A first group of patients received MTX monotherapy only. Children from second group had an inadequate response to methotrexate15-25 mg/m2 per week intramuscular treatment prior to TZC administration. Patients at or above 30 kg weight TZC intravenous doses were 8 mg per kg every 4 weeks and for patients less than 30 kg weight we gave TZC intravenously 10 mg per kg every 4 weeks with no need to increase this dose.

Effectiveness of JIA treatment is assessed by ability of drug agent to accelerate symptom regression [7] In our study monotherapy of MT with standard doses had no significant influence on the destruction of joints progression according to modified Sharp method assessment score within 2 years of follow-up. Highest score by assessment means X-ray symptom progression. In our study, children from group 1 with monotherapy with MTX had higher scores by assessment compared to group 2 with combined MTX + TZC therapy. Differences between two groups had been significant, according to Students test criteria. See table 4.

CONCLUSION

Type and time to start of the drug administration for the management of JIA are important in terms of joint destruction prevention for children with SoJIA. Early start of therapy significantly reduces the severity of joint destruction. Compared with MTX, tocilizumab-MTX significantly inhibited structural joint damage and improved physical function in patients with SoJIA who previously had an inadequate response to MTX. However, environmental factors also should be taken into account: it is known that food insecticides and pesticides may provoke JIA [17]; some of them may act at very low doses [18].

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