# Guideline Corner:
# Living Guidelines in the CRA

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Did you know that the CRA has transitioned to a "living" guideline model? This means that guideline recommendations can be updated as needed when new evidence becomes available. Guidelines are available and maintained online at *rheum.ca/resources/publications/*

**Guidelines for the following topics and diseases are currently available or under development:**


- COVID-19 vaccination (released 2022)
- Rheumatoid arthritis (released 2022)
- Juvenile idiopathic arthritis (JIA)-associated Uveitis (released 2022)
- Axial spondyloarthritis (in development)
- Transition to adult care (in development)
- Immune-Mediated Adverse Events to Oncology Medications (in development)

This section of the *CRAJ* will highlight recommendations from the CRA's living guidelines. In this installment, we focus on JIA-associated uveitis: screening, monitoring, and treatment.

## Clinical case:

Molly is a 4-year-old girl seen in your office with a swollen knee for 9 months who is otherwise systemically well. You have diagnosed her with JIA, oligoarthritis subtype, following today's visit.

## As a next step, would you. . .

A) Order an ANA

B) Discuss the need for regular eye screening with her caregivers

C) Refer to an eyecare provider

D) A, B, C

Answer: D

The CRA recommendation is that patients with newly diagnosed JIA should be screened as early as possible after diagnosis (within the first 1-3 months if asymptomatic). Children with JIA at high risk of developing chronic anterior uveitis should have an ophthalmic screening at least every 3 months for the first 4 years.

## Discussion:

Chronic, asymptomatic anterior uveitis occurs in up to 20% of children with JIA and can be associated with significant morbidity, including permanent vision loss. Female sex, young age at onset of JIA (age <7) and ANA positivity are risk factors for JIA-associated uveitis.

The large geographic area that pediatric rheumatology/ophthalmology centres serve and the lack of a sufficient number of ophthalmologists in many urban centres can be prohibitive to timely access to screening. This may be particularly challenging for patients living in rural/remote areas who must travel to access eyecare and for those requiring funding for the same. Ophthalmic screening is optimally completed by an ophthalmologist but could include another eye care provider.

Care for patients with JIA-associated uveitis requires a collaborative approach between rheumatology and ophthalmology and, in some cases, other eye care providers for screening. Caregiver(s)/patient understanding of the importance of timing of examination is critical given the asymptomatic nature of uveitis which can lead to a delay in diagnosis if initial and ongoing regular screening is delayed. Treatment for uveitis can be complex and may require combinations of topical and/or systemic therapies, with frequent healthcare visits and treatment changes.

Are you a CRA member interested in getting involved with guideline development? Reach out to Sarah Webster at *swebster@rheum.ca* to express your interest.