Early combination plan for polyarticular onset/ course JIA with poor prognostic factors[1]	2019
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Visit 1

Begin TNF inhibitor[2] and methotrexate (MTX) 10 mg/m^{2}

Optional 1) Intraarticular steroid injections (IAC), or 2) prednisolone (PDN) max 0.2 mg/kg for 7 weeks

Optional visit at 6 weeks: if no response, increase MTX dose/sc to 15 mg/m2, consider 1) IAC or 2) PDN mg/kg

At 3 months - Visit 2

If much improved: (approx. ΔJADAS10>50%) Continue same or increase therapy	**OR**	**If not much improved:** Increase MTX 15 mg/m2 (sc) 1) Consider IAC 2) Consider PDN max 0.2 mg/kg Also, consider to increase dose (if possible) or change anti-TNF2 if no response

At 6 months - Visit 3

If much improved: (approx. ΔJADAS10>50%) and off PDN Continue same or increase MTX	**OR**	**If not much improved:** Consider increased dose of or change to another anti-TNF[2] Increase MTX (if not max 15 mg/m^{2}) Optional IAC or PDN max 0.2 mg/kg 7wks

Optional 9 months: if target not reached, consider to change biologic treatment, increase therapy

At 12 months - Visit 4

If inactive/remission: JADAS <1 and off PDN Consider tapering therapy	**OR**	**If not much improved:** Change to another biologic mechanism3 Optional IAC

Footnote 1: Moderate/high disease activity defined as > 1 active joint, elevated ESR or CRP, or MD or Pts global > 3 (see ref 2)
Footnote 2 Adalimumab, etanercept (if no uveitis or IBD), golimumab, or infliximab (in line with the Norwegian LIS TNF BIO recommendations)
Footnote 3: If tried 2 anti TNFs, change mechanism to tocilizumab or abatacept

The treatment plan based on the Childhood Arthritis and Rheumatology Research Alliance (CARRA) Consensus treatment plans, expert reviews, the American College of Rheumatology (ACR) treatment plans.

Referanser

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