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2026 American College of Rheumatology (ACR) Juvenile Idiopathic Arthritis (JIA) Guidelines

Summary

Juvenile idiopathic arthritis (JIA), the most common pediatric rheumatic diagnosis, encompasses multiple biologically and clinically distinct conditions characterized by chronic joint inflammation. These guidelines for the management of JIA, both in children and adults, reflect the consensus of clinical experts following a rigorous review of the available evidence. The overarching goals are to: promote early and aggressive treatment of JIA to preserve function and maximize outcomes and quality of life; encourage timely screening and monitoring to prevent articular and extra-articular damage; and facilitate effective shared decision-making among clinicians, patients, and caregivers. Given the large scope, these guidelines have been split into four manuscripts: 1) nonpharmacologic management of JIA, medication monitoring, and imaging; 2) systemic JIA; 3) non-systemic JIA; and 4) JIA-associated chronic anterior uveitis.

Treatment of Systemic Juvenile Idiopathic Recommendations

Recommendations	Strength	Level of Evidence
INITIAL THERAPY: sJIA WITHOUT MAS		
In people with newly diagnosed sJIA without MAS		
…We **strongly** recommend bDMARD (IL-1i or IL-6i) therapies as first-line treatment. There is no preferred agent	Strong	Low
…We **strongly** recommend *against* NSAIDs as initial monotherapy.	Strong	Very Low
…We **conditionally** recommend *against* oral glucocorticoids as initial monotherapy.	Conditional	Very Low
...We **strongly** recommend *against* csDMARDs as initial monotherapy.	Strong	Low
SUBSEQUENT THERAPY: sJIA WITHOUT MAS		
In people with sJIA without MAS with ongoing systemic symptoms who do not respond to or are intolerant to initial therapy with a bDMARD		
...We **conditionally** recommend a different bDMARD (IL-1i or IL-6i) or targeted synthetic DMARD (tsDMARD) (Janus kinase inhibitor [JAKi]) over the addition of a csDMARD (e.g., MTX) or glucocorticoids. IL-1i and IL-6i are preferred over JAKi.	Conditional	Very Low
In people with sJIA without MAS with well-controlled systemic symptoms but residual arthritis on bDMARD		
... We **conditionally** recommend changing to a different bDMARD (IL-1i, IL-6i, TNFi, abatacept) or tsDMARD (JAKi), adding csDsMARD (e.g., MTX, leflunomide), or intraarticular glucocorticoid injection (IAGC), over the addition of systemic glucocorticoids. Methotrexate and/or IAGC are preferred over alternative bDMARD followed by JAKi.	Conditional	Very Low

INITIAL THERAPY: sJIA WITH MAS		
In people with newly diagnosed sJIA with MAS		
…We **strongly** recommend bDMARD (IL-1i or IL-6i) therapies as first-line treatment. There is no preferred agent.	Strong	Low
…We **strongly** recommend systemic glucocorticoids as part of initial therapy.	Strong	Very Low
SUBSEQUENT THERAPY: sJIA AND MAS		
In people with sJIA with active MAS who do not respond to or are intolerant to initial therapy with a bDMARD		
…We **conditionally** recommend a different bDMARD or tsDMARD (IL-1i, Il-6i, emapalumab, JAKi) over addition of a csDMARD (cyclosporine or tacrolimus).	Conditional	Very Low
In people with inactive sJIA with or without history of MAS		
…We **strongly** recommend tapering and discontinuing glucocorticoids after clinical inactive disease (CID) has been attained for sJIA.	Strong	Very Low
…We **conditionally** recommend tapering and discontinuing bDMARDs over immediately stopping bDMARDs after CID has been attained for sJIA.	Conditional	Low
In people with sJIA with or without a history of MAS who have achieved CID on DMARDs		
No consensus could be reached regarding a specific length of time in CID (3 months, 6 months, 1 year, >1 year) before tapering or stopping DMARD.	NA	Low
In people with sJIA with or without a history of MAS who have flared upon DMARD taper or discontinuation		
…We **conditionally** recommend restarting the same medication regimen as the most recently effective regimen over starting a new regimen to recapture inactive disease and remission after flare.	Conditional	Very Low
ASSOCIATED LUNG DISEASE		
In people with sJIA		
…We **conditionally** recommend routine screening for sJIA-LD.	Conditional	Very Low
…We **strongly** recommend that the presence or development of lung disease should not be considered an absolute contraindication to the use of IL-1/6 inhibitors.	Strong	Very Low

Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Polyarthritis, Oligoarthritis, Enthesitis, Dactylitis, Temporomandibular Joint Arthritis, and Deprescribing Recommendations

Recommendations	Strength	Level of Evidence
GENERAL RECOMMENDATIONS		
In people with non-systemic JIA		
GPS: Risk factors for poor outcomes (e.g., involvement of ankle, wrist, sacroiliac (SI) joint, hip and/or TMJ, presence of erosive disease, enthesitis, delay in diagnosis, elevated inflammatory markers, rheumatoid factor (RF) or cyclic citrullinated peptide (CCP) positivity, symmetric disease) should be considered in non-systemic JIA to guide treatment decisions.	Strong	Very Low

…We **conditionally** recommend use of validated JIA disease activity measures to guide treatment decisions for non-systemic JIA, especially to facilitate treat-to-target approaches.	Conditional	Very Low
POLYARTHRITIS		
In people with polyarthritis		
…We **conditionally** recommend a trial of scheduled oral NSAIDs as adjuncts to initial therapy.	Conditional	Very Low
…We **conditionally** recommend intra-articular glucocorticoids (IAGCs) as adjuncts to initial therapy.	Conditional	Very Low
…We **strongly** recommend triamcinolone hexacetonide as the preferred agent for IAGC injections.	Strong	Moderate
…We **conditionally** recommend *against* oral glucocorticoids as adjuncts to initial therapy.	Conditional	Very Low
…We **strongly** recommend DMARDs (csDMARD and/or bDMARDs) as first-line therapy.	Strong	Very Low
…We **conditionally** recommend methotrexate as the first csDMARD over leflunomide, sulfasalazine, or hydroxychloroquine (in that order).	Conditional	Very Low
…We **conditionally** recommend oral methotrexate over subcutaneous methotrexate.	Conditional	Very Low
…We **conditionally** recommend tumor necrosis factor inhibitors (TNFi) as the first bDMARD over the following bDMARDS: IL-6i, T cell costimulation-modulators, IL-17i, IL-12/23i.	Conditional	Very Low
In people with polyarthritis treated with TNFi		
…We **conditionally** recommend using a csDMARD concurrently.	Conditional	Low
In people with polyarthritis treated with bDMARDs		
…We **conditionally** recommend *against* routinely monitoring anti-drug antibodies.	Conditional	Very Low
OLIGOARTHRITIS		
In people with oligoarthritis		
…We **conditionally** recommend a trial of scheduled oral NSAIDs as first-line therapy.	Conditional	Very Low
…We **strongly** recommend IAGCs as first-line therapy.	Strong	Very Low
…We **strongly** recommend triamcinolone hexacetonide as the preferred agent for IAGC injections.	Strong	Low
…We **conditionally** recommend *against* oral glucocorticoids as adjuncts to initial therapy.	Conditional	Very Low
…We **strongly** recommend csDMARDs over no csDMARDs for an inadequate response to scheduled NSAIDs and/or IAGCs.	Strong	Low
…We **conditionally** recommend methotrexate as the first csDMARD over leflunomide, sulfasalazine, or hydroxychloroquine (in that order).	Conditional	Low
…We **conditionally** recommend oral methotrexate over subcutaneous methotrexate.	Conditional	Very Low
…We **strongly** recommend bDMARDs for an inadequate response to or intolerance of NSAIDs and/or IAGCs and first-line csDMARD.	Strong	Very Low
…We **conditionally** recommend TNFi as the first bDMARD over the following bDMARDs: IL-6i, T cell costimulation-modulators, IL-17i, IL-12/23i.	Conditional	Very Low
In people with oligoarthritis treated with TNFi		
…We **conditionally** recommend using a csDMARD concurrently.	Conditional	Very Low
In people with oligoarthritis treated with biologic bDMARDs		
…We **conditionally** recommend *against* monitoring ADA levels routinely.	Conditional	Very Low

