Table 1 Treat-to-Target (T2T) recommendations in giant cell arteritis (GCA) and polymyalgia rheumatica (PMR)

Overarching principles	LoE	LoA
A. Clinical management of GCA and PMR should be driven by the awareness that they are closely interrelated conditions in a common spectrum of inflammatory diseases and can occur separately, simultaneously or in temporal sequence to each other.	n.a.	9.8 (0.6) 96.3% >8
B. GCA is a medical emergency because of the imminent risk of sight loss and other ischaemic events, and therefore, requires immediate treatment; management usually requires multidisciplinary collaboration.	n.a.	9.9 (0.3) 100% >8
C. Patients should be offered access to information about GCA and PMR, including clinical disease features, patient-reported outcomes, potential complications, treatment-related benefits and risks, as well as relevant comorbidities.	n.a.	9.7 (1.0) 96.3% >8
D. Management of GCA and PMR should be based on shared decision making between the informed patient and the physician.	n.a.	9.8 (0.5) 100% >8
E. Treatment of GCA and PMR should aim at maximising health-related quality of life through control of symptoms, preventing disease-related damage and minimising treatment-related adverse consequences, taking relevant comorbidities into account.	n.a.	9.9 (0.4) 100% >8
Recommendations		
1. The treatment target of GCA and PMR should be remission; remission is the absence of clinical symptoms and systemic inflammation.	5*	9.6 (0.9) 96.3% >8
2. Treatment of GCA should also aim to prevent tissue ischaemia and vascular damage.	5	9.9 (0.4) 100% >8
3. Treatment selection in GCA and PMR should be based on disease severity and activity, presence of relevant comorbidities and potential predictors of outcome; treatment should be modified as needed during follow-up.	5	9.9 (0.3) 100% >8
4. Comorbidities may influence the assessment of the treatment target and should be considered before modifying treatment.	5	9.8 (0.5) 100% >8
5. Once remission is reached, it should be maintained with the minimal effective dose of medication[#]; drug-free remission may be achieved in a proportion of patients[##].	5[#] - 2[##]	9.9 (0.3) 100% >8
6. Disease activity in GCA and PMR should be monitored regularly, as frequently as every 1–4 weeks until remission has been achieved, and at longer monitoring intervals (eg, between 3 and 6 months) in patients in stable remission on therapy; monitoring of patients off therapy should be discussed on an individual basis.	5	9.8 (0.6) 100% >8

Numbers in column 'LoE' indicate the LoE supporting the respective recommendation according to the Oxford Centre for Evidence-based Medicine 2011 levels of evidence (LoE).[27] Accordingly, LoE 2=randomised trial or observational study with dramatic effect; LoE 5=mechanism-based reasoning.
Numbers in column 'LoA' indicate the mean and SD (in parenthesis) of the LoA (range 0–10 with 0= 'completely disagree' to 10= 'completely agree'), as well as the percentage of task force members with an agreement ≥8; 27/29 (93.1%) task force members expressed their level or agreement.
*While 'remission' has been an outcome in several trials in GCA and PMR, (Hysa *et al*, manuscript in preparation) there is no comparison of the performance of remission with another treatment target.
LoA, level of agreement; LoE, level of evidence; n.a., not applicable.

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