## The Art and Science of Tapering Glucocorticoids in Patients with Rheumatic Diseases

*To the Editor:*

We compliment Volkmann and colleagues for their excellent recent editorial[1]. The authors addressed an important aspect of rheumatologic care, practice, and scholarship.

We too have been interested in this topic[2,3]. We carried out a systematic search[3,4] of the US National Library of Medicine, the Cochrane Central Registry of Controlled Trials, the Science Citation Index Expanded, and the Conference Proceedings Citation Index-Science from 1950 through August 2013; included in the search were randomized, controlled trials consisting of adult participants, with diagnoses of rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), polymyalgia rheumatica (PMR), or giant cell arteritis (GCA), who were being withdrawn from glucocorticoid therapy as part of the intervention. We also found insufficient randomized controlled trials of steroid-tapering regimens similarly relating outcome measures to perform statistical comparisons of data for safety and efficacy[5]. We concur that randomized, controlled trials reporting outcome measures uniformly would be desirable to inform us better about how to taper steroids for patients with rheumatic diseases, although we consider it unlikely that such studies will be completed.

Current practices for tapering steroids for patients with rheumatic diseases derive largely from recommendations that are experiential, authoritative, based on consensus or opinion, and/or intuitive. We are not aware of consistent, comparable, rigorous, controlled data to support any specific approach to tapering steroids for RA, SLE, PMR, or GCA other than doing so judiciously and gradually, as seems appropriate for the individual patient. Perhaps this represents an area of medicine that simply cannot be reduced to protocols or algorithms, reflecting the art of medicine[6].

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