Paediatric and adult rheumatology share many similarities in practice, patterns of disease and treatment and care of patients, but they have some important differences. Paediatric consultations emphasize family, education and developmental concerns as compared with more individualistic consultations in adult services. Young people (YP) with rheumatological disease encounter adult rheumatology during the crucial, tumultuous developmental stage of adolescence (ages 10–19 years) [1]. This may be during a move, ideally through a planned process of transition, from children’s to adult services, or as a first-time referral. YP therefore experience the interface of paediatric and adult rheumatology at a time of profound personal change and development [2]. The process of transition is important to adult and paediatric rheumatology alike, and rheumatology leads research in this area [3]. However, from the perspective of adult rheumatologists, what is necessary to know about paediatric rheumatology to meet in the middle?

Patients with rheumatic disease starting in childhood and adolescence are an important part of adult rheumatologists’ clinical work and a significant proportion require biologic therapy [4]. Therefore adult rheumatologists need to appreciate the features, spectrum and natural history of paediatric rheumatological disease. They also need to be familiar and comfortable with the specific developmental features of adolescence, such as risky behaviours and non-compliance, which impact on health care provision for YP. Adaptations that make services more YP friendly—holding specific YP’s clinics in appropriate environments, adjusting timings to reduce time off school and the innovative use of virtual resources—help engage adolescents [5]. Key in all these aspects are effective, multidisciplinary links between local adult and paediatric rheumatology services in both service delivery and training of staff.

In terms of specific disease management, adult rheumatologists need to appreciate paediatric rheumatic disease phenotypes and treatments and how they differ from adult disease. JIA is an umbrella term for several different forms of arthritis, and when JIA exhibits disease activity into adulthood, it should not be seen as seronegative RA. Relabelling risks overtreating the proportion of JIA that will go into remission spontaneously, where treatment should be stopped. Relabelling may also mean patients are lost to follow-up in important registry studies of biologics in JIA. In turn, this contributes to the relative lack of knowledge and invisibility of JIA symptoms, signs and management in adult rheumatology for patients who continue to have active disease into adulthood.

The window of opportunity concept in paediatric rheumatology is increasingly recognized, and this imperative to treat inflammatory disease, as well as the range of effective therapies, are very familiar to adult rheumatologists. What may be less familiar to these professionals are some specific features and complications of paediatric rheumatic disease. In JIA, the importance of temporomandibular joint disease, the use of repeated joint injections as monotherapy for oligoarticular disease and the high index of suspicion for recognition and early treatment of macrophage activation syndrome (most typically in systemic JIA) are often underrecognized in adult rheumatology. Similarly, the understanding that presentation of SLE in adolescence is associated with increased morbidity and mortality and the different phenotypes and management strategies of JDM as compared with the adult form are crucial in effective adult rheumatology care. Training programmes for health care professionals often teach either paediatric or adult rheumatology, and wider integration of adolescent rheumatology in each is required. Integration of programmes with each other and the consequent improved knowledge are likely to benefit patient care.

In addition to improved training, good links with local paediatric services ensure that YP do not fall into potential knowledge gaps and that individual professionals from multidisciplinary backgrounds in both paediatric and adult rheumatology continually learn from each other. These links are particularly important for adult rheumatologists in understanding issues, such as needle phobia, that YP experience and the potential impact of loss of school time and peer contact during periods of severe illness. Both adult and paediatric rheumatologists routinely see patients with musculoskeletal symptoms and pain that do not have an inflammatory basis. Adult rheumatologists seeing YP need to adopt a paediatric perspective in understanding that such symptoms may be an important marker of psychological distress related to family dynamics or problems in education and may be associated with self-harm. YP and their families have often developed significant trust in and reliance on paediatric services, which can make engagement for YP in adult services problematic. Understanding of such issues requires adult rheumatologists to modify services accordingly. Similarly, paediatric rheumatologists benefit...
from the wealth of experience (particularly in the burgeoning field of biologic therapy) that adult rheumatologists can provide.

In adult clinics, YP will be expected to act autonomously, self-advocate and self-manage their health care, yet they do not have a complete repertoire of adult skills to facilitate this. Risk-taking behaviour and non-adherence with appointments and therapy are normal in the complex neurocognitive development that characterizes adolescence [6]. This process continues into the mid-20 s [7], when development of adult brain functions such as long-term reasoning and abstract thought are completed. The combination in YP of potentially severe disease, normal adolescent development, high life stressors, previous experience of disease and treatment and incomplete neurocognitive development can pose real challenges for adult rheumatology teams. A lack of training in addressing and dealing with these generic, adolescent-specific issues is a recognized barrier to care [8]. Adult rheumatology professionals may miss important clinical information and opportunities to intervene effectively if they do not tailor communication in a developmentally appropriate way or screen adequately for adolescent-specific features of patients’ histories. One practical way to address this latter point is the use of the HEADSS schema [9], an aide-memoire for systematically asking important questions (see Table 1).

Fundamental in answering the question this editorial poses is YP’s views and participation in services. Evidence suggests that YP want competent, knowledgeable and empathetic professionals to provide their care, and there is an increasing focus on how to meaningfully engage YP in shaping health care services [10]. Solutions for successfully meeting in the middle of adult and paediatric rheumatology depend on local resources and relationships coupled with training in the spectrum of inflammatory and non-inflammatory paediatric disease, how this continues into adulthood and how health care should be adapted in the context of adolescence. The translation of this knowledge into health care is exciting for adult rheumatology in empowering YP to engage effectively with their disease and its management.

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Table 1: HEADSS questions for guiding adolescent consultations

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<tr>
<td>E</td>
<td>Education/employment (eating)?</td>
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<tr>
<td>A</td>
<td>Activities outside school and home?</td>
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<td>D</td>
<td>Drugs (smoking, alcohol, recreational drug use)?</td>
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<td>S</td>
<td>Sexuality and sexual health?</td>
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<td>Stress/suicidal intent/sexual health/safety from injury and violence?</td>
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Adapted from Goldenring and Rosen [9].

References


