How to stop prednisone in SLE in remission?: Response to: 'Withdrawal of low-dose prednisone in inactive SLE patients: is there another alternative?' by Sabio

We thank Dr Sabio *et al* for his interest in our study.^{1,2} Dr Sabio in his letter suggests that the one-time withdrawal of 5 mg/day of prednisone is too abrupt and could have favoured the appearance of systemic lupus erythematosus (SLE) flares. Dr Sabio describes the practice of his unit which is to decrease by 1.25 mg of prednisone every 2 to 3 months until a complete stop. In the event of a relapse or flare, an effective dose is maintained for a longer period of time and then slowly lowered. The opinion that an abrupt cessation of a very low dose of glucocorticoids (GCs), such as 5 mg of prednisone per day, during a period of remission would be in itself a factor favouring the relapse of SLE and, in consequence, would require a slow and gradual tapering of this treatment is shared by many physicians. However, to our knowledge, no studies to date do support this hypothesis in SLE. In an observational study reporting a gradual GC withdrawal in SLE, about a quarter of the patients relapsed, similar to the number reported in our study.³ Furthermore, although one should be careful in drawing a comparison between diseases, it has been reported that continued administration of a very low dose of prednisone or prednisolone to patients with rheumatoid arthritis with a low disease activity status provided better disease control than GC withdrawal, even in case of slow tapering.^{4,5} It is important to also consider that in our study the vast majority of patients, following the interruption of GC intake, remained on long-term treatment with hydroxychloroquine and thus, indeed, in daily practice SLE treatment is almost never abruptly stopped.

The issue raised by Dr Sabio is of major importance and emphasises that clinicians should in the future (1) determine whether clinical characteristics and biomarkers could help to identify patients with SLE who are at a lower risk of relapse and therefore would benefit from discontinuation of their chronic maintenance treatment and (2) challenge, in academic clinical trials, the modalities of therapeutic de-escalation in patients in remission, in particular in view of the low number of studies that have been reported in this field.⁶ New knowledge on the disease will undoubtedly lead to a better understanding of its treatment. Our study, by concluding that maintenance of 5 mg prednisone is superior to its withdrawal in order to prevent flares in patients with clinically quiescent SLE, provides a rationale that we think paves the way for future studies, aiming to improve patient management.

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