Guidelines Corner – Living Guidelines in the CRA

On behalf of the CRA Guidelines Committee

Did you know the CRA has transitioned to a "living" guideline model? This means that guideline recommendations can be updated as needed when new evidence becomes available. Guidelines are available and maintained online at *rheum.ca/resources/publications/*

Guidelines

- COVID-19 vaccination (released 2022)
- Rheumatoid arthritis (RA) (released 2022)
- Juvenile idiopathic arthritis (JIA) Uveitis (released 2022)
- Axial Spondyloarthritis (in development)
- Transition care (in development)
- Immune-Mediated Adverse Events (in development)

This section of the *CRAJ* will highlight recommendations from the CRA's living guidelines. In this installment, we focus on rheumatoid arthritis and treatment tapering.

Clinical case: Diane is a 56-year-old woman with seropositive RA, who comes in for an annual appointment. She has been taking etanercept for 6 years as monotherapy and has been in remission for most of that time, with the occasional mild flare, that resolves on its own without needing a change in disease-modifying anti-rheumatic drugs (DMARDs)/steroids.

Would you?
A) Stay the course, renew her etanercept
B) Discuss tapering her etanercept
C) Discontinue (stop) her etanercept
D) Discuss tapering only if she asks about it

Answer: B

The CRA recommendation is to suggest offering a stepwise reduction in the dose of biologic/targeted synthetic (b/ts) DMARD without discontinuation, in the context of a shared decision, provided patients are able to rapidly access rheumatology care and re-establish their medications in case of a flare.

In patients where rapid access to care or re-establishing access to medications is challenging, we conditionally recommend against tapering.

Discussion

In this situation, Diane has been in a prolonged remission, is not taking corticosteroids (which would be tapered first, if possible), and would be a suitable candidate to reduce her biologic therapy. There is moderate certainty evidence that people with RA who are in remission for at least 6 months can reduce their biologic therapy with little impact on their disease control. Most patients who do flare can regain control promptly when medications are re-established. Whether tapering is right for Diane will depend on her preferences. A decision aid (*rheum.ca/wp-content/uploads/2022/07/RA_decisionaid_July-20-2022.pdfclick*) has been developed to provide more information for patients and help them choose the best option considering their values and preferences. A typical way to reduce etanercept would be to increase the dosing interval from every week to every 10 days, then (if tolerated) to every 14 days after a period of 3-6 months. Stopping abruptly is linked to additional flares and is generally not recommended. Prior to tapering, it would be important to discuss a flare management plan.

Rapid access to care and the ability to re-establish medications was highlighted as a particularly important consideration when deciding whether to taper. In situations where access to care is challenging, tapering may be difficult. Implementation of the recommendation would therefore be supported with models of care that allow rapid access to care from a rheumatology care team, including in populations at risk for inequity, and reimbursement policies that facilitate immediate re-escalation of doses in case of a flare.

Are you a CRA member interested in getting involved with guidelines? E-mail Sarah Webster at *swebster@rheum.ca* to express your interest.