ENTHESITIS		
In people with enthesitis		
…We **conditionally** recommend a trial of scheduled oral NSAIDs as adjuncts to initial therapy.	Conditional	Very Low
…We **conditionally** recommend *against* oral glucocorticoids as adjuncts to initial therapy.	Conditional	Very Low
…We **strongly** recommend DMARDs (csDMARDs and/or bDMARDS as first-line therapy.	Strong	Low
….We **conditionally** recommend methotrexate as the first csDMARD over sulfasalazine.	Conditional	Low
…We **conditionally** recommend oral methotrexate over subcutaneous methotrexate.	Conditional	Very Low
…We **conditionally** recommend TNFi as the first bDMARD over the following bDMARDs: IL-17i, IL-12/23i.	Conditional	Low
In people with enthesitis treated with TNFi		
…We **conditionally** recommend using a csDMARD concurrently.	Conditional	Very Low
In people with enthesitis treated with bDMARDs		
…We **conditionally** recommend *against* routinely monitoring anti-drug antibodies.	Conditional	Very Low
DACTYLITIS		
In people with dactylitis		
…We **conditionally** recommend a trial of scheduled oral NSAIDs as adjuncts to initial therapy.	Conditional	Very Low
…We **strongly** recommend IAGCs and tendon injections as adjuncts to initial therapy.	Strong	Very Low
There is **no preferred agent** for IAGC.	NA	Very Low
…We **conditionally** recommend *against* oral glucocorticoids as adjuncts to initial therapy.	Conditional	Very Low
…We **strongly** recommend DMARDs (csDMARDS and/or bDMARDs) as first-line therapy.	Strong	Very Low
…We **conditionally** recommend methotrexate as the first csDMARD over leflunomide, sulfasalazine, or hydroxychloroquine (in that order).	Conditional	Very Low
…We **conditionally** recommend oral methotrexate over subcutaneous methotrexate.	Conditional	Very Low
…We **conditionally** recommend TNFi as the first bDMARD over the following bDMARDs: IL-17i, IL-12/23i.	Conditional	Very Low
In people with dactylitis treated with TNFi		
…We **conditionally** recommend using a csDMARD concurrently.	Conditional	Very Low
In people with dactylitis treated with bDMARD		
…We **conditionally** recommend *against* routinely monitoring anti-drug antibodies.	Conditional	Very Low
TMJ ARTHRITIS		
In people with TMJ arthritis		
…We **conditionally** recommend a trial of scheduled oral NSAIDs as adjuncts to initial therapy.	Conditional	Very Low
…We **conditionally** recommend IAGCs as adjuncts to initial therapy. No agent is preferred.	Conditional	Very Low
…We **conditionally** recommend *against* oral glucocorticoids as adjuncts to initial therapy.	Conditional	Very Low

