

## **SUPPLEMENTARY APPENDIX 1: Methods**

### **2018 American College of Rheumatology/Arthritis Foundation Guideline for the Screening, Monitoring, and Treatment of Juvenile Idiopathic Arthritis-Associated Uveitis**

*NOTE: Recommendations for the treatment of JIA, including therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis are published in a separate guideline paper, but the guidelines were developed together so the methods description includes all parts.*

#### ***Methodology Overview***

This guideline was developed following the American College of Rheumatology (ACR) guideline development process

([https://www.rheumatology.org/Portals/0/Files/ACR%20Guideline%20Manual\\_Appendices\\_updated%202015.pdf](https://www.rheumatology.org/Portals/0/Files/ACR%20Guideline%20Manual_Appendices_updated%202015.pdf)). This process includes the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology ([www.gradeworkinggroup.org](http://www.gradeworkinggroup.org)) (1-3).

#### ***Teams Involved***

This project was a collaboration between the American College of Rheumatology (ACR) and the Arthritis Foundation (AF). A Core Leadership Team (6 members) supervised the project and was responsible for defining the scope, drafting the clinical (Patient/Intervention/Comparator/Outcomes – PICO) questions, coordinating with the Literature Review Team, overseeing the voting process, and drafting the manuscript. The Core Team, together with the Literature Review Team, was comprised of individuals with content and methodological expertise, and included a GRADE methodologist who advised on the process of developing and presenting the evidence and provided input on the quality assessment of evidence and summary of findings (SoF) tables (provided in Supplementary Appendix 6).

The Literature Review Team (7 members) conducted a systematic search, screened papers for relevance, assessed study quality, extracted data, computed pooled estimates of

outcomes, graded the quality of evidence, generated the SoF tables, and compiled an evidence report.

The role of the Expert Panel, comprised of 9 content experts, was to provide consultation and feedback on the project scope, design, and PICO questions.

The Voting Panel (15 members) included pediatric rheumatologists and two adult patients who were diagnosed with JIA in childhood. The role of the Voting Panel was to participate in the development of the scope and PICO questions, including making judgments regarding the relative importance of the outcomes, and vote on the PICO questions, keeping the evidence report, their expertise and experience, and patient values and preferences in mind.

A Patient and Parent Panel was convened to discuss patient values and preferences related to outcomes and evidence. The two patients on the Voting Panel also participated in the Patient Panel discussions. The Voting Panel used the input from the patient meeting to help guide their votes in balancing tradeoffs between the harms and benefits of the alternative management strategies.

The ACR provided training for everyone involved in the development of this guideline, which included sessions on the ACR guideline process and GRADE methodology. See Supplementary Appendix 2 for team/panel rosters.

### ***Patient and Parent Panel***

The Patient and Parent panel, consisting of 7 adults with juvenile idiopathic arthritis (JIA) and two parents of children with JIA, was convened on October 31, 2017. Eight of the 9 patients/parents were female. A rheumatologist who was not otherwise involved in the project and one ACR staff person facilitated the day-long discussion.

The participants were first presented with the background and scope of the guideline project. They were then specifically queried on the relative importance of beneficial and adverse events of drugs and drug classes, including but not limited to efficacy, route of administration, and side effects, with particular attention paid to how values and preferences might differ in a pediatric population. The patient and parent panel reviewed the evidence synthesized by the Literature Review Team as several PICO questions were discussed. The participants were encouraged to consider their personal experiences relevant to the questions and judge the importance of the outcomes accordingly. One AF staff member and the two patients on the Voting Panel, all of whom had been at the patient meeting, presented the values and preferences of the patient panel and the voting results to the Voting Panel during the two-day Voting Panel meeting held November 3-4, 2017.

#### ***Disclosures and Management of Conflicts of Interest***

Per ACR policy, everyone who was intellectually involved in the project (i.e., considered for guideline authorship) disclosed all relationships (<https://www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines/Juvenile-Idiopathic-Arthritis>). Disclosures were compared against a previously drafted list of “affected companies” (i.e., companies or organizations that were considered reasonably likely to be positively or negatively affected by care delivered in accordance with the guideline) to determine which relationships were considered potential conflicts of interest for purposes of this project. Individuals were also asked to explicitly highlight relationships with any companies *not* on the affected companies list that related to the topic of the guideline. Individuals whose primary employment (> 51% of work time/effort) was with a company that manufactured or sold therapeutics or diagnostics were not eligible to participate.

The project's principal investigator (PI) and the literature review leader had no relevant conflicts of interest for the full 12 months before this project began, and the majority of the guideline development team members had no relevant conflicts of interest for the duration of the project. A participant who had any relationship with an affected company was counted as conflicted (i.e., toward the allowed threshold) regardless of the type or subject of the relationship. Intellectual conflicts, such as a prior publication or scientific presentation on JIA therapy, were recognized as important and were required to be disclosed, but because they were ubiquitous, intellectual conflicts were not counted as conflicted toward the allowed threshold.

