Supplementary Table

The essentially same table is shown in the main paper as table 1. Here those items of the 2010 recommendations that were deleted are highlighted in italics and those items that were addedare shown in bold. In the most left column, a number in bold indicates a shift forward, a number in italics indicates a shift downward compared with the 2010 recommendations.

Overarching principles			
2014		**2010**	
A.	The treatment of rheumatoid arthritis must be based on a shared decision between patient and rheumatologist.	A.	The treatment of rheumatoid arthritis must be based on a shared decision between patient and rheumatologist.
B.	The primary goal of treating patients with rheumatoid arthritis is to maximize long term health-related quality of life through control of symptoms, prevention of structural damage, normalization of function and **participation in social and work related activities**.	B.	The primary goal of treating the patient with rheumatoid arthritis is to maximise long-term health-related quality of life through control of symptoms, prevention of structural damage, normalisation of function and social participation.
C.	Abrogation of inflammation is the most important way to achieve these goals.	C.	Abrogation of inflammation is the most important way to achieve these goals.

D.	Treatment to target by measuring disease activity and adjusting therapy accordingly optimises outcomes in rheumatoid arthritis.	D.	Treatment to target by measuring disease activity and adjusting therapy accordingly optimises outcomes in rheumatoid arthritis.
Final set of 10 recommendations on treating rheumatoid arthritis to target based on both evidence and expert opinion*			
2014		**2010**	
1.	The primary target for treatment of rheumatoid arthritis should be a state of clinical remission.	1.	The primary target for treatment of rheumatoid arthritis should be a state of clinical remission.
2.	Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity.	2.	Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity.
3.	While remission should be a clear target, low disease activity may be an acceptable alternative therapeutic goal, particularly in long-standing disease.	3.	While remission should be a clear target, *based on available evidence* low disease activity may be an acceptable alternative therapeutic goal, particularly in *established* long-standing disease.
4	The use of validated composite measures of disease activity, which	6.	The use of validated composite measures of disease activity, which

	include joint assessments, is needed in routine clinical practice to guide treatment decisions.		include joint assessments, is needed in routine clinical practice to guide treatment decisions.
5	The choice of the (composite) measure of disease activity and the target value **should** be influenced by co-morbidities, patient factors and drug related risks.	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.
6.	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 6 months**) for patients in sustained low disease activity or remission.	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.
7.	Structural changes, functional impairment **and comorbidity** should be considered when making clinical decisions, in addition to assessing composite measures of disease activity.	7.	Structural changes and functional impairment should be considered when making clinical decisions, in addition to assessing composite measures of disease activity.
8.	Until the desired treatment target is reached, drug therapy should be adjusted at least every 3 months.*	4.	Until the desired treatment target is reached, drug therapy should be adjusted at least every 3 months.

9.	The desired treatment target should be maintained throughout the remaining course of the disease.	8.	The desired treatment target should be maintained throughout the remaining course of the disease.
10.	**The rheumatologist should involve the patient in setting the treatment target and the strategy to reach this target.**	10.	*The patient has to be appropriately informed about the treatment target and the strategy planned to reach this target under the super-vision of the rheumatologist.*