Ped Patients Need Faster Access to Arthritis Care

BY SARA FREEMAN

FROM THE ANNUAL MEETING OF THE BRITISH SOCIETY OF RHEUMATOLOGY

BIRMINGHAM, ENGLAND — Young people and children with juvenile idiopathic arthritis need better and faster access to arthritis care services, according to the first standards-of-care document to be issued for the condition in the United Kingdom.

"Standards of Care for Children and Young People With Juvenile Idiopathic Arthritis," developed by the U.K.-based Arthritis and Musculoskeletal Alliance (ARMA), was made public for the first time at the meeting.

Central to the standards is the need for a holistic treatment approach: not only managing disease activity, but also considering the impact that arthritis has on young patients' overall health, mental well-being, educational and employment prospects, and social integration.

"Rarely a day has gone by when I haven't been frustrated by the lack of service that I feel able to provide, and the knowledge that with the appropriate resources I could provide a much better experience for these young people," said Dr. Karen Davies, a consultant pediatric rheumatologist at New Cross Hospital in Wolverhampton, England. "I think these standards of care are very timely."

The document consists of 44 statements that are aimed at improving the care of young people with juvenile idiopathic arthritis (JIA). The first—and perhaps most important—standard states that all health care professionals who are likely to come into contact with a young person with JIA should have the necessary skills to recognize the condition.

"I was diagnosed with juvenile idiopathic arthritis in 1993, or JCA [juvenile chronic arthritis] as it was called then, when I was 11," said Sally Watt, who was involved in developing the standards.

Despite having repeated fractures from about the age of 5 years, Ms. Watt said it took several years for her condition to be recognized as JIA. She repeatedly heard from primary care physicians that "kids don't get arthritis," and "you're too young for arthritis." She started to receive expert care only when her family eventually paid to see a rheumatologist.

"As I have got older, it has become very apparent that my life is very different" from that of friends, Ms. Watt said. Now 28 years old, she commented that one of the main problems she had with the health care system was obtaining information and getting access to available support services, which the standards of care also address.

"The aim of the standards-of-care document is to try to break down the barriers to prompt diagnosis," said Dr. Penny Davis, cochair of the group that developed the recommendations.

Dr. Davis, a consultant pediatric rheumatologist at Birmingham (England) Children's Hospital, added that the standards also aimed "to ensure equitable access to holistic and multidisciplinary care, and to ensure that every child and young person has the most appropriate treatment."

Ros Meek, director of ARMA, commented that "there's clearly an immense amount of work needed to take these standards of care forward. Their dissemination and implementation are what is going to make all the difference." ■

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Rethink Labs in Kids on NSAIDs for Arthritis

BY SHARON WORCESTER

FROM PEDIATRIC RHEUMATOLOGY

Routine laboratory monitoring of children with juvenile idiopathic arthritis who take nonsteroidal anti-inflammatory medications has limited clinical utility and most likely is not cost effective, a medical records review suggests.

The records of 91 children who were diagnosed with JIA, treated with an NSAID for at least 1 month, and followed in a pediatric rheumatology clinic between January 1996 and September 2006 were reviewed for the results of laboratory monitoring of hemoglobin, transaminases, blood urea nitrogen, serum creatinine, and urinalysis, as well as for clinically significant NSAID-related effects.

Laboratory abnormalities were recorded for 24 of the 91 patients included in the study, but nearly all were mild and were not associated with clinical sequelae, said Dr. Sheetal S. Vora of the Medical College of Wisconsin, Milwaukee.

Of the 62 patients with oligoarticular disease, abnormalities included low hemoglobin in 5, elevated serum transaminases in 7, elevated BUN in 9, and trace proteinuria in 1. Five had abnormalities in two categories, and one of these patients discontinued NSAIDs.

Of the 29 patients with polyarticular disease, abnormalities included low hemoglobin in 5, elevated BUN in 1, and trace proteinuria in 1; none of these patients had more than one abnormality recorded, and none discontinued NSAID treatment, the investigators found (Pediatr. Rheumatol. 2010;8:11).

