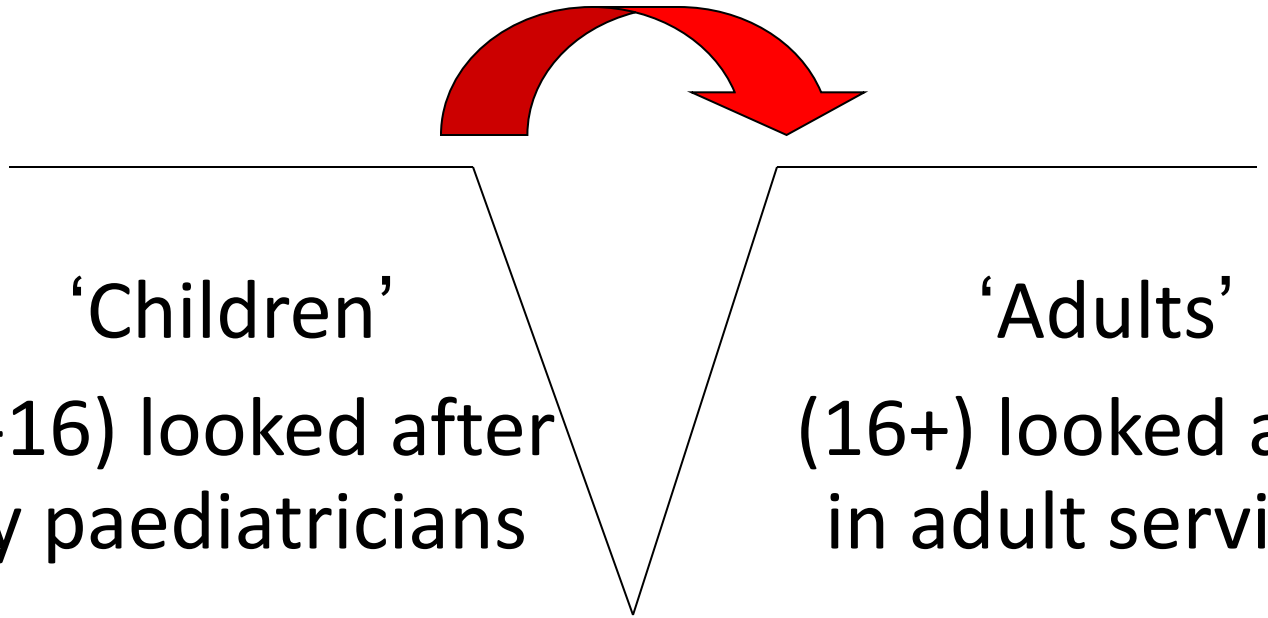
JIA and transition – an overview

Overview

- These slides give some key points about juvenile arthritis and transition from childrens to adult services
- Juvenile idiopathic arthritis (JIA)
  - affects 1:1000 children under 16
  - diagnosis is often delayed
  - Is commonly associated with uveitis
  - There are really good treatments
  - If in doubt, refer for an opinion

The Gap



‘Children’

(0-16) looked after by paediatricians

‘Adults’

(16+) looked after in adult services

Transition bridges the gap

ALL children move from childhood to adulthood

Young people with ill health have more to lose if they 'fall into the gap' while growing up

multi-faceted, active process attending to the medical, psychological and educational/ vocational needs of *adolescents* as they move from child to adult-centered care

Transition and Primary Care

- Sheffield Children's Hospital and Sheffield Teaching Hospital have good transition links and a seamless service for 10-25 year olds
  - New patients under 16 seen at SCH
  - New patients over 16 seen at STH in the young adult clinic
- Liaison with primary care is essential; children and young people do get arthritis
  - If in doubt refer young people for an opinion

NICE guidance on transition (NG43, 2016)

Overarching principles

- Involve YP in services
- Ensure transition is developmentally appropriate
- Professionals should work across services to provide YP with person centred care
- Involve and engage GP

https://www.nice.org.uk/guidance/ng43

NICE guidance on transition (NG43)

