

American College of Rheumatology (ACR)  
Juvenile Idiopathic Arthritis Guideline

Public Comments

*The ACR Juvenile Idiopathic Arthritis Guideline public comment was posted on the ACR website July 12, 2017. The announcement was e-mailed to the Practice Guidelines Subcommittee, Quality of Care Committee and ACR Board of Directors, and was included in multiple ACR publications and on ACR social media platforms. **Eight (8)** responses were received via the online form. The public comment period closed on August 10, 2017.*

**RESPONSES RECEIVED ONLINE:**

- **Name:** Nadia Luca
- **Institution:** Alberta Children's Hospital
- **Position:** Pediatric Rheumatologist
- **Disclosure (optional):** Nothing to disclose

**Comment:**

1. Did you consider including the BASDAI and BASFI as outcome measures for axial arthritis? 2. Did you consider including intra-ocular steroid as a treatment for uveitis?

- **Name:** Ann Reed
- **Institution:** Duke
- **Position:** N/A
- **Disclosure (optional):** Nothing to disclose

**Comment:**

I think a major treatment that needs to be included is use of Plaquenil therapy. I sorry if i missed that it is included in DMARDS. Even though not superior to the other therapies, there are good reasons why it is used in isolation as treatment, i.e., cost, tolerability, parental choice and concerns of starting with MTX, overuse of biologics in the health care system, which I believe will be limited by our payers in the near future, to name a few.

- **Name:** Nicole Johnson
- **Institution:** University of Calgary
- **Position:** Pediatric Rheumatologist
- **Disclosure (optional):** Nothing to disclose

**Comment:**

Line 32. The goal is to look at polyarticular course, however, would there be any role for another objective to look at persistent oligo JIA with less than five joints who have failed joint injections, systemic steroids, DMARDS. So, could there be development of the role in these patients for biologics. Some of these children would benefit from a biologic, but at this time if they do not have five or more joints they are ineligible in many centres.

- **Name:** Ioannis Kalampokis
- **Institution:** UNM
- **Position:** Assistant Professor of Pediatrics

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- **Disclosure (optional):** Nothing to disclose

**Comment:**

How were the participating “experts” and other members chosen? By whom and with what criteria? What was the process? The majority of individuals participating in the development of the guideline have received financial support by the pharmaceutical industry. That makes whatever guideline will be developed highly questionable.

- **Name:** Ruben Burgos Vargas
- **Institution:** Hospital General de Mexico & Universidad Nacional Autonoma de Mexico
- **Position:** Research Scientist
- **Disclosure (optional):** Abbvie, BMS, Eli Lilly, Novartis, Pfizer, Roche, UCB

**Comment:**

I can't find a list and definition of risk factors. If risk factors and their definitions are the same those described in the previous guidelines, there will be a problem in regard to SEA or SI subgroup. Page 16, line 359 and so on. Sacroiliitis, by any means, is rare in children and adolescents. Inflammatory back pain (IBP) is also rare before 18 years old. Despite specificity and PP values are high, its sensitivity is very low. The text says (line 363): “This group is intended to include patients with sacroiliitis who will most ...” According to data I've collected for many years, active SI and/or IBP are detectable in 15% of patients with jSpA, ERA, and related entities before the age of 16 and seldom occur as a unique manifestation; most patients have arthritis and or enthesitis. On the other hand, the extrapolation of poly and oligo JIA recommendations to ERA would be certainly inappropriate since there is no evidence at all that MTX, HXCL, and leflunomide produce some benefit in these children; such circumstance would delay the onset of TNFi and other biologics for at least three months. Sulfasalazine has a marginal effect. In brief, peripheral disease in ERA patients should be treated with biologics as soon as the lack of efficacy of NSAIDs and perhaps glucocorticoids has been confirmed. Outcomes – I don't understand the difference between critical and important outcomes. Nevertheless, bone overgrowth, including bone ankyloses, at peripheral and axial entheses, should be included in the list of outcomes. I agree with most questions presented in the document.