Participant disclosures were included in the project plan that was posted online for public comment (see description below). In addition, disclosures of all participants were shared, in writing, with each project participant. At the face-to-face Voting Panel meeting, verbal disclosures were provided before the content discussion began. Updated participant disclosures, as well as ACR committee reviewer disclosures, are included online with this manuscript. Finally, author disclosures are also included in this paper.

### ***Scope and Target Audience***

The scope of this project included both pharmacologic and non-pharmacologic treatment of patients with JIA. JIA was defined as a collection of chronic idiopathic autoimmune non-infectious arthritides, including non-systemic polyarthritis, sacroiliitis, enthesitis and JIA-associated uveitis. The target audience for this guideline includes health care providers and patients who are at risk for or have JIA. The ACR and the AF plan to develop derivative products to facilitate implementation of this guideline.

### ***Establishing Key Principles and PICO Development***

The Core Team collaborated with the Voting and Expert Panel members to develop the initial set of PICO-formatted clinical questions for the guideline. The critical outcomes varied among the different subgroups of pediatric patients with JIA (polyarthritis, sacroiliitis/enthesitis) and/or uveitis.

For polyarthritis and sacroiliitis/enthesitis, critical outcomes included quality of life measures, disease activity measures (pediatric ACR response, JADAS, active joint count, ESR/CRP, patient/parent global, active entheses count [enthesitis only], BASDAI [sacroiliitis/enthesitis only], BASFI [sacroiliitis/enthesitis only], and other sacroiliitis/enthesitis-specific measures), ACR provisional criteria for clinical inactive disease, functional ability (CHAQ, PROMIS), joint damage requiring surgical intervention, and serious adverse events (e.g., hospitalization, infection, malignancy). An additional critical outcome for sacroiliitis was resolution of MRI findings consistent with active sacroiliitis.

For JIA-associated uveitis, critical outcomes differed for questions related to screening, monitoring, and medication. For screening questions, critical outcomes included new diagnosis of uveitis and new diagnosis of uveitis with any ocular complications. For monitoring questions, critical outcomes included loss of control of uveitis and new complications due to inflammation. For medication questions, critical outcomes included loss of control of uveitis, incidence of loss of control of uveitis, control of uveitis at 1 month and 3 months, new ocular steroid complications (cataracts, glaucoma/increased IOP, infection), new ocular complications due to inflammation, incidence of uveitis, and recurrence of uveitis.

The Core Team held weekly conference calls, convened an initial face-to-face meeting of the Core Team, Voting Panel and Expert Panel in which the scope of the guideline was determined, and then developed the PICO questions. The PICO questions were posted for 30 days on the ACR website for public comment and revised accordingly. Once the PICO questions

were finalized, individual online voting took place to ascertain any existing consensus, followed by a face-to-face meeting of the voting panel, where voting on the PICO questions was finalized. Following the meeting, additional clarifying questions were discussed by email and related voting took place via online survey.

### ***Framework for the JIA Guideline Development***

At the initial scoping meeting, the Core Team, Voting Panel and Expert Panel members agreed that the scope of the populations to be addressed would include children with JIA with the phenotypes of polyarthritis, sacroiliitis, and enthesitis, as well as children with JIA-associated uveitis. Other JIA populations were thought to be important but were postponed until another ACR JIA guideline project was conducted, to prevent the overall scope of this project becoming too large.

After defining population risk groups, interventions and comparators were specified for each PICO question (see list of PICO questions in Supplementary Appendix 5). The Core Team agreed that the guideline should include both pharmacologic and non-pharmacologic treatment approaches and elected to include the following interventions: NSAIDs (polyarthritis and sacroiliitis/enthesitis only); glucocorticoids (oral and intra-articular injections for polyarthritis and sacroiliitis/enthesitis; topical, oral, and intraocular injections for uveitis); non-biologic disease modifying anti-rheumatic drugs (DMARDs), including methotrexate, sulfasalazine, leflunomide (polyarthritis only), cyclosporine (uveitis only), mycophenolate (uveitis only); TNF inhibitors (adalimumab, etanercept, infliximab, golimumab, certolizumab pegol); other biological response modifiers, including abatacept, tocilizumab, rituximab; and physical therapy and occupational therapy (polyarthritis and sacroiliitis/enthesitis only).

### ***Systematic Synthesis of the Literature***

#### ***Literature Searches***

To identify relevant evidence for the PICO questions, a medical librarian, in collaboration with the Literature Review Team, performed systematic searches of the published English language literature. OVID Medline, PubMed, Embase, and the Cochrane Library (including Cochrane Database of Systematic Reviews; Database of Abstracts of Reviews of Effects (DARE); Cochrane Central Register of Controlled Trials (CENTRAL); and Health Technology Assessments (HTA)) were searched from the beginning of each database through June 12, 2017 (Supplementary Appendix 4), and update searches were conducted on October 13, 2017. For PICO questions for which no direct evidence in the JIA field was found, indirect evidence was sought, in particular, meta-analyses of randomized trials in non-JIA populations. For PICO questions for which systematic reviews were not found, individual RCTs or observational studies of non-JIA populations were sought.