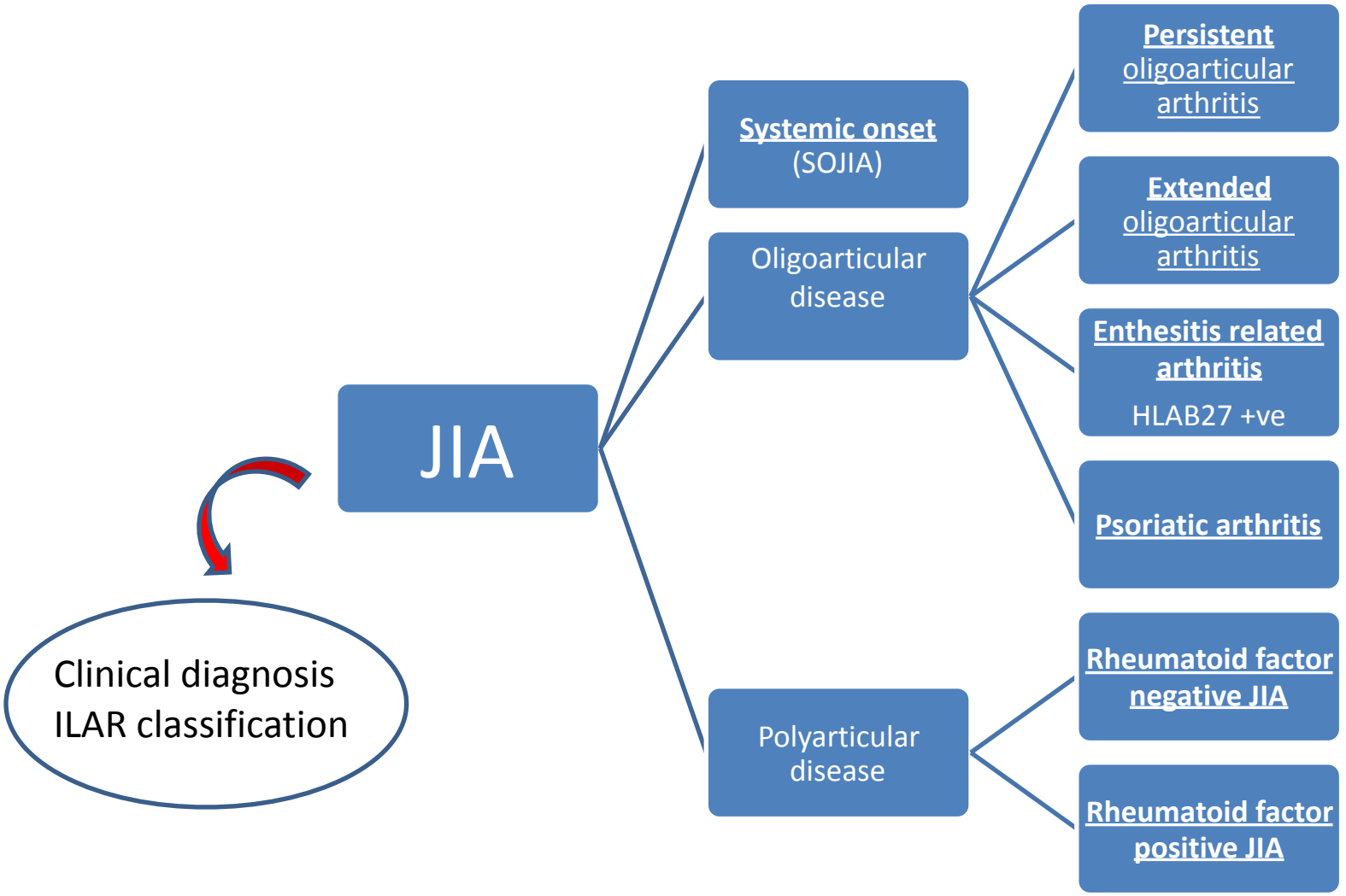
- Plan early – by year 9 at the latest
- Have at least one annual transition planning meeting
- Services should have key worker
- Consider joint clinics
- Consider patient held transition notes/passport
- Support post transfer

https://www.nice.org.uk/guidance/ng43

What causes JIA?

