Layman's version of article: "Low-dose glucocorticoid therapy in rheumatoid arthritis: an obligatory therapy".

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Introduction

Glucocorticoids (GCs) are anti-inflammatory drugs, often (25-75% of the patients) used in rheumatoid arthritis (RA) as well as in other rheumatic diseases. An example of a GC is prednisolone. In recent studies, low dose treatment with GCs, often combined with other drugs, are found to be highly effective for relieving symptoms of RA.

Efficacy

When used for a period of approximately 6 months, improvement has been found in pain, joint-scores, morning stiffness, fatigue, and in bloodtests (ESP and CRP). Besides this improvement in symptoms, there is also a positive effect on radiological joint damage, found in several studies (see article). There is less joint damage over periods of 2-5 years in patients who used GCs combined with other DMARDs, compared to patients who used a DMARD but no GCs. DMARDs are Disease Modifying Anti Rheumatic Drugs, prescribed in an early stage of RA to try to stabilize the disease. Patients who used GCs besides other drugs, needed less additonal therapies, such as GC injections or pain-relievers. This positive effect could last for several years after the use of the GCs. All this positive evidence in patients who recently (<2 years, described as early RA) developed RA, has led to GCs being classified as DMARDs which should be offered to patients within three months of the onset of the symptoms.

Adverse events; the possible negative side-effects of taking medication (besides the aimed beneficial effect)

Although it seems likely that patients who have had RA for more than 3 years would benefit as much from GC therapy, there is yet no firm evidence. Results of studies regarding toxicity of GCs are often difficult to interprete, because patients can have different severity of the RA, they can also have other diseases besides RA and patients can use different dosages. Some adverse events can be important to patients, such as skin thinning or Cushingoid appearance (e.g. a "blown-up" or "moon"face) while other more severe adverse events such as osteoporosis, cataracts, and GC-hypertension may go unrecognized. The three most common adverse events that are ranked in a study in GC-treated patients with rheumatic diseases per 100 patients, are: psychological and behavioral 19 of 100 patients, cardiovascular 6 of 100 patients and dermatological 6 of 100 patients. Compared with other antirheumatic drugs, short term adverse events of GC treatment are low, and patients rarely discontinue therapy for these reasons. If a patient needs GC for a longer period, the GC dosage should be kept to a minimum and be gradually reduced when the patient's disease activity is low or in remission.

In conclusion: Glucocorticoid therapy are considered as DMARDs. When GCs are used carefully and in low doses (see Eular recommendations), the balance between efficacy and adverse events is clearly in favor of the efficacy. The symptom-relieving effects come and go within a few hours, but when patients are treated with GCs early on in the disease, a long-term beneficial effect is less joint damage. The balance between beneficial and side effects of GCs favors the use of low dosage, for instance for a period of 3-6 months.