- **Name:** Daniel Horton
- **Institution:** Rutgers University
- **Position:** Assistant Professor
- **Disclosure (optional):** Nothing to disclose

**Comment:**

These are sound, well-conceived plans with important objectives and excellent organization. I have several comments: Objectives, Lines 34-39 “safety and efficacy issues.” Aims should also consider drug effectiveness, not just efficacy, given that much of the available evidence is from real-world or otherwise observational data. Lines 115-117 Benefits and harms generally are outcomes themselves, so it is unclear what the “benefits and harms for each outcome” means, perhaps this should read “for each treatment?” Also, I find the phrase “assumed and corresponding risk for comparators and interventions” confusing. Line 124 “[control for] all plausible confounding...?” Appendix A. The recommendation questions in each section have inconsistent subjects (“patients” in polyarthritis

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questions, “children and adolescents” in sacroiliitis questions, and “JIA children” in uveitis questions). Consider standardizing, preferably without the phrase “JIA children.” Also these discrepancies raise the question: will be there an age restriction to patients discussed in these guidelines, or will they include studies of older teenagers and young adults diagnosed with JIA? Sacroiliitis & Enthesitis questions: Lines 371-374. The definitions that include clinical exam findings rely on unreliable signs of both sacroiliitis and enthesitis. These definitions are certainly practical and likely correspond to many studies that investigated treatment and outcomes of these conditions, but they are nonetheless problematic. Levels of evidence and recommendations should consider the definitions of sacroiliitis and enthesitis that studies used. Line 465 hypopyon is misspelled. Weaning therapy questions, Lines 551-552, these questions are included for uveitis but not the other sections. Was there consideration of evaluating evidence and making recommendations for weaning therapy for polyarthritis and sacroiliitis?

- **Name:** Philip Hashkes
- **Institution:** Shaare Zedek Medical Center
- **Position:** Head, Pediatric Rheumatology Unit
- **Disclosure (optional):** Nothing to disclose

**Comment:**

Timely update, especially with added objective on uveitis. Personnel: Similar to my (and Prof. Woo) comment for the 2013 systemic JIA ACR update project, which was accepted, there should be international participation in this project (both to the task force and voting panel), including ACR international members. I think that more than two experts (as in 2013) from various parts of the world should be added. Methods: Summary efficacy/safety data from the major registries (Germany, Pharmachild/PRINTO, CARRA, UK), if possible, should be made available to the task force/voting panel. The registries have come a long way since the 2011 recommendations and add important info that should be considered in the decision process. Questions: I thought some of the questions, like NSAID use, were settled in the 2011 recommendations. Scope: The treatment of polyarthritis is not complete without specifically addressing TMJ arthritis (which has caused much controversy). The question should include IA steroids vs. systemic therapy (DMARD +/- biologics) and how many maximum injections.

- **Name:** Kathleen O’Neil
- **Institution:** University of Indiana
- **Position:** Professor of Pediatrics, Chief, Pediatric Rheumatology
- **Disclosure (optional):** Nothing to disclose

**Comment:**

I am worried that current guidelines need to be researched beyond “what we have always done” and “what is good clinical practice in adults.” For example, JIA patients under age 14 or 15 usually do not have the risks of hepatotoxicity with methotrexate that is seen in adults. I reviewed the information on methotrexate and liver disease, and really, we have been terrorizing children for decades by drawing blood as often as we do. Most rises in hepatic enzymes are minimal and we must remember that most of the enzymes rise with a sports practice or exertion, a viral infection, or gastroenteritis because the colon makes abundant aminotransferases, the lung is a great source of these enzymes and LDH, etc. Please examine the evidence. I found a marvelous editorial in Medicine, I think, from the 1980s, by Marshall Kaplan that reported his lab pushed the dose of MTX in rats to doses high enough that the

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animals died of marrow failure, but none had any histologic or physiologic abnormalities of their livers. His conclusion was that use of MTX in low dose should not be justification for routine liver biopsies or every 3 month liver blood tests.