



Pediatric rheumatology red flags

All 18 pediatric conditions on RheumReferral by urgency, and the red flags for infection and malignancy

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Infection first

Fever with an acutely painful joint or bone, or refusal to bear weight: same-day emergency assessment for septic arthritis or osteomyelitis. Fever with a non-blanching rash: treat as possible meningococcal sepsis first.

Malignancy can mimic JIA

Night pain, bone pain rather than joint pain, pain out of proportion, pallor, bruising, low blood counts or blasts, a high LDH, or an ill-appearing child: urgent hematology-oncology, and avoid glucocorticoids until malignancy is excluded.

EMERGENT Emergent Same day (within 24 hours)

Systemic JIA / macrophage activation syndrome

Daily spiking fevers with rash and arthritis. Cytopenias and a rising ferritin signal MAS, a life-threatening emergency.

First step: Suspected MAS needs the emergency department and same-day pediatric rheumatology. ICU care is often needed.

Kawasaki disease

Fever for 5 days or more with conjunctivitis, oral changes, rash, extremity changes or cervical nodes. Treat early to protect the coronaries.

First step: Send to the emergency department or admit.

Multisystem inflammatory syndrome in children (MIS-C)

Fever with high CRP and illness in two or more organ systems after SARS-CoV-2 infection or exposure.

First step: Admit for multidisciplinary care with rheumatology, cardiology, infectious disease and critical care as needed.

Pediatric vasculitis with organ threat

Childhood ANCA vasculitis, PAN or Takayasu with kidney, lung, gut, nerve or limb ischemia.

First step: Contact pediatric rheumatology directly. Organ threat needs the ED or admission.

URGENT Urgent Within 2–4 weeks

Juvenile idiopathic arthritis (JIA)

Joint swelling for 6 weeks or more in a child under 16, often with morning stiffness or a limp and few complaints of pain.

First step: Refer within 2–4 weeks. Send CBC with differential, ESR, CRP, metabolic panel and ANA (for uveitis risk). Add HLA-B27 if enthesitis or back pain is present.

JIA-associated uveitis

Usually painless and silent. Detected only by slit-lamp screening, so every child with JIA needs scheduled eye exams.

First step: High-risk children need a slit-lamp exam every 3 months (ACR 2019; reaffirmed 2026).

Pediatric (childhood-onset) SLE

More severe than adult lupus, with higher rates of nephritis, cytopenias and neuropsychiatric disease.

First step: Send ANA, anti-dsDNA, ENA, C3/C4, CBC, metabolic panel, urinalysis with microscopy, urine protein-to-creatinine ratio and BP.

Juvenile dermatomyositis (JDM)

Heliotrope rash, Gottron papules and proximal weakness in a child. Calcinosis is more common than in adults.

First step: Send CK, aldolase, AST/ALT, LDH, CBC, metabolic panel, ANA and a myositis antibody panel.

IgA vasculitis (Henoch-Schönlein purpura)

The most common childhood vasculitis: leg and buttock purpura with joint, gut and kidney involvement. Usually self-limited.

First step: First exclude infection: fever, an ill-appearing child or a rapidly spreading non-blanching rash needs emergency assessment for sepsis.

Pediatric systemic sclerosis

Raynaud's with skin thickening, digital ulcers or GI and lung involvement in a child.

First step: Send ANA, ENA including Scl-70 and centromere, CBC, metabolic panel and urinalysis, and check BP.

Acute rheumatic fever

Migratory arthritis, carditis or chorea 2–4 weeks after group A streptococcal pharyngitis.

First step: Send ASO, anti-DNase B, ESR, CRP, CBC and an ECG. Get an echocardiogram.

Neonatal lupus

From maternal anti-SSA/Ro ($\pm$ SSB/La): congenital heart block, rash, cytopenias or hepatitis in the infant.

First step: Fetal bradycardia or heart block needs urgent fetal cardiology or MFM.

SEMI-URGENT Semi-urgent Within 4–8 weeks**Pediatric sarcoidosis / Blau syndrome**

Under age 5: rash, arthritis (boggy tenosynovitis) and uveitis (Blau or early-onset sarcoid). Older children resemble adult sarcoid.

First step: Arrange an ophthalmology exam. Send calcium, CBC, metabolic panel and urinalysis, and get a chest X-ray.

Chronic nonbacterial osteomyelitis (CNO/CRMO)

Recurrent bone pain from sterile bone inflammation, often multifocal. It can mimic infection or malignancy.

First step: Whole-body MRI is the preferred imaging.

Periodic fever / autoinflammatory syndromes

Stereotyped recurrent fevers: PFAPA, FMF, CAPS, TRAPS, mevalonate kinase deficiency.

First step: Keep a fever diary and photograph rashes.

Localized scleroderma (morphea)

Patches or bands of skin thickening. Linear lesions on a limb or the face can affect growth, eyes or the brain.

First step: Refer early for linear, facial, deep, generalized or rapidly progressive disease. These are urgent.

Reactive arthritis (pediatric)

Arthritis after an enteric or GU infection, usually in the legs and asymmetric.

First step: NSAIDs. Check ESR, CRP and HLA-B27.

Pediatric Sjögren's disease

Recurrent parotid swelling is the most common presentation in children, more often than dryness.

First step: Send ANA, SSA/SSB, RF, CBC, metabolic panel, IgG and urinalysis.

REDIRECT

Usually referred elsewhere first

Septic arthritis or osteomyelitis in a child	Emergency department / pediatric orthopedics	Fever with an acutely painful joint or bone, or refusal to bear weight. Treat as infection until proven otherwise.
Possible leukemia or other malignancy	Pediatric hematology-oncology (urgently)	Bone pain (especially at night), pain out of proportion, cytopenias or blasts, high LDH, or an ill-appearing child. Malignancy can mimic JIA.
Slipped capital femoral epiphysis, Perthes disease, fractures	Pediatric orthopedics	Hip or knee pain with a limp in a child or adolescent, especially with obesity (SCFE) or ages 4–8 (Perthes). Get hip X-rays.
Possible non-accidental injury	Child protection team / pediatrics	Injuries that don't fit the history or the child's developmental stage, or multiple fractures at different ages.

For any child with suspected JIA

Arrange an ophthalmology screening exam now, without waiting for the rheumatology visit. JIA-associated uveitis is usually painless and silent.

Sources

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