Behandlingsplaner

Early treatment plan for active predominantly systemic JIA and insufficient response to NSAIDs	2019

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Visit 1

Begin anakinra[1]

If signs of MAS2 consider Solu-Medrol 15-30 mg/kg day 1-3 →PDN 1-2 mg/kg/day
If > 1 active joint consider MTX 10 mg/m2/wk

At 1 months - Visit 2

If much improved and no fever: (approx ΔJADAS>50%) Continue same therapy	**OR**	**If not much improved arthritis:** Start MTX. Optional PDN or IAC **If not much improved systemic:** Consider to increase dosis. Consider PDN max 0.5 mg/kg

At 3 months - Visit 3

If much improved no fever: (approx. ΔJADAS>50%) Continue same therapy	**OR**	**In not much improved arthritis:** Increase MTX. Optional IAC or PDN Consider change of biologic[3] **If not much improved systemic:** Consider change of biologic[3] Adjunct low dose PDN optional

At 6 months - Visit 4

If inactive and no fever: JADAS<1/MD inactive and off PDN Consider tapering biologic	**OR**	**If not inactive:** Consider change to another biologic[4] Consider increased MTX if possible. Consider low dose PDN. Adjunct IAC/low dose PDN optional

At 9 and 12 months - Visit 5 and 6

If inactive no fever: Consider tapering biologic	**OR**	**If not inactive:** Same strategy as visit 4

JADAS= Juvenile Arthritis Disease Activity Scale. MD= Physicians global assessment of disease activity.

Footnote 1: Anakinra 2-3mg/kg/day
Footnote 2: Ferritin>800, platelets < 150, ASAT >90, decrease in ESR, TG >
Footnote 3: Canakinumab, Tocilizumab
Footnote 4: Tocilizumab or TNF inhibitor

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

1. 2013 update of the 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: recommendations for the medical therapy of children with systemic juvenile idiopathic arthritis and tuberculosis screening among children receiving biologic medications. Ringold S, Weiss PF, Beukelman T, DeWitt EM, Ilowite NT, Kimura Y, Laxer RM, Lovell DJ, Nigrovic PA, Robinson AB, Vehe RK; American Collge of Rheumatology. Arthritis Rheum. 2013 Oct;65(10):2499-512

2. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. Beukelman T, Patkar NM, Saag KG, Tolleson-Rinehart S, Cron RQ, DeWitt EM, Ilowite NT, Kimura Y, Laxer RM, Lovell DJ, Martini A, Rabinovich CE, Ruperto N. Arthritis Care Res (Hoboken). 2011 Apr;63(4):465-82

3. Methotrexate in juvenile idiopathic arthritis: towards tailor-made treatment. Ćalasan MB1, Wulffraat NM. Expert Rev Clin Immunol. 2014 Jul;10(7):843-54. doi: 10.1586/1744666X.2014.916617.

4. Consolaro Consolaro A, Ruperto N, Bazso A, Pistorio A, Magni-Manzoni S, Filocamo G, et al. Development and validation of a composite disease activity score for juvenile idiopathic arthritis. Arthritis Rheum 2009 May 15;61(5):658-66.

5. Experience with etanercept, tocilizumab and interleukin-1 inhibitors in systemic onset juvenile idiopathic arthritis patients from the BIKER registry. Horneff G et al. Arthritis Res Ther. 2017 22;19(1):256.