Withdrawal of low-dose prednisone in inactive SLE patients: Is there another alternative?

I read with great interest, the recently published article in your journal titled ‘Withdrawal of low-dose prednisone in systemic lupus erythematosus (SLE) patients with a clinically quiescent disease for more than 1 year: a randomised clinical trial’ by Mathian *et al.*¹ In this article, the authors conclude that the maintenance of long-term 5 mg prednisone in SLE patients with inactive disease prevents relapses. In the recent update of European League Against Rheumatism (EULAR) recommendations for the management of SLE,² the experts say that the ‘treatment in SLE should aim at remission or low disease activity and prevention of flares in all organs, maintained with the lowest possible dose of glucocorticoids (GC)’. However, in my opinion, a daily dose of prednisone of 5 mg might not be the lowest possible dose in patients with long-term inactive SLE, and there is an alternative strategy that consists of the progressive reduction of this dose, which has not been considered. I believe that the one-time withdrawal of 5 mg/day is too abrupt and it could favour the appearance of flares. In contrast, many patients could benefit from a more gradual reduction. In this situation, the protocol of our unit is to decrease 1.25 mg of prednisone every 2–3 months until it is suspended, or in case of relapse or flare, we maintain the previous effective dose for a longer time and then lower more slowly. The aim of this strategy is to decrease the accumulated dose of GC in order to prevent irreversible organ damage (Systemic Lupus International Collaborating Clinics/American College of Rheumatology Damage Index (SDI)) associated with its use. In this study, no significant differences in SDI and adverse effects were found between those who discontinued prednisone and those who maintained a daily dose of 5 mg after 1 year of follow-up. However, this period may be too short, as some studies suggest that sustained low doses of GC may be associated with increased SDI.³ In summary, the alternative of a progressive dose reduction of prednisone in patients with long-term inactive SLE should be explored before deciding on indefinite maintenance of a daily dose of 5 mg.⁴

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REFERENCES

- Mathian A, Pha M, Haroche J, *et al.* Withdrawal of low-dose prednisone in SLE patients with a clinically quiescent disease for more than 1 year: a randomised clinical trial. *Ann Rheum Dis* 2020;79:339–46.
- Fanouriakis A, Kostopoulou M, Alunno A, *et al.* Update of the EULAR recommendations for the management of systemic lupus erythematosus. *Ann Rheum Dis* 2019;2019:736–45.
- Zonana-Nacach A, Barr SG, Magder LS, *et al.* Damage in systemic lupus erythematosus and its association with corticosteroids. *Arthritis Rheum* 2000;43:1801–8.
- Strehl C, Bijlsma JWJ, de Wit M, *et al.* Defining conditions where long-term glucocorticoid treatment has an acceptably low level of harm to facilitate implementation of existing recommendations: viewpoints from an EULAR Task force. *Ann Rheum Dis* 2016;75:952–7.