HOKKAIDO UNIVERSITY

Title	Golimumab in combination with methotrexate in Japanese patients with active rheumatoid arthritis : results of the GO-FORTH study
Author(s)	Tanaka, Yoshiya; Harigai, Masayoshi; Takeuchi, Tsutomu et al.
Citation	Annals of the Rheumatic Diseases, 71(6), 817-824 https://doi.org/10.1136/ard.2011.200317
Issue Date	2012-06
Doc URL	https://hdl.handle.net/2115/62832
Rights	This article has been accepted for publication in Golimumab in combination with methotrexate in Japanese patients with active rheumatoid arthritis: results of the GO-FORTH study, Yoshiya Tanaka, Masayoshi Harigai, Tsutomu Takeuchi, Hisashi Yamanaka, Naoki Ishiguro, Kazuhiko Yamamoto, Nobuyuki Miyasaka, Takao Koike, Minoru Kanazawa, Takuya Oba, Toru Yoshinari and Daniel Baker, Ann Rheum Dis, 2012, 71(6), pp.817-824, following peer review and can also be viewed on the journal's website at ard.bmj.com.
Rights(URL)	https://creativecommons.org/licenses/by-nc/3.0/
Type	journal article
File Information	ARD_text_317.pdf, Supplementary Text

Hokkaido University Collection of Scholarly and Academic Papers : HUSCAP

ONLINE SUPPLEMENTAL TEXT

Concomitant medication and tuberculosis screening criteria

Concurrent nonsteroidal anti-inflammatory drug, RA analgesic, and oral corticosteroid (≤10mg prednisolone/day or equivalent) use was allowed with stable doses prior to (≥2weeks) and during the study. Prior receipt of anti-TNF biological therapy, alkylating agents (cyclophosphamide), or any investigational agents within the previous 4 months excluded patients.

Patients who met the third criteria listed below could be enrolled into this study only if administration of anti-tuberculosis (isoniazid) therapy was started within 3 weeks prior to the initial administration of study agent. Patients who had received preventive anti-tuberculosis therapy over the prior 6 months were also allowed to enter the study.

1) A history of tuberculosis or active tuberculosis based upon screening medical history.

2) Not "1)" but thoracic (posterio-anterior and side) radiographic or thoracic computed tomography imaging performed within 1 month of study registration, and results of such testing revealed tuberculosis findings, including fibrotic scarring of the lungs or pleura, tuberculosis nodules, swelling of the hilus or diaphragmic lymph nodes, reduced volume of upper pulmonary lobe, vacuole formation, and/or shadows consistent with old pulmonary tuberculosis (pleural thickening, tram line shadows, and darkening in excess of 5mm).

3) Not “2)” but with evidence as outlined above in 2), red indurations of 20 mm or larger observed via tuberculin reaction testing performed either at the time of study registration or within 1 month of registration.

Prespecified data handling rules and sample size determination

ACR response rates and HAQ were calculated employing last-observation-carried-forward methodology at weeks14 and 24. In the analysis of DAS28 response at weeks14 and 24, observed data were used with no imputation for missing data, with the exception of the DAS28 remission analysis for which patients with missing data were deemed nonresponders. Observed data were employed in analyses of erosion scores, joint space narrowing scores and pharmacokinetic data.

For any ACR component, DAS28 component and HAQ scores, missing values were replaced by the last non-missing observation (including baseline). Patients who were missing data for all ACR components were considered to be nonresponders. Similarly, patients who were missing data for all DAS components were considered to not be in remission and were treated as missing for DAS response status.

Patients were also considered nonresponders if they met any one of the following treatment failure criteria: (1) initiated treatment with any disease-modifying antirheumatic agent, systemic immunosuppressive agents, or biologics agents for RA; (2) increased the MTX dose above the baseline dose for treatment of RA; (3) initiated treatment with oral corticosteroids for RA, increased the dose of oral corticosteroids for RA above the baseline dose, or received intravenous or intramuscular administration of corticosteroids for RA; or (4) discontinued study agent injections due to lack of efficacy.

Week-16 efficacy data for patients in Groups 1 and 2 who entered early escape were carried forward to week 24. No treatment adjustment options were available for patients in Group 3 even if they met the criteria for early escape. Therefore, actual observed data at week 24 were used for these patients with the normal data imputation rules applied as described above.

For erosion and JSN scores, no imputation rule was applied. For changes in total vdH-S scores, if either the baseline or week-24 score was missing, but scores were available for two other time points between baseline and week 24 (including at the time of discontinuation), linear extrapolation was used to impute the missing score. If both of the baseline and week 24 total vdH-S scores were missing, the change from baseline to week 24 was imputed with the median change from baseline to week 24 among all patients.

The planned sample size (n=255) provided >90% power to detect a difference in ACR20 response between Combined Groups2&3 *vs.* Group1 (α=0.05) at week14. This power calculation assumed ACR20 response rates similar to those observed in a previously conducted Phase 3 golimumab trial in a similar population of RA patients receiving background MTX therapy (33.1%, 55.1% and 56.2% of patients who received placebo+MTX, golimumab 50mg+MTX and golimumab 100mg+MTX, respectively).[5]