Where in the World is Oral Triamcinolone?

To the Editor:

Recent reports regarding circadian treatment of rheumatoid arthritis (RA) with a modified form of prednisone indicate this affords significant control of arthritis without affecting the hypothalamic-pituitary axis by maximizing the glucocorticoid's effect in early morning. They support previous reports on the beneficial effects of evening triamcinolone (9 alpha-fluoro-11 beta, 16 alpha, 17 alpha, 21-tetrahydroxy-1, 4 pregnanidine-3, 20-dione) presented in a 1991 longitudinal study of early therapy in RA.

Now that the European League Against Rheumatism intends to assess and set guidelines for this use of modified prednisone, the American College of Rheumatology (ACR) and all drug trial groups in the USA should request from the pharmaceutical industry the immediate reintroduction of oral triamcinolone, a vastly superior disease-modifying glucocorticoid.

Although the steroid-sparing concept is the worst and longest-lasting therapeutic tragedy ever suffered on this planet, it still remains publicly at the core of rheumatologic therapeutics. For decades this concept gained support from didactic sectors limited by an almost exclusive exposure to prednisone side effects and the contradiction of prednisone's use in drug trials for the therapy of RA as an irrelevant adjunct to other disease-modifying antirheumatic drugs (DMARD) without a disease-modifying role of its own.

Prednisone is a dysfunctional glucocorticoid, and experience has shown its surreptitious use has failed to affect the index of remission and major improvement in RA significantly. Oral triamcinolone's side effects are minimal compared to prednisone's; it is also more effective in combination with other DMARD or with the now lengthy, confusing list of expensive biologics, most of which are not accessible to our patients for reasons of cost. Oral adjunct triamcinolone opened a therapeutic window of remission and justified its claim as a disease-modifying drug by reducing the incidence of erosions when given alone in RA. We also know that first-line nonsteroidal antiinflammatory drug (NSAID) therapy is less effective than oral triamcinolone and set guidelines for this use of modified prednisone, the American College of Rheumatology (ACR) should request from the pharmaceutical industry the immediate reintroduction of oral triamcinolone, a vastly superior disease-modifying glucocorticoid.


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REFERENCES


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