In Reply In response to our study on tapering of csDMARDs in patients with RA in remission,1 Dr Baker and colleagues discuss the potential for successful tapering, and even drug-free remission, in RA. They highlight that our study results can be interpreted differently than the main conclusion of the article, which was also discussed in the Editorial by Curtis et al.2 Although the ARCTIC REWIND trial showed an almost 4-fold increase in flare rate for patients randomized to half-dose csDMARDs compared with stable-dose csDMARDs, the results also showed that 75% of patients receiving half-dose csDMARDs did not experience a flare after 1 year. Additionally, most patients with flares regained remission after reinstituting full-dose csDMARD treatment. However, studies indicate that even manageable flares and fluctuations in disease activity can affect the daily lives of patients, yielding reminders of the unpredictability of RA.3,4 Baker and colleagues suggest that successful tapering can be possible within subgroups of patients, eg, based on serologic status or achievement of rigorous remission criteria such as the ACR/EULAR Boolean remission.5,6 Analyses of the primary end point of the ARCTIC REWIND csDMARD study revealed no statistically significant difference in flare rate based on serologic status in patients receiving half-dose therapy; 24% (16/67) among seropositive patients vs 30% (3/10) among seronegative patients (P = .70). Additionally, 22% (11/50) of patients in remission, as defined by ACR/EULAR Boolean criteria, experienced a flare compared with 30% (8/27) of patients not fulfilling these criteria at baseline (P = .58).

We also assessed baseline predictors for successful tapering in the 77 patients randomized to half-dose csDMARDs who were treated per protocol. During the 1-year follow-up, 25% (19 patients) experienced a flare. The final multivariate model shows anticitrullinated protein antibody level (range, 0-340 IU/mL; odds ratio, 1.05 [95% CI, 1.00-1.09]) per 10 units; P = .03) and Disease Activity Score (odds ratio, 6.43 [95% CI, 1.07-38.84]; P = .04) at time of tapering to be associated with a subsequent disease flare, although the cross-validated area under the curve for the model was low (0.55 [95% CI, 0.43-0.68]). The results of subgroup analyses and predictor analyses indicate there still is an unmet need for risk stratification variables that can successfully guide personalized tapering of treatment in RA.

The ARCTIC REWIND data can inform shared decision-making, which takes into account the consequences of a potential flare for an individual patient and the benefits of drug reduction. In a second phase of the current study, patients with RA who maintained remission for a year after tapering csDMARD to a half dose were randomized to either continued half-dose treatment or withdrawal of csDMARD. These data will add to the understanding of whether drug-free remission can be achievable for patients with RA.

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Incorrect Classification of Pharmaceutical Agent: In the JAMA Insights article titled “Novel Lipid-Lowering Therapies to Reduce Cardiovascular Risk,” published in the June 1, 2021, issue of JAMA,1 the statement “Similar to the loss of analgesic effects of opioids over time, the anxiolytic effects provided by benzodiazepines disappear within weeks” did not accurately reflect the findings of the reference it cited, and the statement and reference have been removed. This article was corrected online.


Incorrect Description in Patient Page: In the Patient Page titled “Pain Management During Vaginal Childbirth,” published in the August 3, 2021, issue of JAMA,1 an incorrect description appeared. In the third sentence of the second paragraph under “Pharmacologic Pain Management,” the description of the anesthetic drug used in neuraxial analgesia should have read “mainly a local anesthetic such as bupivacaine, with a small amount of opioid added” instead of “(an opioid such as fentanyl).” This article was corrected online.