Valley Children's HEALTHCARE

Central California
Pediatrics

JUNE 2021

Specialty information for physicians who treat children and expectant mothers.

Kids Get Arthritis, too!

Reshma Patel, MD
Valley Children's Pediatric Rheumatologist; Clinical Assistant Professor (affiliated), Stanford University School of Medicine; Rheumatology Academic Chief; and Pediatric Core Faculty and Faculty Coach

More than 300,000 children in the United States have been diagnosed with juvenile idiopathic arthritis, but there is much more need to spread the word. July is juvenile arthritis month, which is the perfect reminder of how prevalent this condition can be among children and how we can remain diligent about looking for early signs and symptoms.

Juvenile idiopathic arthritis (JIA) is often referred to as juvenile rheumatoid arthritis (JRA) in the U.S., but it really is different than adult rheumatoid arthritis and so named juvenile idiopathic arthritis.

Subtypes of JIA all have distinguishing features, disease and treatment:

- Systemic onset JIA or Still's disease
- Oligoarticular JIA (affecting fewer than 5 joints)
- RF positive polyarticular JIA (affecting five or more joints)
- RF negative polyarticular JIA
- Enthesitis-related arthritis
- Juvenile psoriatic arthritis
- Undifferentiated JIA

Early diagnosis of JIA is important to prevent long-term complications. However, as many disease-modifying antirheumatic drugs (DMARDs) target the immune system, it is imperative that non-rheumatologic processes are ruled out prior to starting these treatments.

Some of the other causes of joint pain include infection, malignancy, as well as noninflammatory causes such as benign limb pains of childhood, hypermobility, mechanical pain and overuse syndromes. Some important questions to ask to help distinguish joint pain and tailor workup can include:

- What were the preceding events before joint pain?
- Was there any trauma?
- What time of the day does the pain occur?
- What are alleviating and aggravating triggers?
- Is there any morning stiffness?
- Does the pain improve with movement?
- Does pain disrupt sleep?
- Does the pain interfere with activities of daily living?
- Is there any swelling of any joints?
- Are there any constitutional symptoms such as fever, weight loss, night sweats?
- Were there any illnesses before the onset of joint pain?

Valley Children's HEALTHCARE

9300 Valley Children's Place
Madera, CA 93636-8762

RETURN SERVICE REQUESTED

NON-PROFIT ORG.
US POSTAGE
PAID
FRESNO, CA
PERMIT NO. 114

When a child has joint pain or swelling, the natural instinct is to assume there was an injury or, if present with other symptoms, to be a sequelae of an infection. The symptoms might even regress slightly before showing up again, sometimes delaying diagnosis for quite some time.

Differentiating Between Arthralgia and Arthritis

Arthralgia simply means joint pain and usually used as a reported symptom. Arthritis means inflammation of the joint. In children, inflammatory arthritis physiologically occurs in the synovial membrane and physically causes joint effusion, warmth, pain with movement and limitation in movement or joint stiffness. Thus, arthritis, is more of an objective finding that can be examined on a patient or seen on imaging modality. By definition, a child with inflammatory JIA will have these findings in one or more joints for at least six weeks and occur in a child age 16 or younger. After their sixteenth birthday, a diagnosis would be rheumatoid arthritis.

Treating and Referring JIA

Awareness, earlier diagnosis and initiation of treatment has had a remarkable reduction in complications such as joint deformities, disabilities, joint replacements and overall quality of life in the field of rheumatology. There have been tremendous advances in rheumatic treatments over the past 25 years with the advent of immunosuppressive biologic and biosimilar drugs that target inflammation. These are typically prescribed when conventional disease-modifying antirheumatic drugs (DMARD) such as methotrexate, luflunomide or sulfasalazine are sub therapeutic. As many of these target the immune system, it is imperative that infectious and oncologic processes are ruled out prior to starting biologics. Some of the biologics used to treat JIA include abatacept, adalimumab, anakinra, canakinumab, etanercept, infliximab and tocilizumab.

If a child has signs of joint inflammation, it is recommended that they contact their pediatrician, and depending on clinical status they may be directed to a specialist for further care. Early labwork can include CRP, ESR, rheumatoid factor, cyclic citrulinated peptide, Human leukocyte antigen 27 (HLA B27), ANA as well as baseline CBC, CMP and other screening labs to rule out other processes. Valley Children's pediatric rheumatology specialists continue to be available to consult with healthcare providers with management of such cases.

Medical Staff News

The following pediatric specialists recently joined Valley Children's:

Child Advocacy
Jennie Daly, MD

Hospitalist
Irmeen Ashraf, MD
Jaimie Brandley, DO
Sindhura Gandham, MD

Neonatology
Pulak Agrawal, MD
Uche Nwokidu-Adibigbe, MD
Himanshu Singh, MD

Pathology
Natalie Ellington, MD
Elizabeth Martinez, DO

Primary Care
William Holm, MD
Neha Vashishtha, MD

Upcoming CME Opportunities

Pediatric Clinical Symposium: Pediatric Constipation
Presented by Dr. Neha Ahuja
Wednesday, July 28
12:15 p.m. - 1:15 p.m.

Register for Valley Children's CME events through our CME Tracker, cmetracker.net/VCH

@valleymeded

@valleychildrensmeded