

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Juvenile Rheumatoid Arthritis

To the Editor: I read with interest and then concern Dr. Ronald W. Chapman's summary report on the diagnosis of juvenile rheumatoid arthritis (J Am Board Fam Pract 1995; 8:46-8). This concern has compelled me to comment on his guidelines for drug therapy for juvenile rheumatoid arthritis.

Recent controlled studies have shown that neither oral gold therapy nor therapy with penicillamine or antimalarials is any better than placebo in juvenile arthritis. Intramuscular gold therapy has not been tested in a controlled fashion, but it is not widely used anymore. Instead, methotrexate (10 to 15 mg/m²/wk) has become the second-line agent most often used in children with severe disease who have not responded to nonsteroidal therapy.¹⁻³ Sulfasalazine is also used as a second-line drug in some children, although there are no controlled studies as yet. Methotrexate and sulfasalazine (40 to 60 mg/kg/d initial; 25 mg/kg/d maintenance) have been used to advantage during the last 5 to 8 years.⁴ In our program at UMDNJ — Robert Wood Johnson Medical School, the intervention with methotrexate has been very promising and without untoward side effects in severe progressive disease, and its use is supported by corresponding literature. I personally have less experience with sulfasalazine, as in the 8 years of my participation in the program, it has not been used. Regarding the nonsteroidal agents, because of concerns about possible associated Reye syndrome, aspirin is no longer as widely used as it used to be; however, the following three orally administered nonsteroidal drugs have been approved by the Food and Drug Administration for use in children: tolmetin (25 mg/kg/d in a four times daily dosing schedule), naproxen (15 mg/kg/d in a twice a day dosing schedule), and ibuprofen (35 mg/kg/d in a twice a day or four times a day regimen).⁴

My purpose in writing is to convey briefly more current therapeutic modalities and, I hope, to assist the management of a severe disorder that is uncertain in prognosis. Patient care must be individualized as demanded by both the subset of juvenile rheumatoid

arthritis and the most efficacious drug(s) with the fewest side effects utilized.

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Dr. Jane G. Schaller, a nationally recognized pediatric rheumatologist, assisted in the preparation of my commentary.

References

1. Speckmaier M, Findeisen J, Woo P, Hall A, Sills JA, Price T, et al. Low-dose methotrexate in systemic onset juvenile chronic arthritis. Clin Exp Rheumatol 1989; 7:647-50.
2. Truckenbrodt H, Hafner R. Methotrexate therapy in juvenile rheumatoid arthritis. A retrospective study. Arthritis Rheum 1986; 29:801-7.
3. Wallace C, Bleyer WA, Sherry DD, Salmanson KL, Wedgwood RJ. Toxicity and serum levels of methotrexate in children with juvenile rheumatoid arthritis. Arthritis Rheum 1989; 32:677-81.
4. Kelley WN, Jr, Harris ED, Ruddy S, Sledge CB. Textbook of rheumatology. 4th ed. Philadelphia: WB Saunders Company, 1993:1194-1202.

The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: I greatly appreciated Dr. Freis's interest in the case report on juvenile rheumatoid arthritis.

Salicylates and nonsteroidal anti-inflammatories (NSAIDs) remain first-line treatment for juvenile rheumatoid arthritis, but there are no studies to show that NSAIDs are more effective.^{1,2} In discussions with local pediatricians and rheumatologists, salicylates remain widely used. There is also no evidence to support an increased incidence of Reye syndrome among juvenile rheumatoid arthritis patients receiving salicylates therapy; however, it is prudent to discontinue salicylates in a juvenile rheumatoid arthritis patient who has chickenpox or flu-like symptoms. Although the less frequent dosing intervals of some NSAIDs is an advantage, salicylate use offers the advantage of monitoring blood levels to avoid side effects. I appreciate the correction offered by Dr. Freis that naprosyn, ibuprofen, and tolmetin are approved for use by the Food and Drug Administration in juvenile rheumatoid arthritis.

In terms of the second-line treatment, I was unable to find studies that compared the choice of gold therapy with the choice of methotrexate therapy. A recent pediatric text does state that methotrexate is replacing injectable gold as second-line therapy.³ The US-Russian collaborative study has certainly paved the way for more extensive use of methotrexate⁴; however, in discussions with local experts, there remains a great concern with the long-term side effects of methotrexate,