EXPERT COMMENTARY

Keep Young Athletes With Arthritis in the Game

Approximately 2 out of 1,000 children in any given year are diagnosed with arthritis. Decades ago these children would be easily identifiable because of their physical limitations. Today the combination of increased awareness of the many guises of juvenile rheumatoid arthritis, early diagnosis, and therapeutic advances has substantially altered not only how children experience the disease but also how physicians counsel and manage their young patients.

BY THOMAS J.A. LEHMAN, M.D.

The advent of disease modifying antirheumatic drugs (DMARDs) in particular has changed the face of juvenile rheumatoid arthritis by minimizing the scope of disease-related joint damage over time. For this reason, children are often able to keep functioning at relatively normal levels despite their disease. However, because the quest for normalcy is important to children and adolescents who fear being singled out from their peers for any reason, physicians must walk a fine line between encouraging physical activity and stressing the possibility of problems if children don't listen to their bodies and proceed with caution, according to Dr. Thomas J.A. Lehman, chief of the division of pediatric rheumatology at the Hospital for Special Surgery in New York. Awareness of this fine line is particularly relevant when caring for young athletes, who may be loath to report pain, stiffness, or disability for fear that doing so may cause them to be benched for a game, for the season, or forever.

Here, Dr. Lehman offers guidelines for managing young athletes with arthritis.

Q: In a young athlete with a new diagnosis of juvenile arthritis, what types of activities are off-limits or discouraged?

Dr. Lehman: We don't specifically make any activities off-limits, but rather advise common sense. Specifically, we tell patients not to participate in activities where other people are trying to hurt them, such as team tackle football or high school wrestling, because it's too easy to get hurt. Also, we tell them that if something makes them worse every time they do it, they shouldn't be doing it.

Q: Are juvenile arthritis patients at an increased risk for injury relative to their peers, and if so why and what types of injury?

Dr. Lehman: Juvenile arthritis patients may be at increased risk of injury, but the most serious injury we see is the psychological one from being told what they can't do. It's more important to emphasize that they can be as normal as possible as long as they use common sense and accept the reality that there will be an occasional normal injury.

Q: What impact, if any, might prolonged use of medications have on a young athlete's ability to participate in sports, and how can management be designed to minimize any such impact without sacrificing safety and efficacy?

Dr. Lehman: Most of the medications have no impact on ability to participate in sports. The important thing is not to take pain medications to participate in sports. Unlike muscle activity where "no pain no gain" makes sense, if there is bone pain, there is never a gain, only more damage.

Q: What signs of trouble should physicians be on the lookout for?

Dr. Lehman: Children who repeatedly engage in an activity that makes them worse should be stopped. They may feel they have to keep going because of pressure from their peers or even from parents or coaches. Everyone involved with these kids should be made to understand not to hold the children back but also not to allow them to injure themselves. ■

DR. LEHMAN *is chief of the division of pediatric rheumatology at the Hospital for Special Surgery and professor of clinical pediatrics at Cornell University in New York.*

Data Back Etanercept's Safety, Efficacy for Children With JIA

BY NANCY WALSH
New York Bureau

AMSTERDAM — Reassuring data on the use of etanercept in patients with juvenile idiopathic arthritis are emerging from a multicenter Spanish registry, with significant improvements being seen on all clinical parameters and no serious adverse events being reported, Dr. Inmaculada Calvo said at the annual European Congress of Rheumatology.

Etanercept was approved for the treatment of JIA in 1999, but few phase IV studies have been done evaluating the long-term safety and efficacy of tumor necrosis factor (TNF)–α blockade in these patients, noted Dr. Calvo.

A total of 103 patients have been enrolled in the registry, with follow-up extending as long as 48 months.

Fifty-three of the patients were female, the median patient age was 12.3 years, and the median age at disease onset was 5.6 years. During the 3 years prior to recruitment, 91.6% had undergone treatment with methotrexate but had shown an inadequate response, according to Dr. Calvo of the Hospital Infantil la Fe, Valencia, Spain.

All patients had polyarticular disease, 55.3% were seronegative, and 15.5% had systemic-onset disease.