…We **strongly** recommend DMARDs (csDMARDS and/or bDMARDs) as first-line therapy.	Strong	Very Low
…We **conditionally** recommend methotrexate as the first csDMARD over leflunomide.	Conditional	Very Low
…We **conditionally** recommend oral methotrexate over subcutaneous methotrexate.	Conditional	Very Low
…We **conditionally** recommend TNFI as the first bDMARD over the following bDMARDs: IL-6i, T cell costimulation-modulators, IL-17i, IL-12/23i.	Conditional	Very Low
In people with TMJ arthritis taking TNFi		
…We **conditionally** recommend using a csDMARD concurrently.	Conditional	Very Low
In people with TMJ arthritis treated with bDMARDs		
…We **conditionally** recommend *against* routinely monitoring anti-drug antibodies.	Conditional	Very Low
SUBSEQUENT THERAPY		
In people with JIA with inadequate response or intolerance to first-line csDMARD		
…We **strongly** recommend bDMARDS.	Strong	Very Low
In people with JIA with inadequate response or intolerance to first-line TNFi		
…We **conditionally** recommend increasing the dose of first TNFi, changing to a second TNFi or using a medication with a different mechanism of action (IL-6i, T cell costimulation-modulators, IL-17i, IL-12/23i, JAKi). No strategy is preferred.	Conditional	Very Low
DMARD DEPRESCRIBING		
In people with non-systemic JIA in clinical remission on bDMARDs		
…We **conditionally** recommend tapering bDMARDs over immediately stopping bDMARDs to prevent disease exacerbation.	Conditional	Very Low
In people with non-systemic JIA in clinical remission on combination DMARDs		
…We **conditionally** recommend tapering or stopping csDMARDs first over tapering or stopping bDMARdsor tsDMARDs.	Conditional	Very Low
In people with non-systemic JIA in clinical remission on DMARDs		
…We **conditionally** recommend imaging joints that are difficult to assess over not performing imaging when considering tapering or stopping medication.	Conditional	Very Low
In people with non-systemic JIA with flare after DMARD deprescribing		
…We **conditionally** recommend *against* IAGCs over restarting DMARDs to recapture inactive disease.	Conditional	Very Low
…We **conditionally** recommend restarting the most recently effective DMARD regimen over starting a new regimen to recapture inactive disease.	Conditional	Very Low

Treatment of Juvenile Idiopathic Arthritis: Recommendations for Nonpharmacologic Management, Medication Monitoring, and Imaging Recommendations

Recommendations	Strength	Level of Evidence
NON-PHARMACOLOGIC THERAPIES		
In people with JIA		
…We **conditionally** recommend screening for mental health concerns whenever possible and referral for appropriate treatment.	Conditional	Very Low

...We **conditionally** recommend PT and OT regardless of concomitant pharmacologic therapy.	Conditional	Low
...We **conditionally** recommend physical activity regardless of concomitant pharmacologic therapy.	Conditional	Low
...We **strongly** recommend *against* use of a specific diet alone to treat JIA; however, a discussion of healthy, age-appropriate diet is encouraged.	Strong	Very Low
...We **conditionally** recommend *against* use of supplemental or herbal interventions specifically to treat JIA.	Conditional	Low
...We **strongly** recommend assessment for transition readiness and creation of a transition plan.	Strong	Very Low
MEDICATION MONITORING		
In people with JIA		
…We **conditionally** recommend baseline laboratory testing prior to treatment initiation for all medications.	Conditional	Very Low
In people with JIA receiving chronic treatment with oral or intravenous glucocorticoids		
…We **strongly** recommend monitoring for dyslipidemia, hyperglycemia, bone and ocular health at least annually.	Strong	Very Low
…We strongly recommend monitoring growth (height and weight) and blood pressure at least twice a year.	Strong	Very Low
NSAIDs		
In people with JIA receiving treatment with NSAIDS		
…We **conditionally** recommend monitoring via CBCD, LFTs, and renal function tests every 6-12 months.	Conditional	Very Low
Methotrexate		
In people with JIA receiving treatment with methotrexate		
…We **strongly** recommend monitoring via CBCD, LFTs, and renal function tests within the first 1-2 months of usage and every 3-4 months thereafter.	Strong	Very Low
…We **conditionally** recommend altering methotrexate administration if a clinically relevant elevation in liver enzymes occurs (temporary holding methotrexate if the ALT level is >3 times the upper limit of normal [ULN]).	Conditional	Very Low
…We **strongly** recommend using folic/folinic acid in conjunction with methotrexate.	Strong	Very Low
Sulfasalazine		
In people with JIA receiving treatment with sulfasalazine		
…We **conditionally** recommend monitoring via CBCD, LFTs, and renal function tests within the first 1-2 months of usage and every 3-4 months thereafter.	Conditional	Very Low
…We **conditionally** recommend decreasing the sulfasalazine dosage or holding sulfasalazine if a clinically relevant elevation in liver enzymes or decreased neutrophil or platelet count is found.	Conditional	Very Low
Leflunomide		
In people with JIA receiving treatment with leflunomide		
…We **conditionally** recommend monitoring via CBCD and LFT's within the first 1-2 months of usage and every 3-4 months thereafter.	Conditional	Very Low
…We **conditionally** recommend altering leflunomide administration if a clinically relevant elevation in liver enzymes occurs (temporary holding of leflunomide if the ALT level is >3 times the upper limit of normal [ULN]).	Conditional	Very Low
Hydroxychloroquine		
In people with JIA receiving treatment with hydroxychloroquine		
…We **conditionally** recommend monitoring via CBCD and LFTs annually.	Conditional	Very Low

