PATIENT FACT SHEET

Juvenile Arthritis

CONDITION DESCRIPTION

Juvenile idiopathic arthritis (JIA) is chronic arthritis that affects children. About one in every 1,000 children develops chronic arthritis. It may happen at any age before 16, but rarely younger than six months. Juvenile arthritis is not usually inherited. Children with JIA may lead normal, active lives. Early diagnosis and treatment help prevent joint damage.

JIA may affect one or many joints. Children may also have silent eye inflammation, fevers or rash. Systemic onset JIA may affect many joints and organs. Oligoarticular JIA affects half of all children with JIA, more often girls, and affects fewer than five joints. Polyarticular JIA affects five or more joints. Other forms of JIA include juvenile psoriatic arthritis and enthesis-related arthritis, which affects the spine.

SIGNS/ SYMPTOMS

Children may have pain and joint swelling, but these may not be obvious at first. Signs of JIA include limping, morning stiffness, reluctance to use an arm or leg, reduced activity, persistent fever and difficulty with fine motor activities.

Children with systemic onset JIA often have repeating, high fevers and pink skin rash that comes and goes. Older children with oligoarticular JIA may have arthritis into adulthood, while joint disease may subside over time in younger children with this form of JIA. Oligoarticular JIA raises the risk of eye inflammation. Early signs of juvenile psoriatic arthritis are nail changes and swollen digits. Enthesis-related arthritis may cause back pain and stiffness.

Diagnosis of JIA is based on physical exam and medical history. Children often test negative for blood tests that are commonly found in patients with rheumatoid arthritis such as rheumatoid factor. Lyme disease, childhood cancer and other causes must be ruled out first.

COMMON TREATMENTS

A pediatric rheumatologist should lead the treatment and management of JIA. Goals of treatment are to control symptoms, improve function and prevent joint damage. Children need regular eye exams from an ophthalmologist and exams by other specialists, such as dentists or orthopedists, as needed.

If only a few joints are affected, a steroid injection into the joints may ease pain and swelling. Low-dose, short-term oral corticosteroids, such as prednisone (Deltasone, Orasone, Prelone, Orapred), may be used in some situations. When many joints are involved or steroid injections fail to work, disease-modifying antirheumatic drugs (DMARDs), such as methotrexate (Rheumatrex) or leflunomide (Arava), may be used.

Biologic drugs like etanercept (Enbrel), infliximab (Remicade), adalimumab (Humira), abatacept (Orencia), anakinra (Kineret), canakinumab (Ilaris), tocilizumab (Actemra) and rituximab (Rituxan) are also approved JIA treatments. Children taking biologics need careful monitoring by a pediatric rheumatologist.

CARE/ MANAGEMENT TIPS

Children with JIA should attend school, and engage in social, extracurricular and family activities. Adolescents with JIA can get part-time jobs and learn to drive, just as teens without JIA do.

Positive outlook and regular physical activity are helpful. Some children with JIA may need physical or occupational therapy to improve function, pain, endurance, joint flexibility and strength. Therapists can fit children with splints if needed, or develop modifications to help children with tasks at school. Federal Act 504 provides for special accommodations at school for children with JIA. Families may also be eligible for assistance through state agencies.

There are summer camps and support groups for children and teens with JIA. The Juvenile Arthritis Alliance provides JIA-focused information and activities.

Updated March 2017 by James Udell, MD, and reviewed by the American College of Rheumatology Communications and Marketing Committee. This information is provided for general education only. Individuals should consult a qualified health care provider for professional medical advice, diagnosis and treatment of a medical or health condition.

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