### ***Study Selection***

DistillerSR software (<https://distillercer.com/products/distillersr-systematic-review-software>) was used to aid screening the literature search results. Teams of two independent reviewers performed duplicate screening of each title and abstract with articles identified as potentially eligible passing to review of full text. Eligible articles underwent full-text screening by two independent reviewers. Selected manuscripts were then matched to PICO questions. See Supplementary Appendix 5 for details related to the study selection process.

### ***Data Extraction and Analysis***

Data from RCTs for each PICO question was extracted into RevMan software (<http://tech.cochrane.org/revman>). Risk of bias of each primary study was assessed using the Cochrane risk of bias tool (<http://handbook.cochrane.org/>). The critical/important outcomes selected for this guideline were binary, and they were analyzed using the Mantel-Haenszel

method in a random effects model and reported as relative risks with 95% confidence intervals.

In clinical scenarios not addressed by RCT data, data from observational cohort studies was used to estimate relative effects. In situations in which the intervention had not been tested in JIA but had been tested in a non-JIA population, the relative risk values from that study were applied, postulating that the effect was generalizable but rating down the quality of evidence for indirectness.

### ***Evidence Report Formulation***

RevMan files were exported into GRADEpro software to formulate a GRADE Summary of Findings (SoF) table for each PICO question (4). The quality of evidence for each outcome was evaluated in duplicate by two independent reviewers using GRADE quality assessment criteria (1) with discordance resolved by discussion. The resulting SoF tables were compiled in an evidence report (Supplementary Appendix 6). The Core Team reviewed the evidence report and addressed possible evidence gaps prior to presentation to the Voting Panel.

### ***Moving from Evidence to Recommendations***

GRADE methodology specifies that panels make recommendations based on a consideration of the balance of benefits and harms of the treatment options under consideration, the quality of the evidence (i.e., confidence in the effect estimates), and patients' values and preferences. Key to the recommendation is the trade-off between desirable and undesirable outcomes; recommendations require estimating the relative value patients place on the outcomes.

A recommendation could be either in favor of or against the proposed intervention and either strong or conditional. According to GRADE, a recommendation is categorized as strong if the panel is very confident that the benefits of an intervention clearly outweigh the harms (or

vice versa); a conditional recommendation denotes uncertainty regarding the balance of benefits and harms, such as when the evidence quality is low or very low, or when the decision is sensitive to individual patient preferences, or when costs are expected to impact the decision. Thus, conditional recommendations refer to decisions in which incorporation of patient preferences is a particularly essential element of decision making.

We are unaware of published literature exploring patient values and preferences regarding these issues in the context of JIA. Our judgments are based on the experience of the clinician panel members in shared decision making with their patients, on the experience and perspectives of the two patient panel members and, to a considerable extent, on the results of discussion with our patient focus group.

### ***Consensus Building***

The Voting Panel received the evidence report for review before it met to discuss and decide on the final recommendations. During a two-day, face-to-face meeting held November 3-4, 2017, the Voting Panel, for each PICO question, reviewed the evidence and provided votes on the direction and strength of the recommendations. The in-person voting process was conducted using Poll Everywhere software (<http://www.polleverywhere.com/>), with a follow-up online survey to vote on clarifications/unresolved questions. A 70% consensus was used as the threshold for a recommendation; if 70% consensus was not achieved during an initial vote, the panel members held additional discussions before re-voting until at least 70% consensus was achieved.

Consistent with GRADE guidance, in some instances, the Voting Panel chose to provide a strong recommendation despite a low or very low quality rating of evidence (3). In such cases, a written explanation is provided describing the reasons behind this decision with reference to GRADE guidance on the matter (3).

### ***Final Review and Approval of the Manuscript by the ACR***

In addition to journal peer reviews, the manuscript was reviewed by the following committees and subcommittees of the ACR: ACR Guideline Subcommittee; ACR Quality of Care Committee; and ACR Board of Directors. The vice president for scientific strategy and the director of patient engagement for the AF also reviewed the manuscript. These ACR and AF oversight groups did not mandate that certain recommendations be made within the guideline, but rather, served as peer reviewers.

### ***Moving from Recommendations to Practice***

These recommendations are designed to help health care providers work with parents and patients in selecting therapies. Health care providers, parents and patients must take into consideration not only clinical phenotype and level of disease activity, but also comorbidities, response and tolerance of prior therapies, patient's values and preferences, and patient's functional status and functional goals in choosing the optimal therapy for an individual patient at the given point in treatment.

## REFERENCES

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