In JIA, Clinical Presentation Is Key to Diagnosis

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BIRMINGHAM, ENGLAND — Early diagnosis and prompt treatment of juvenile idiopathic arthritis can prevent complications and improve quality of life for affected children. A thorough clinical examination and the recognition of behavioral and other symptoms in young patients are essential to proper diagnosis and management.

Prediction of which one-third or so of children with oligoarthritis will progress to polyarthritis is difficult. In the absence of really accurate prognostic indicators, clinical presentation gives the most precise data on which to estimate likelihood of whether the disjoint involvement will worsen, said Dr. Helen Foster at the annual meeting of the British Society for Rheumatology.

Examine all joints. Look for extra-articular features, such as eye and skin involvement. Uveitis can arise at any time and is usually without symptoms, so close monitoring is warranted. "We need to screen children's eyes regularly."

Pain is not commonly reported in children with juvenile idiopathic arthritis (JIA). "It's not a universal symptom, and in making a diagnosis of JIA, doctors can't be reassured by a lack of pain," said Dr. Foster, a pediatric rheumatologist at Newcastle University, Newcastle upon Tyne (England). With a young child, it is important to ask parents about behavior, irritability, and sleep quality, as these signs—rather than the child's complaints of pain—are often present. In addition, teachers might provide insight into behavior and other effects, such as any difficulty with handwriting.

Given the uncertainty regarding clinical course, careful counseling, education, and support are essential for all patients and families. "Often parents want to know what their child can and cannot do," Dr. Foster said.

Earlier initiation of medical therapy is another advantage with earlier diagnosis, Dr. Foster said. "The sooner JIA is diagnosed, the sooner treatment can start and the better the outcome."

In treating JIA, methotrexate is often used and is very effective. For older children taking methotrexate, it is important to start discussions sooner (at 10 years of age and older) rather than later about avoiding alcohol and pregnancy, Dr. Foster said. Methotrexate is a teratogen. It is important to document the discussions carefully, and from a medicolegal point of view.

Some physicians are resistant to prescribing methotrexate in children, Dr. Foster said. "Many general practitioners refuse to prescribe and monitor. It's an unlicensed use for this age group. We have to negotiate with them."

Dr. Foster cited the case of a young girl who presented with pain and stiffness. She had two swollen fingers. "That is bad news. She is likely to progress." Small-joint and upper-limb involvement can indicate psoriasis; in such cases, ask about relatives with psoriatic arthritis, she advised.

The patient was prescribed about 10 mg/m^2 methotrexate. "This is a big dose compared to what you would start an adult on," Dr. Foster said. "Is the family going to be happy with a drug used for leukemia? No." However, it usually will not undermine treatment response to delay methotrexate a week or two. "You have time to work with the family and allow them to get their anxieties out. You have to tell them about the risks and the benefits of this drug. And compare this to the alternatives, which usually include steroids."

The patient fared well on oral methotrexate and achieved clinical remission, but stopped because of significant nausea. If this is anticipatory nausea and vomiting, take a break from methotrexate and then start it again, Dr. Foster said. Other options include splitting the dose, prescribing it at night, or switching the patient to subcutaneous methotrexate.

The patient had only a partial response to subcutaneous methotrexate, and was switched to a combination of oral methotrexate and etanercept. "We tend to combine these two—methotrexate and etanercept—and watch them very carefully," Dr. Foster said.

A meeting attendee asked when Dr. Foster takes a patient off methotrexate. "We wait until they are symptom free for at least 1 year. [Children] with one joint affected tend to do well. But those who require methotrexate, they tend to stay on it for a long time." ■

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