 (17)	42 (84)	8 (16)
5. In DMARD naïve patients, irrespective of the addition of GCs, synthetic DMARD monotherapy rather than combination therapy of synthetic DMARDs may be applied.	56 (79)	15 (21)	41 (82)	9 (18)
6. GCs added at low to moderately high doses to synthetic DMARD monotherapy (or combinations of synthetic DMARDs) provide benefit as initial short-term treatment, but should be tapered as rapidly as clinically feasible.	64 (90)	7 (10)	43 (86)	6 (14)
7. If the treatment target is not achieved with the first DMARD strategy, addition of a biological DMARD should be considered when poor prognostic factors are present; in the absence of poor prognostic factors, switching to another synthetic DMARD strategy should be considered	60 (85)	11 (15)	39 (78)	11 (22)
8. In patients responding insufficiently to MTX and/or other synthetic DMARDs with or without GCs, biological DMARDs should be started; current practice would be to start a TNF inhibitor (adalimumab, certolizumab, etanercept, golimumab, infliximab) which should be combined with MTX	61 (86)	10 (14)	41 (82)	9 (18)
9. Patients with RA for whom a first TNF inhibitor has failed, should receive another TNF inhibitor, abatacept, rituximab or tocilizumab	67 (94)	4 (6)	45 (90)	5 (10)
10. In cases of refractory severe RA or contraindications to biological agents or the previously mentioned synthetic DMARDs, the following synthetic DMARDs might be also considered, as monotherapy or in combination with some of the above: azathioprine, ciclosporin A (or exceptionally, cyclophosphamide)	49 (69)	22 (31)	32 (64)	18 (36)
11. Intensive medication strategies should be considered in every patient, although patients with poor prognostic factors have more to gain.	67 (94)	4 (6)	42 (86)	7 (14)
12. If a patient is in persistent remission, after having tapered GCs, one can consider tapering biological DMARDs, especially if this treatment is combined with a synthetic DMARD	54 (76)	17 (24)	37 (76)	12 (24)
13. In cases of sustained long-term remission, cautious titration of synthetic DMARD dose could be considered, as a shared decision between patient and doctor	61 (86)	10 (14)	43 (88)	6 (12)
14. DMARD naïve patients with poor prognostic markers might be considered for combination therapy of MTX plus a biological agent	47 (86)	10 (14)	31 (63)	18 (37)
15. When adjusting treatment, factors apart from disease activity, such as progression of structural damage, comorbidities and safety concerns should be taken into account	69 (97)	2 (3)	47 (96)	2 (4)

*LF=Lost to follow-up, DMARDS=disease modifying anti-rheumatic drugs, MTX=methotrexate, SSZ=Sulphasalazine, GCs=Gluccocortiocoids, RA=Rheumatoid Arthritis

Attachment II

Treat to target (2010), differences between participating rheumatologists and rheumatologists that stopped during the study.

	participants		Drop outs/LF*	
	Always	(Some)times /Never	Always	(Some)times /Never
Are you aware of the recommendations? N (%)	70 (97)	2 (3)	47 (96)	2 (4)
Are you following the recommendations? N (%)	55 (79)	15 (21)	31 (66)	16 (34)
1. **The primary target for treatment of rheumatoid arthritis should be a state of clinical remission.**	65 (93)	5 (7)	41 (93)	3 (7)
2. **Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity.**	68 (97)	2 (3)	39 (89)	5 (11)
3. **While remission should be a clear target, based on available evidence low disease activity may be an acceptable alternative**	67 (96)	3 (4)	42 (95)	2 (5)
4. **Until the desired treatment target is reached, drug therapy should be adjusted at least every 3 months.**	65 (93)	5 (7)	37 (84)	7 (16)
5. **Measures of disease activity must be obtained and documented regularly, as frequently as monthly for patients with high/moderate disease activity or less frequently (such as every 3–6 months) for patients in sustained low disease activity or remission**	60 (86)	10 (14)	31 (70)	13 (30)
6. **The use of validated composite measures of disease activity, which include joint assessments, is needed in routine clinical practice to guide treatment decisions.**	65 (93)	5 (7)	39 (89)	5 (11)
7. **Structural changes and functional impairment should be considered when making clinical decisions, in addition to assessing**	64 (91)	6 (9)	41 (93)	3 (7)
8. **The desired treatment target should be maintained throughout the remaining course of the disease.**	65 (93)	5 (7)	37 (84)	7 (16)
9. **The choice of the (composite) measure of disease activity and the level of the target value may be influenced by consideration of co-morbidities, patient factors and drug-related risks.**	67 (96)	3 (4)	38 (86)	6 (14)
10. **The patient has to be appropriately informed about the treatment target and the strategy planned to reach this target under the supervision of the rheumatologist.**	65 (93)	5 (7)	41 (93)	3 (7)

*LF=lost to follow-up

Attachment III: baseline characteristics for patients in the IRIS study

Table 1. Baseline characteristics for patients in the IRIS study *

	Total patients, n=378
Female, n (%)	300 (82)
Age, mean (SD)	55 (14)
Diagnosis until first visit (wks), median (IQR)	8 (0-25)
CCP positive, n (%)	222 (67)
RF-Factor positive, n (%)	255 (70)
DAS, mean (SD)	3.1 (1.3)
HAQ, mean (SD)	1.2 (0.8)
ESR, median (IQR)	30 (16-49)
TJC, mean (SD)	9 (8)
SJC, mean (SD)	7 (7)
VAS, median (IQR)	
Patient global	67 (60-67)
Doctor global	60 (40-80)

* ESR= Erythrocyte Sedimentation Rate, DAS=Disease Activity Score 44 joints, HAQ= Health Assessment Questionnaire, IQR= Inter Quartile Range, CCP=Cyclic Cictrullinated Peptide Antibody, RF=Rheumatoid Factor