Policy Statement

Sections on Rheumatology and Ophthalmology

Guidelines for the Frequency of Ophthalmologic Exams in Children with Juvenile Rheumatoid Arthritis

The suggested frequency of ophthalmologic visits for children with juvenile rheumatoid arthritis (JRA) without known iridocyclitis is presented in Table 1. Once iridocyclitis is diagnosed, the treating ophthalmologist will determine the frequency of visits.

The subtype of juvenile arthritis is determined by the systemic features of the illness and the number of joints with arthritis during the first six weeks of the illness. Pauciarticular JRA is defined by involvement of four or fewer joints, polyarticular JRA is defined by involvement of more than four joints and systemic JRA is defined by a characteristic rash associated with spiking fevers during the first six weeks of the illness. Initial referral to an ophthalmologist should be made at the time of diagnosis of JRA.

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Table 1. Frequency of Ophthalmologic Visits for Children with Juvenile Rheumatoid Arthritis (JRA) and Without Known Iridocyclitis

JRA Diseases Subtype at Onset	Age of Onset	
	<7 years old†	≥7 years old‡
Pauciarticular	¶	
+ ANA§	H	M
– ANA	M	M
Polyarticular	¶	
+ ANA	H	M
– ANA	M	M
Systemic	L	L

*High Risk (H) indicates ophthalmologic examinations every 3-4 mo.
Medium Risk (M) indicates ophthalmologic examinations every 6 mo.
Low Risk (L) indicates ophthalmologic examinations every 12 mo.

†All patients are considered at low risk 7 years after the onset of their arthritis and should have yearly ophthalmologic examinations indefinitely.

‡All patients are considered low risk 4 years after the onset of their arthritis and should have yearly ophthalmologic examinations indefinitely.

§ANA indicates antinuclear antibody test.

¶All high-risk patients are considered at medium risk 4 years after the onset of their arthritis.

Editor's note: The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The full text of this policy statement will appear in an upcoming issue of Pediatrics. *Individual copies of the statement will be available at that time.*

This policy statement is not for release to the media until June 21.

Ribavirin

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c. All patients mechanically ventilated for RSV infection.

2. *Treatment for Hospitalized Infants.* — Ribavirin treatment should also be considered for hospitalized infants who may be at increased risk of progressing from a mild to a more complicated course by virtue of young age (less than 6 weeks) or underlying condition, such as multiple congenital anomalies or certain neurologic or metabolic diseases (eg, severe cerebral palsy, myasthenia).

3. *Diagnosis of RSV Infection.* — Rapid diagnostic techniques to identify RSV antigen in respiratory secretions should be performed when the child is admitted to the hospital. Tissue culture isolation requires 3 to 5 days. If rapid tests are not available, patients in the recommended categories who have bronchiolitis or pneumonia clinically compatible with RSV infection and who are admitted during the RSV season (generally November to April) should be considered for ribavirin therapy. If the etiology of the infant's pulmonary disease is subsequently found to be an agent other than RSV, ribavirin therapy can be discontinued. If no agent is identified initially as the cause of the lower respiratory tract disease, but the most likely clinical diagnosis remains RSV infection and the infant is severely ill, continuation of treatment is reasonable. Further diagnostic efforts to ascertain the causative agent should be undertaken, recognizing that false-negative rapid diagnostic test results have been noted in 5% to 20% of cases.

4. *Administration.* — Ribavirin is nebulized by a small-particle aerosol generator into an oxygen hood, tent, or mask from a solution containing 20 mg of ribavirin per milliliter of water. The generator is supplied with the drug by the manufacturer. The aerosol is administered for 12 to 20 hours per day, usually for 3 to 5 days depending on the patient's clinical course; a longer duration of therapy may be useful in immunodeficient patients. A recent study noted good patient tolerance and favorable ribavirin pharmacokinetics employing a regimen of 60 mg/mL for 2 hours three times daily; however, the efficacy of this dosage has not been proven. Maximal therapeutic responses usually are noted following 2 to 4 days of treatment.

5 . *Isolation of Patients.* — Treatment with ribavirin does not eliminate the need for contact isolation of patients with RSV.

6. *Precautions for Health Care Personnel and Visitors.*— Health care personnel and visitors should be informed about the potential but unknown risks of environmental exposure to ribavirin. In-service education for hospital personnel is most effective just prior to the RSV season. While evidence of human teratogenicity is lacking, in view of the embryopathic effects in nonprimate animals, pregnant women should be advised not to care directly for patients who are receiving ribavirin. Several methods have been employed to lower environmental exposure. For example, aerosol administration should be stopped temporarily when the hood or tent is open. Also, the drug should be administered in well-ventilated rooms (at least six air changes per hour).

No additional precautions to protect patients, visitors, or hospital workers in the room are required. Masks designed to block absorption of 1- to 2-μg particulate droplets may reduce inhalation of ribavirin, but clinical studies are lacking. Standard surgical masks do not block particles of this size. Gloves and gowns are not essential since dermal absorption of ribavirin appears to be negligible. However, gloves and gown may lower the risk of nosocomial spread of RSV. Scavenger devices to lower the escape of aerosolized ribavirin into a room also can be used. Additional research and clinical experience are needed to establish more specific guidelines regarding occupational exposure.

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