…We **conditionally** recommend baseline and annual retinal screening after starting hydroxychloroquine.	Conditional	Very Low
Calcineurin Inhibitors		
In people with JIA receiving treatment with calcineurin inhibitors		
…We **conditionally** recommend monitoring CBCD, uric acid, liver enzymes, electrolytes, magnesium, renal function, and blood pressure 4-8 weeks after starting treatment and then every 1-3 months thereafter.	Conditional	Very Low
,,,We **conditionally** recommend monitoring lipids at baseline, then 4 weeks after starting treatment and every 6 months thereafter.	Conditional	Very Low
…We **conditionally** recommend reducing the dose by 50% administration if serum creatinine increases by more than 50%. Drug should be discontinued if serum creatinine does not improve.	Conditional	Very Low
Mycophenolate		
In people with JIA receiving treatment with mycophenolate		
…We **conditionally** recommend monitoring via CBCD and LFTs within the first 1 month of usage and every 3 months thereafter.	Conditional	Very Low
Tumor Necrosis Factor Inhibitors (TNFi)		
In people with JIA receiving treatment with tumor necrosis factor inhibitors		
…We **conditionally** recommend monitoring via CBCD and LFTs annually.	Conditional	Very Low
Abatacept		
In people with JIA receiving treatment with abatacept		
…We **conditionally** recommend doing no routine laboratory monitoring.	Conditional	Very Low
Interleukin-6 Inhibitors (IL-6i)		
In people with JIA receiving treatment with interleukin-6 inhibitors		
…We **conditionally** recommend monitoring via CBCD and LFTs within the first 1-2 months of usage and every 3-4 months thereafter.	Conditional	Very Low
…We **conditionally** recommend altering IL-6i administration if monitoring reveals elevated liver enzymes (if 1-3 times the ULN, decrease the dosage or increase the interval between doses; if >3 times the ULN, withhold administration; if >5 times the ULN, discontinue treatment), neutropenia (500–1000/mm^3), or thrombocytopenia (50,000–100,000/mm^3) as per package insert.	Conditional	Very Low
…We **conditionally** recommend monitoring of lipid levels every 6 months.	Conditional	Very Low

Screening, Monitoring, and Treatment of Juvenile Idiopathic Arthritis-Associated Uveitis Recommendations

Recommendations	Strength	Level of Evidence
OPHTHALMIC SCREENING		
In children and adolescents with JIA at high risk of developing CAU		
…We **strongly** recommend ophthalmic screening every 3 months as compared to monitoring less frequently.	Strong	Very Low
OPHTHALMIC MONITORING OF CHILDREN WITH JIA DIAGNOSED WITH CAU		
In children and adolescents with JIA and controlled CAU on stable therapy		
…We **strongly** recommend ophthalmic monitoring no less frequently than every 3 months as compared to monitoring less frequently.	Strong	Very Low

