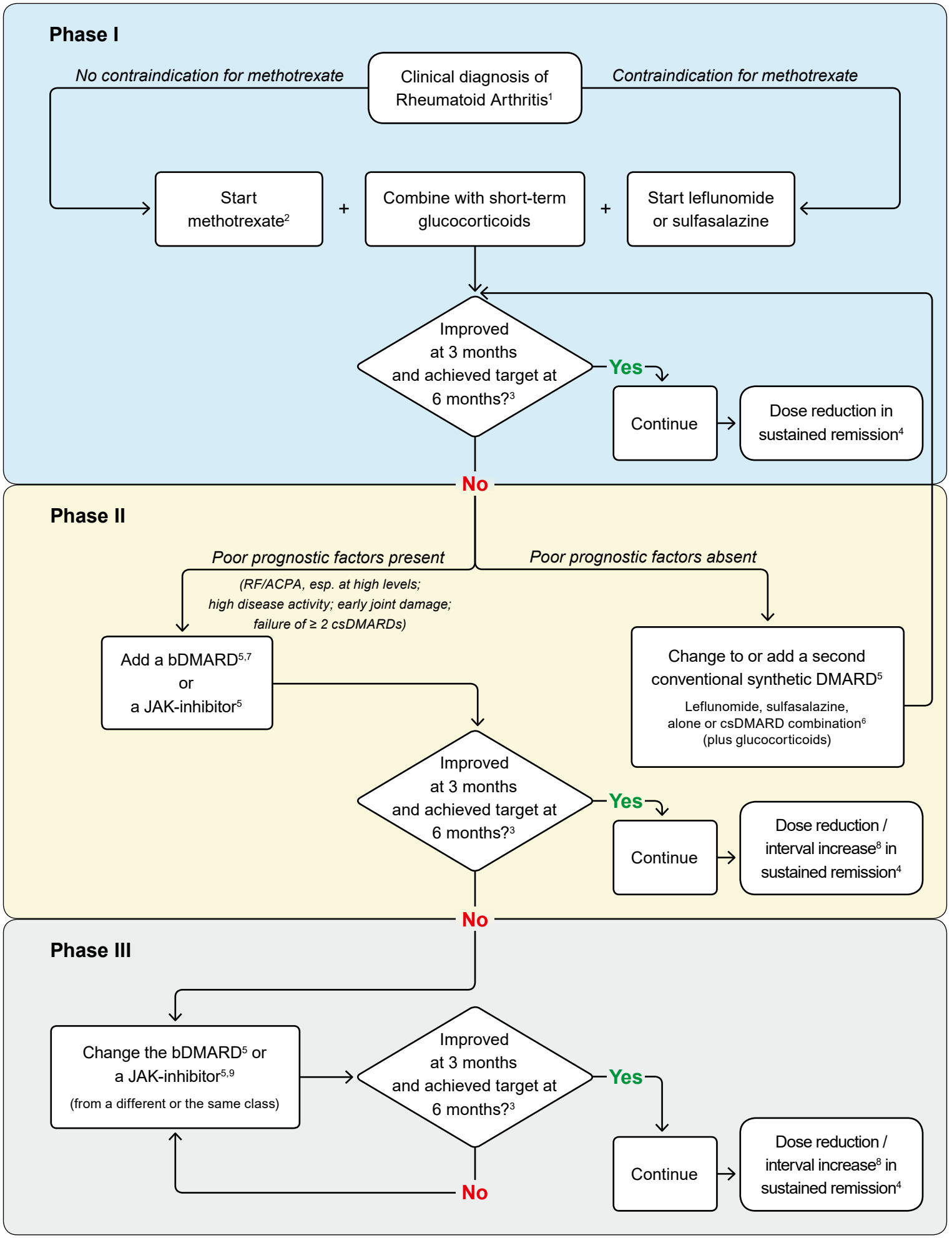

1. *2010 ACR-EULAR classification criteria can support early diagnosis.*
2. *"Methotrexate should be part of the first treatment strategy". While combination therapy of csDMARDs is not preferred by the Task Force, starting with methotrexate does not exclude its use in combination with other csDMARDs although more adverse events without added benefit are to be expected, especially if MTX is combined with glucocorticoids..*
3. *The treatment target is clinical remission according to ACR-EULAR definitions or, if remission is unlikely to be achievable, at least low disease activity; the target should be reached after 6 months, but therapy should be adapted or changed if insufficient improvement (less than 50% of disease activity) is seen after 3 months.*
4. *Sustained remission: ≥ 6 months ACR/EULAR index based or Boolean remission.*
5. *Consider contraindications and risks.*
6. *The most frequently used combination comprises methotrexate, sulfasalazine and hydroxychloroquine.*
7. *TNF-inhibitors (adalimumab, certolizumab, etanercept, golimumab, infliximab, including EMA/FDA approved bsDMARDs), abatacept, IL-6R inhibitors, or rituximab (under certain conditions); in patients who cannot use csDMARDs as comedication, IL6-inhibitors and tsDMARDs have some advantages.*
8. *Dose reduction or interval increase can be safely done with all bDMARDs and tsDMARDs with little risk of flares; stopping is associated with high flare rates; most but not all patients can recapture their good state upon re-institution of the same bDMARD/tsDMARD.*
9. *Efficacy and safety of bDMARDs after JAK-inhibitor failure is not fully known; also, efficacy and safety of an IL-6 pathway inhibitor after another one has failed is currently unknown. Efficacy and safety of a JAK-inhibitor after insufficient response to a previous JAK-inhibitor is unknown.*