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CLINICAL SYMPTOMS OF JUVENILE IDIOPATHIC ARTHRITIS, MANIFESTED BY JOINT PAIN IN CHILDREN

Nasirdinov Mavlonjon Ziyomiddinovich
Central Asian Medical University Head of the Department of Pathology and Forensic Medicine, PhD

Ahmadjonova Robiyaxon Abdumutallib qizi
Student of Central Asian Medical University

Annotation
Juvenile idiopathic arthritis (JIA) is characterized by chronic arthritis in one or more joints for at least 6 weeks. There are four main subtypes of JIA: oligoarticular, polyarticular, systemic, and enthesitis-associated. The exact cause of JIA is not known, but there is substantial evidence that it is an autoimmune process with genetic susceptibility factors.

Keywords: juvenile idiopathic arthritis, joint, synovitis, uveitis, antinuclear antibody, polyarticular disease, fever,

The most common type of JIA is the oligoarticular form, which constitutes approximately 30%–40% of patients and is characterized by arthritis of four or fewer joints. This type of JIA often affects medium to large joints. Because the arthritis is often asymmetrical, children may develop a leg-length discrepancy in which the involved leg grows longer due to increased blood flow and growth factors. The synovitis is usually mild and may be painless. Systemic features are uncommon except for inflammation in the eye. Up to 20% of children with this type of JIA develop insidious, asymptomatic uveitis, which may cause blindness if untreated. The activity of the eye disease does not correlate with that of the arthritis. Therefore, routine ophthalmologic screening with slit-lamp examination must be performed at 3-month intervals if the antinuclear antibody (ANA) test is positive, and at 6-month intervals if the ANA test is negative, for at least 4 years after the onset of arthritis, as this is the period of highest risk.

Polyarticular disease is defined as arthritis involving five or more joints. This type of JIA affects 25% of patients. Both large and small joints are involved, typically in a symmetrical pattern. Systemic features are not prominent, although low grade fever, fatigue, rheumatoid nodules, and anemia may be present. This group is further divided into rheumatoid factor (RF)-positive and RF-negative disease. The former resembles adult rheumatoid arthritis with more chronic, destructive arthritis.

The systemic form, previously known as Still disease, comprises 5%–10% of patients with JIA. The arthritis can involve any number of joints and affects both large and small joints, but may be absent at disease onset. One of the classic features is a high fever, often as high as 39°C–40°C, typically occurring one to two times per day. In between fever spikes, the temperature usually returns to normal or subnormal. Around 90% patients have a characteristic evanescent, salmon-pink macular rash that is most prominent on pressure areas and when fever is present. Other systemic features that may be present, but are not specific for JIA, include hepatosplenomegaly, lymphadenopathy, leukocytosis, and serositis.

Enthesitis-associated arthritis is most common in males, older than 10 years of age, and is typically associated with lower extremity, large joint arthritis. The hallmark of this form is inflammation of tendinous insertions (enthe-sopathy), such as the tibial tubercle or the heel. Low back pain and sacroiliitis are also commonly seen in this form of arthritis which comprises approximately 10%–20% of patients with JIA.

All in all, there are two additional subtypes of JIA. Children with psoriatic arthritis may have typical psoriasis, but may also present prior to the onset of the classic thick scaly plaques and have more subtle changes such as nail pitting. Patients with psoriatic arthritis may also present with dactylitis or “sausage digit,” which is painful swelling of an entire finger or toe. Undifferentiated JIA, comprising 10% of patients, includes children with chronic arthritis that do not meet criteria for any of the other sub groups or meet more than one criterion and therefore could be classified into multiple subgroups.

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