In children and adolescents with JIA and controlled CAU who are tapering or stopping glucocorticoids		
…We **strongly** recommend ophthalmic monitoring withing one month after each change of topical glucocorticoids as compared to monitoring less frequently.	Strong	Very Low
In children and adolescents with JIA and controlled CAU who are tapering or discontinuing DMARDs		
…We **strongly** recommend ophthalmic monitoring withing two months of changing DMARD therapy as compared to monitoring less frequently.	Strong	Very Low
GLUCOCORTICOIDS		
In children and adolescents with JIA and active CAU		
…We **conditionally** recommend adding or increasing topical prednisolone acetate 1% for short-term control over adding systemic glucocorticoids.	Conditional	Very Low
…We **conditionally** recommend using prednisolone acetate 1% topical drops over difluprednate topical drops.	Conditional	Very Low
In children with JIA with CAU, irrespective of use of or DMARD therapy		
…We **conditionally** recommend *against* intraocular and periocular glucocorticoid injections as part of therapy.	Conditional	Very Low
In children and adolescents with JIA who develop new CAU activity		
…We **conditionally** recommend adding or increasing topical glucocorticoids only for short-term control over changing/escalating DMARD therapy immediately.	Conditional	Very Low
In children and adolescents with JIA and CAU still requiring 1-2 drops/day of prednisolone acetate 1% (or equivalent) for CAU control, and not on DMARD therapy		
…We **conditionally** recommend addding DMARD therapy in order to taper topical glucocorticoids over not adding DMARD therapy and maintaining on topical glucocorticoids alone.	Conditional	Very Low
In children and adolescents with JIA and CAU still requiring 1-2 drops/day of prednisolone acetate 1% (or equivalent) for at least 3 months and on DMARD therapy for CAU control		
…We **conditionally** recommend changing or escalating DMARD therapy over maintaining current DMARD therapy.	Conditional	Very Low
INITIAL DMARD THERAPY		
In children and adolescents with JIA and active CAU requiring 1-2 drops/day of prednisolone acetate 1% (or equivalent)		
…We **conditionally** recommend DMARDS when a patient is newly diagnosed with JIA-associated CAU.	Conditional	Very Low
In children and adolescents with JIA and CAU		
…We **conditionally** recommend methotrexate over leflunomide, mycophenolate, and cyclosporine (in that order).	Conditional	Very Low
In children and adolescents with JIA and CAU who are starting DMARD treatment for CAU		
…We **conditionally** recommend using oral methotrexate over subcutaneous methotrexate.	Conditional	Very Low
In children and adolescents with JIA and CAU		
…We **conditionally** recommend adalimumab as a DMARD over infliximab, tocilizumab, and either golimumab, abatacept, Janus kinase inhibitors (JAKi) or rituximab (in that order).	Conditional	Very Low
In children and adolescents with JIA with severe active CAU and sight-threatening complications		
…We **conditionally** recommend starting a csDMARD and a bDMARD at treatment onset over csDMARD monotherapy.	Conditional	Very Low
For initial treatment in children and adolescents with JIA with active CAU regardless of joint activity		
…We **conditionally** recommend using above-standard JIA dosing of TNFi over standard JIA dosing for TNFi.	Conditional	Very Low

SUBSEQUENT DMARDS THERAPY		
In children and adolescents with JIA and active CAU who have an inadequate response to one monoclonal antibody TNFi at standard JIA dose		
…We **conditionally** recommend escalating the dose and/or frequency to above-standard vs. switching to another monoclonal antibody TNFi.	Conditional	Very Low
In children with JIA and CAU, requiring 1-2 drops/day of prednisolone acetate 1% (or equivalent) for at least 3 months despite csDMARD and two successive TNFi monoclonal antibodies		
…We **conditionally** recommend a different csDMARD, non-TNFi bDMARD, or tsDMARD therapy.	Conditional	Very Low
DEPRESCRIBING THERAPY FOR INACTIVE UVEITIS		
In children and adolescents with JIA and CAU that is controlled on DMARD therapy but remain on 1-2 drops/day of prednisolone acetate 1% (or equivalent)		
…We **conditionally** recommend tapering topical glucocorticoids first over tapering DMARD therapy.	Conditional	Very Low
In children and adolescents with CAU that is well controlled on DMARD only		
…We **conditionally** recommend that there be at least 2 years of well-controlled disease before tapering therapy.	Conditional	Very Low

This summary was approved by the ACR Board of Directors on February 20, 2026. These recommendations are included in full manuscripts, which will be submitted for publication in Arthritis & Rheumatology and Arthritis Care & Research.