At the time of analysis, 83 patients (80.6%) had been followed for at least 6 months, 72 (69.9%) had been followed for 12 months, and 49 (47.6%) had been followed for 24 months. In addition, 29 (28.2%) and 15 (14.6%) had been followed for 36 and 48 months, respectively.

No serious adverse events have been observed, and the infections reported were typical for patients of this age (see box). The median number of tender joints and swollen joints decreased from 9.09 to 0.3 and 9.24 to 3.13, respectively, Dr. Calvo wrote in a poster session at the meeting, sponsored by the European League Against Rheumatism.

Physician global assessment decreased from a median of 5.96 to 1.13, and patient global assessment fell from a median of 5.43 to 1.30. The Childhood Health Assessment Questionnaire index also decreased, from a median of 1.61 to 0.44. Laboratory parameters also improved, with the erythrocyte sedimentation rate falling from 43 to 11 mm/h and C-reactive protein level decreasing from 12 to 0.1 mg/L. ■

Reported Adverse Events Are Few

Event	Cases
Fever	2
Gastroenteritis	2
Mononucleosis	2
Cerebral pseudotumor	2
Uveitis	2
Tonsillitis	1
Diarrhea	1
Pharyngitis	1
Shingles	1
Erysipelas	1
Facial paralysis	1

Source: Dr. Calvo

DMARDs Alone Inadequate For Early Rheumatoid Arthritis

BY NANCY WALSH
New York Bureau

AMSTERDAM — Initial therapy using traditional disease-modifying antirheumatic drugs—even early, aggressively, and in combination—is inadequate for a significant proportion of patients with inflammatory arthritis, according to preliminary data from a prospective Canadian study.

In rheumatoid arthritis (RA), joint damage and the resulting disability occur during the first years of disease, and current therapeutic strategies aim to be aggressive in minimizing inflammation and preventing irreversible damage.

But among a cohort of 79 patients followed for 12 months in a real-world setting, fewer than half achieved remission with disease-modifying antirheumatic drug (DMARD) treatment, Dr. Vivian P. Bykerk said at the annual European Congress of Rheumatology.

For inclusion in the Toronto Early Arthritis Cohort, patients were required to be at least 16 years old and to have had symptoms for at least 6 weeks but less than 1 year. They had to have at least two swollen joints or one swollen metacarpophalangeal joint or proximal interphalangeal joint and to have more than one of the following characteristics: rheumatoid factor positive, anti-CCP positive, morning stiffness exceeding 45 minutes' duration, a response to nonsteroidal anti-inflammatory drugs, and a painful metatarsophalangeal joint squeeze test.

At baseline the mean patient age was 45.5 years, and 80% were female. Median duration of symptoms was 161 days.

Mean erythrocyte sedimentation rate was 28 mm/h, and mean C-reactive protein level was 13 mg/L. The mean tender joint count was 19, mean swollen joint count was 11, and mean Disease Activity Score (DAS) was 5.3. A total of 28% of patients were rheumatoid factor positive, and 67% met the criteria for RA. In addition, 26% already had erosions present in the hands or feet.

Recommended initial treatment for RA in Canada involves combination therapy, but only 60% of patients in this cohort were started on more than one DMARD. This probably reflects a lower disease burden and also possibly patient preference, said Dr. Bykerk of Mount Sinai Hospital, Toronto.

When combination therapy was used, it generally was methotrexate plus hydroxychloroquine or sulfasalazine. The methotrexate dose was 15-25 mg/week, the mean dose at 12 months was 18 mg/week, and for two-thirds of patients the dose exceeded 20 mg/week. A third of the patients opted to take their methotrexate subcutaneously, she said. "In Canada we are strong proponents of subcutaneous methotrexate in doses of 20-25 mg early on," she said at the meeting, sponsored by the European League Against Rheumatism.

The sulfasalazine dose was 2 g/day, and the hydroxychloroquine dose was 400 mg/day.

By 12 months, only 47% of patients achieved remission as defined as a DAS28 less than 2.6, even using an aggressive DMARD strategy followed by biologic therapies in patients who were inadequate responders at 6 months.

"For a significant proportion of patients with early RA or inflammatory arthritis, a different strategy than early DMARD therapy may be required," she said. Studies are needed to validate the earlier use of biologics and to identify prognostic factors. ■