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Research Letter

Canadian Rheumatology Association Living Guidelines for Rheumatoid Arthritis: Update #2

To the Editor:

We have updated the Canadian Rheumatology Association (CRA) guidelines for rheumatoid arthritis (RA) with 3 recommendations for the use of glucocorticoids (GCs). The recommendations address the use of short-term GCs for RA flares or as bridging therapy when disease-modifying antirheumatic drugs (DMARDs) are initiated or changed, and the use of long-term GCs as adjuncts to DMARDs. These add to our prior Best Practice Statements and existing treatment recommendations. The full list of recommendations and Best Practice Statements are presented in the Table.

We continue to host the full version of the guideline with supporting evidence via an interactive web-based platform for guideline authoring and publication (MAGICapp).[1] The online version includes the full evidence-to-decision framework that summarizes the evidence and rationale for each recommendation according to Grading of Recommendations, Assessment, Development and Evaluation (GRADE) guidance.[2] We also include practical information for implementation. For the GC recommendations, this includes common dosing regimens and other practical points related to prescribing. The recommendations and statements were developed using the GRADE-ADOLOPMENT approach,[3] with source recommendations from the Australia & New Zealand Musculoskeletal Clinical Trials Network.[4]

How to cite the CRA Living Guidelines for RA. When citing the guidelines, both the original journal publication[5] and online MAGICapp version[1] should be cited, as these outline the full methods of development. Authors may choose to also cite this publication or other update articles.[6]

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Table. Full list of current CRA treatment recommendations for the management of rheumatoid arthritis.

Treatment Recommendations
Consider using short-term GCs in people with active RA who are initiating, switching, or adding DMARD therapy, using the lowest effective dose until DMARDs take effect. Inability to achieve the treatment target should imply the need for escalation of DMARD therapy rather than the use of additional GCs. (Weak recommendation, low certainty evidence) **(NEW)**
Consider using short-term GCs for the treatment of RA flare in people with previously well-controlled disease, via either a systemic (typically oral or intramuscular) or intraarticular route, in the lowest possible dose for the shortest possible time. Any persistent flare should prompt consideration of the need for adjustment of the DMARD regimen. (Weak recommendation, very low certainty evidence) **(NEW)**
We recommend against the routine use of low-dose GCs as long-term (> 6 months) adjuncts to DMARDs for the treatment of RA. (Weak recommendation against, low certainty evidence) **(NEW)**
In people with RA who have had an inadequate response to a first TNF inhibitor, we suggest treatment with either a different TNF inhibitor, non-TNF biologic, or JAK inhibitor. In the subset of patients at higher risk of cardiovascular morbidity, we suggest treatment with either a different TNF inhibitor or non-TNF biologic over a JAK inhibitor. (Conditional recommendation, moderate certainty evidence) **(Unchanged)**
In people with RA who have been in sustained low disease activity or remission for at least 6 months, we suggest offering stepwise reduction in the dose of b/tsDMARD without discontinuation, in the context of a shared decision, provided patients are able to rapidly access rheumatology care and reestablish their medications in case of a flare. In patients where rapid access to care or reestablishing access to medications is challenging, we conditionally recommend against tapering. (Conditional recommendation, moderate certainty evidence) **(Unchanged)**
Best Practice Statements
All individuals living with RA should have early and equitable access to rheumatologic care. **(Unchanged)**
Treatment should be tailored to the given individual's disease profile and comorbidities, and should be guided by shared decision making. **(Unchanged)**
Treatment should aim to achieve remission and, when not feasible, minimal disease activity. **(Unchanged)**
Patients receiving treatment should be counseled regarding potential harms and appropriate monitoring. **(Unchanged)**
Patients with RA should receive preventive care and screening tailored to individual risk factors. **(Unchanged)**
Patients living with RA should, where possible, be provided opportunities to engage in research, both as participants and as potential research partners or representatives, to further knowledge and understanding. **(Unchanged)**
Patients with RA should have access to interdisciplinary shared care models with rheumatologists and other healthcare professionals trained and experienced in the management of RA, tailored to their needs. **(Unchanged)**

b/tsDMARD: biologic/targeted synthetic DMARD; CRA: Canadian Rheumatology Association; DMARD: disease-modifying antirheumatic drug; GC: glucocorticoid; JAK: Janus kinase; RA: rheumatoid arthritis; TNF: tumor necrosis factor.

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