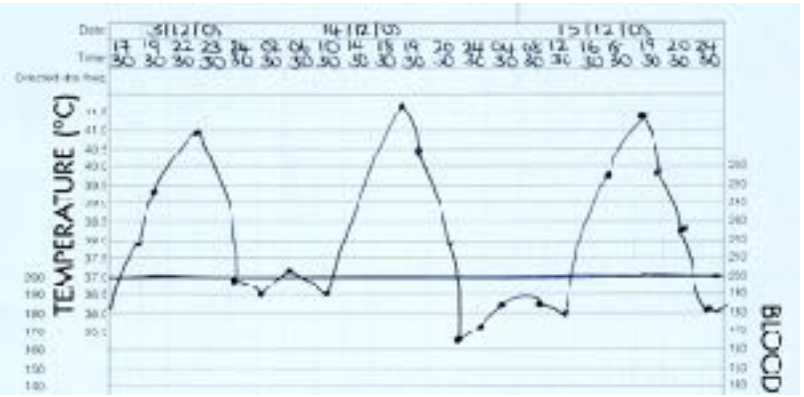
- Unknown (hence idiopathic)
- Autoimmune disease
- Presumably different gene combinations give different forms of JIA
- Probably under-recognized
- Definitely diagnosis is often delayed
- New effective treatments, diagnosis is critical

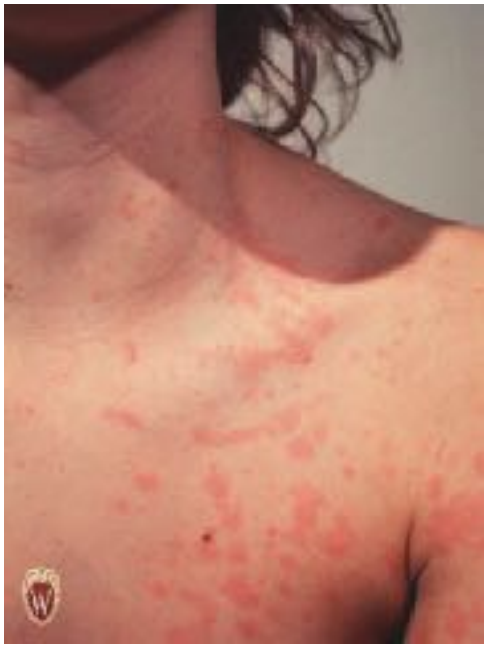
Persistent arthritis in children



Systemic Onset JIA ‘Stills Disease’

- any age but peak 4-6 Male:female ratio equal
- Systemic illness with daily (quotidian) fever,rash + arthritis
- Anaemia, ↑platelets and high ferritin
- lymphadenopathy, hepatosplenomegaly and serositis common





Treatment

Non-medical

- Information
- Education
- Support
- Liaison with school
- Physiotherapy
- Occupational therapy
- Psychology

Medical

- Steroid joint injections
  - GA
  - Entonox
  - Topical
- NSAIDS
- methotrexate
- systemic steroids
- Biologic drugs

What happens if you don't treat?

- Joint damage/deformity/disability
  - Pain
  - Self-esteem, psychological impact
  - Remember the jaw
- Bony overgrowth in affected limbs
  - Leg length inequality
- Anaemia, weight loss, failure to grow
- Uveitis = potential blindness

Making the diagnosis

- Take a history
  - Children don't always volunteer pain
- Exclude other causes
- Think about the pattern of joint disease
- Are there associated features?
- Examine the child (PGALS)
- Think about investigations
- SCREEN THE EYES