

2021 ACR Juvenile Idiopathic Arthritis Guideline

Public Comments

*The 2021 ACR Juvenile Idiopathic Arthritis Guideline public comment was posted on the ACR website August 12, 2019. 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. **Five (5)** responses were received via the online form. The public comment period closed on September 13, 2019.*

RESPONSES RECEIVED:

- **Name:** Randy Cron
- **Institution:** University of Alabama at Birmingham
- **Position:** Professor
- **Disclosure (optional):**
 - Adjudication committee member for tofacitinib for sJIA (Pfizer)
 - Co-principal investigator on investigator-initiated clinical trial of anakinra for macrophage activation syndrome (SOBI)

Comments:

1. Curious as to why herbal supplements are being explored.
2. Rather than exploring preferred order of treatment, the panel should strongly consider an inverted pyramid approach to therapy, starting aggressively and backing off of therapy when prolonged remission is achieved. A “window of opportunity” likely exists for all forms of JIA.

- **Name:** Ken Schikler
- **Institution:** University of Louisville/Norton Children’s Hospital
- **Position:** Professor
- **Disclosure (optional):** I have nothing to disclose.

Comments:

Should line 461, page 21, be changed to include screening for “common regional fungus infections” (for example, histoplasmosis in Midwest/mid-south)?

- **Name:** Susa Benseler
- **Institution:** University of Calgary
- **Position:** Director, Research Institute
- **Disclosure (optional):** I have nothing to disclose.

Comments:

The proposed project plan entails several systematic reviews (oligo, TMJ, vaccinations, other) and follows a traditional recipe. It is important to include more content experts for several of these areas in order to define the scope appropriately. I would suggest including experts of biomarkers beyond Peter Nigrovic for oligo, since the risk factor part was weak in the last versions. I would also suggest adding TMJaw board members for the TMJ treatment, since it is outside of the scope of most rheumatologists (which includes the PICO table and search terms). Overall, given the scope, having a larger, more inclusive team would probably increase the acceptance of what is produced. The SHARE approach is a

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great example for early broad inclusiveness. Also, adding patient and families has been one of the secrets to relevance. I would consider.

- **Name:** Nicole Bitencourt
- **Institution:** UT Southwestern
- **Position:** Fellow (med-peds)
- **Disclosure (optional):** I have nothing to disclose.

Comments:

I recommend that you include a subsection that addresses transition and transition readiness into adult care. Even if it's a small section, including it will emphasize to pediatric rheumatologists and healthcare systems that this is important enough to be recommended by national subspecialty guidelines. I'm sure patients and parents will agree.

- **Name:** Carol Oatis
- **Institution:** Arcadia University
- **Position:** Professor Emeritus
- **Disclosure (optional):** I have nothing to disclose.

Comments:

I applaud the ACR for attempting to address issues unaddressed in the preceding iteration of the JIA treatment guidelines. I am also glad to see that the goals of this project specifically address "pharmacologic and non-pharmacologic" treatments. I reviewed the PICO list and see several PICOs focusing on PT, OT or "non-medical" treatments. I was therefore quite surprised to see no members of the core oversight team, literature review team or voting panel with PT or OT credentials. That may also explain why the 6 aims of the project include pharmacologic treatments or imaging questions with no mention of "non-medical" treatments. If the goal of this project is to include a review of non pharmacologic interventions, then I urge the core team to add PT/OT representation to the core team and to the voting panel at least.