Great Debate: Be it Resolved That Medications Should be Tapered in Patients with Inflammatory Arthritis in Remission

By Volodko Bakowsky, MD, FRCPC, on behalf of Alexandra Charlton, BSc, PharmD; Jaime Guzman, MD, MSc, FRCPC; Glen Hazlewood, MD, PhD, FRCPC; and Bindee Kuriya, MD, MSc, FRCPC

The Great Debate was once again one of the highlights of the Canadian Rheumatology Association (CRA) Annual Scientific Meeting (ASM).

Arguing in favour of the motion were Drs. Glen Hazlewood and Jaime Guzman, while Drs. Bindee Kuriya and Alexandra Charlton reasoned against. The session combined rigorous data with humour and spirited exchanges, reflecting the complexity and clinical relevance of the topic.

The pro-tapering team grounded their argument in current CRA guidelines, which support offering tapering to carefully selected patients with rheumatoid arthritis (RA) and axial spondyloarthritis (axSpA) who have achieved sustained remission. They emphasized that tapering is not synonymous with abrupt discontinuation, but rather a structured, monitored process aimed at finding the minimum effective dose. Evidence from clinical trials and observational studies suggests that a meaningful proportion of patients can successfully reduce therapy without immediate flare, particularly when remission is deep and sustained.

From a patient-centered perspective, the potential benefits of tapering were highlighted. These include reduced exposure to dose-dependent adverse effects, decreased medication burden, and potential cost savings for both patients and healthcare systems. In pediatric populations, Dr. Guzman underscored the heterogeneity of juvenile idiopathic arthritis (JIA), noting that some subtypes may achieve drug-free remission. Tapering, in this context, offers an opportunity to assess whether ongoing therapy is required. The proponents also emphasized the importance of shared decision-making, arguing that involving patients in tapering decisions may improve adherence and trust, and may prevent unsupervised discontinuation of therapy.

In contrast, the opposing team challenged the assumption that remission reflects true disease quiescence. They argued that, in many cases, remission is maintained by ongoing pharmacologic suppression, and that tapering therefore risks reactivation of underlying inflammation. Across inflammatory arthritis conditions—including RA, axSpA, psoriatic arthritis (PsA), and JIA—they presented consistent evidence that tapering is associated with increased rates of flare. In axSpA, tapering biologic therapy may lead to relapse and ongoing structural progression,

while extending dosing intervals in patients with uveitis may increase the risk of extra-articular complications. In PsA, the multidomain nature of disease makes loss of control particularly difficult to manage once it occurs.

The evidence was most robust in RA, where tapering or discontinuing biologic therapy is associated with loss of remission and increased radiographic progression. Both clinical trials and real-world data show that only a minority of patients maintain disease control after tapering. In JIA, the consequences of flare may be especially significant, with potential impacts on growth, development, and long-term outcomes, and recapturing inactive disease is not always guaranteed.

Importantly, the opposing team emphasized that flares are not benign events. They are associated with structural damage, reduced physical function, and diminished quality of life, and often require use of corticosteroids, added medications, and increased healthcare utilization. As such, the perceived cost savings of tapering may be offset by downstream clinical and economic consequences. They further noted that, despite guideline support for individualized tapering, there are currently no reliable biomarkers or clinical tools to predict which patients can safely reduce therapy.

Overall, the debate underscored a central clinical tension: the appeal of minimizing treatment burden versus the risks of destabilizing disease control. While tapering may be right for selected patients within a shared decision-making framework, the discussion highlighted the need for caution, close monitoring, and further research to better identify those patients most likely to succeed. After the exchange of opposing arguments, it was time to vote.

The arguments for both sides were presented clearly and emphatically. Electronic voting ensued and the results proved a clear victory for the proponents, therefore the motion was carried!