

EDITORIAL

Pediatric Rheumatology in Asia

Dr. Arkachaisri's article in this issue of PROJ raises a number of important points for all of us in the field of pediatric rheumatology. Perhaps the most important is that while the population of the United States is 300 million with 73 million children, the population of the world is 6.3 billion with approximately 2.3 billion children. Excellent care for every child in the United States barely scratches the surface of the overall need and we have not succeeded even in reaching that goal. Clearly poverty, war, famine, and social exploitation take a greater toll on the world's children than rheumatic diseases. But the majority of those reading PROJ do so because they have elected to become pediatric rheumatologists. We cannot tackle all the problems, but we must begin to tackle those which interest us the most.

What can we learn from Dr. Arkachaisri's experience? How can we put that knowledge to good use? Let us begin with the most obvious. Dr. Arkachaisri is back in the United States and there is again no fully trained pediatric rheumatologist in Thailand. Why? It's simple. There was inadequate institutional recognition of the need for a pediatric rheumatologist and thus inadequate support. All of us who work to improve international health must work to increase awareness of the need for pediatric rheumatologists. We know we can make a difference and that it is inappropriate for children with rheumatic disease to be spread across a variety of inadequately trained specialists. We need to make sure our pediatric department chairmen know and that the word is spread to pediatric department chairmen around the United States, around the European Union, and around the world. There is a great public hue and cry about childhood AIDS victims in other countries. Has there ever been a day for the victims of childhood arthritis around the world? Have we made the effort to make the public aware?

Within our own field much of Dr. Arkachaisri's experience is enlightening. How can the relative incidence of juvenile arthritis, SLE, vasculitis, and other conditions vary so greatly from region to region? Is this a reflection of genetic variation, referral bias, or simply poorly standardized nomenclature? In the late 1970s in Los Angeles Dr. Hanson never used sulfasalazine because it was ineffective. Dr. Ansell at Taplow found it very useful. It

was not until spondyloarthropathies (which are common in the English population and respond well to sulfasalazine) were recognized to be distinct from JRA (as typically seen in Los Angeles) that this apparent contradiction could be resolved. The continued lumping of a variety of conditions into juvenile arthritis prolongs our ignorance and confusion. It is clear that systemic onset arthritis is a distinct condition which shares only chronic nonspecific synovitis with the other forms of JIA. Even so, is the SoJIA which is so common in Thailand and Japan the same disease as that seen in the US?

As we reflect on these issues we must reflect on an even greater need. The new biologic agents have revolutionized rheumatic disease care in the United States. They are slowly becoming available in the European Union. But they will never be cost effective for the majority of the world's children. One cannot provide drugs which cost \$12,000/year or more in a country where the average annual wage is \$5,000/year or less. Unfortunately this is the case for the majority of the world's children. If we are to improve care of children with rheumatic disease around the world, we must educate the physicians of the world to the need for better care and provide them with the necessary tools to provide that care. Are the children of the world better served if we invest the next \$20,000,000 dollars raised in the search for another \$12,000/year drug or in educating 400 physicians from disadvantaged countries in how to provide the best care with the drugs they have available?

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