CLIPPINGS

EULAR/PRES Recommendations for vaccination of pediatric patients with autoimmune inflammatory rheumatic diseases: update 2021 (Ann Rheum Dis. 2023; 82:35-47)

The paper outlines recommendations for vaccinating pediatric patients with autoimmune and inflammatory rheumatic diseases (AIIRD). The principles emphasize the importance of vaccination, alignment with national immunization programs, administering vaccines before starting immunosuppressive drugs, following specific recommendations for each vaccine, using non-live vaccines for patients on glucocorticosteroids or disease-modifying antirheumatic drugs (DMARDs), and avoiding live-attenuated vaccines for immunosuppressed patients. The specific recommendations include strongly consi-dering non-live seasonal influenza vaccination for patients on glucocorticosteroids or DMARDs, providing pneumococcal vaccination (PCV10 or PCV13) to non-vaccinated patients, following general guidelines for tetanus vaccination with additional precautions for patients on B-cell depleting therapy, recommending HPV vaccination for all AIIRD patients, avoiding yellow fever vaccination for immunocompromized patients, and limiting live attenuated vaccines except for MMR booster and varicella vaccination under specific conditions. These principles and recommendations serve as guidance for healthcare professionals when making vaccination decisions for pediatric AIIRD patients, considering factors such as the disease, treatment, and individual characteristics.

Favorable outcomes with reduced steroid use in juvenile dermatomyositis (Pediatr Rheumatol Online J. 2021; 19:127).

This retrospective analysis of 31 juvenile dermatomyositis (JDM) patients explored the use of reduced doses and durations of glucocorticoids with early steroid-sparing agents. The study revealed that this approach yields comparable outcomes to the conventional high-dose, long-duration steroid therapy for JDM. The median initial gluco-corticoid dose was 0.85 mg/kg/day, and patients achieved control of myositis and cutaneous disease within median durations of 7.1 and 16.7 months, respectively. These findings support the effectiveness of reduced glucocorticoid dosing and duration in combination with early steroid-sparing agents for positive outcomes in JDM, suggesting that high-dose gluco-corticoids may not be necessary. However, to definitively determine whether lower-dose steroid regimens are sufficient or if higher doses are still needed in JDM, further investigation through a randomized controlled trial is necessary. Apart from glucocorticoid therapy, alternative treatment options for JDM include methotrexate, rituximab, hydroxychloroquine, and mycopheno-late mofetil. Encouragingly, emerging therapies like Janus kinase inhibition with baricitinib show promise in managing refractory cases of JDM.

Intravenous immunoglobulin for the treatment of Kawasaki disease (Cochrane Database Syst Rev. 2003; 2003:CD004000)

In a Cochrane systematic review of 31 studies involving 4,609 participants, the efficacy of intravenous immunoglobulin (IVIG) for Kawasaki disease was assessed. The review showed that high-dose IVIG regimens may reduce the occurrence of coronary artery abnormalities (CAA), duration of fever and need for additional treatment compared to medium- or low-dose regimens, while showing little difference in hospital stay or mortality rates. IVIG is likely more effective than acetyl-salicylic acid (ASA) in lowering CAA incidence, with a probable shorter duration of fever, but uncertain impact on additional treatment compared to prednisolone. Regarding secondary treatment options, the review did not find a clear distinction in CAA incidence between IVIG and infliximab, after resistance to initial IVIG treatment. However, there may be reduced need for further tertiary treatment in the infliximab group. Similarly, no definitive difference in CAA incidence was observed between IVIG and prednisolone, after resistance to initial IVIG treatment. These findings provide valuable insights into IVIG and alter-native treatments for Kawasaki disease, particularly regarding CAA incidence, fever duration, and additional treatment needs.

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