The frequency of testing varied widely in the patients studied, with frequency ranging from 0 to 17 times per patient for serum AST, and from 0 to 14 times per patient for serum ALT, for example.

The median frequency of most tests was 1 or 2, except urinalysis, which had a median frequency of 0 tests per patient. The median duration of NSAID treatment was 12 months, and all patients were treated with only one NSAID at a time (most often naproxen). Few patients received any additional medications, the investigators noted.

Although many physicians perform routine laboratory monitoring in children with JIA who are treated with NSAIDS, there are no consensus evidence-based guidelines regarding this practice.

Based on the findings of this study, it appears that such monitoring is unwarranted, they said.

"Our study suggests that clinically significant adverse events requiring the cessation of NSAIDs and detected by routine laboratory monitoring appear to be very infrequent. A prospective study to determine the incidence and prevalence of significant NSAID-related adverse effects detected by routine serial laboratory monitoring in children with JIA would be helpful for better defining the value of routine laboratory testing. ■

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Persistence of Nonfebrile Kawasaki Symptoms Tied to Abnormalities

VITALS

Major Finding: Children with Kawasaki disease who had persistence of only symptoms other than fever after initial IVIG treatment had 18-fold higher odds of developing coronary artery abnormalities relative to their symptom-free peers.

Data Source: A retrospective cohort study of 77 children with Kawasaki disease treated with IVIG and aspirin or the NSAID flurbiprofen.

Disclosures: None was reported.

BY SUSAN LONDON

FROM THE ANNUAL MEETING OF THE PEDIATRIC ACADEMIC SOCIETIES

VANCOUVER, B.C. — Children with Kawasaki disease who have persistence of symptoms other than fever after intravenous immunoglobulin treatment have sharply elevated odds of progressing to coronary artery abnormalities, a retrospective study showed.

In the study, 9% of children had resolution of fever but persistence of lip erythema or bulbar conjunctivitis, and were 18 times more likely to develop coronary artery abnormalities than were their counterparts whose symptoms had resolved. When it comes to identifying children with Kawasaki disease who have resistance to IVIG and need more treatment, clinicians typically watch for a fever that lingers, lead author Dr. Sayaka Fukuda said in an interview. But the importance of persistence of other symptoms is unknown.

Using electronic medical records, Dr. Fukuda and her colleagues retrospectively studied the characteristics and outcomes of children hospitalized with Kawasaki disease who received aspirin (or the NSAID flurbiprofen) plus IVIG as initial treatment.

The children were classified into four groups according to persistence of fever in the 24-36 hours after initial IVIG treatment (yes or no) and persistence of nonfever symptoms 1 month after initial IVIG treatment (yes or no).

Study results reported in a poster session at the meeting were based on 77 children, of whom 8% had persistence of both fever and nonfever symptoms, 9% had persistence of only nonfever symptoms, 18% had persistence of only fever, and 65% had resolution of all their symptoms.

In the group with only nonfever symptoms, these symptoms were lip erythema and bulbar conjunctivitis, according to Dr. Fukuda of the National Center for Child Health and Development in Tokyo.

The only significant difference among the four groups was the duration of hospitalization (P less than .01). The groups were similar with respect to age, sex, season of presentation, presenting symptom, fever duration, and more than a dozen laboratory measures of inflammation and coagulation.

All children with persistent fever had received a second course of IVIG or an alternative treatment, whereas only one of the seven children with persistence of just nonfever symptoms had received further treatment.

Overall, 14% of the children developed coronary artery abnormalities as assessed by ultrasound 1 month after initial treatment. By group, the rate was highest (67%) in those with persistence of both fever and nonfever symptoms, but it was also high (43%) in those with persistence of only nonfever symptoms.

In an adjusted analysis, children with persistence of both fever and nonfever symptoms had 48-fold higher odds of developing coronary artery abnormalities than did the symptom-free group. But children with persistence of only nonfever symptoms had 18-fold higher odds as well. Those with persistence of only fever were not at significantly elevated risk. ■