Response to: 'Tapering antirheumatic drugs in a resource-poor setting: real-world evidence' by Haroon *et al*

We appreciate the interest in our paper by Haroon, *et al*. We presented the 2-year results of the TARA trial, in which we concluded that 'financial arguments may influence the decision to taper tumour necrosis factor-inhibitors first'.[1] Based on this conclusion, Haroon, *et al* decided to respond to that with their real-world data from a resource-poor country.[2]

Ideally, if patients with rheumatoid arthritis (RA) are in sustained remission, then medication is quickly tapered and possibly stopped to reduce healthcare costs. Disease modifying anti-rheumatic drug (DMARD)-free remission is suggested as a preferred ultimate target in a treat-to-target management approach; however, we previously showed, in a systematic literature review, that this outcome is achievable in only 10%–20% of the RA population.[3] Within the TARA trial, we showed that DMARD-free remission was achievable in 15% of the included patients with established RA. Haroon *et al* reported that 5 of 45 (11%) patients with RA and spondyloarthritis were able to completely stop their biological (b)DMARDs. This together confirms that DMARD-free remission is reachable for a minority of patients.

Although DMARD-free remission occurs less frequently, most of the patients with RA with a well-controlled disease can lower their DMARD dosage. To illustrate, 83% of the TARA patients were able to reduce their medication dosage, which is similar to the real-world data of Haroon *et al*. Another benefit of gradual tapering with a treat-to-target approach, which includes close monitoring, is that (severe) disease flares could possibly be prevented due to slower tapering and earlier detection. In our opinion, the aforementioned approach is currently the best way to taper treatment. Especially, as we have previously shown that a disease flare has a significant impact on patients' lives, which outlast the effect of a flare on disease activity.[4] Noteworthy is the fact that although most patients reach low disease activity within 6 months after a flare, most of them have a higher disease activity postflare compared with preflare.[4]

Unfortunately, current tapering strategies are still based on a trial-and-error approach that leads to high flare rates and, therefore, a tailor-made tapering approach is preferred. Moreover, no consensus had been reached on how to taper medication because cohorts/trials directly comparing different tapering strategies are sparse.[5] Haroon, *et al* showed that 60% of patients with RA were able to reduce their bDMARD dosage when a 2-step tapering protocol was used, consisting of dose reductions every 4 months of 30% followed by 50%. Comparing this with our results from the TARA trial, in which we showed that 83% of the patients were able to reduce their DMARD dosages with 50% every 3 months, leads to our advice to gradually taper DMARDs with 30%–50%every 3–4 months in patients with RA with a well-controlled disease.

To summarise, by using a gradual tapering approach, almost all patients with RA with a well-controlled disease can reduce their DMARD dosages. The real-world data of Haroon *et al* underline the fact that the majority of patients with RA are able to gradually taper DMARDs.

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