These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.
Do not send periodic fever syndrome genetic panels prior to infectious and oncologic work up or in a patient without clear evidence of recurrent fever.

Fever is a common complaint in the pediatric age group with infectious etiology as the most common followed by malignancy. Thorough history and physical exam in addition to diligent documentation of fever and accompanying symptoms can often help define underlying etiology, minimizing as well as targeting additional work-up. Of note, most children with a periodic fever syndrome do not have a genetic mutation, and the most common periodic fever syndrome – PFAPA (periodic fever, adenitis, pharyngitis, aphthous ulcer) – is not associated with a monogenic mutation.

Do not order rheumatoid factor (RF) alone, or as part of a “panel” or “cascade” in children to evaluate for rheumatologic disease such as juvenile idiopathic arthritis (JIA) due to musculoskeletal complaints. Do not let laboratory results guide referral.

JIA is a clinical diagnosis, and laboratory studies are used to prognosticate severity. Only 10-30% of children with JIA have a positive RF compared to the majority of adults with rheumatoid arthritis. The relevance of other antibodies such as anti-cyclic citrullinated peptide (anti-CCP) has not been established in the pediatric population. Additionally, RF is nonspecific and can be positive in other diseases, infections, or healthy individuals, and these labs are typically expensive. Patients may still have JIA despite a negative RF, and a positive test with no clinical disease causes significant parental anxiety and may result in additional unnecessary testing.

How This List Was Created

The American Academy of Pediatrics’ Section on Rheumatology (SORh) consists of pediatric rheumatologists, pediatricians, and allied health care professionals who are actively involved in some aspect of the study of rheumatologic disease in children and adolescents. The SORh strives to inform pediatricians, parents, communities, and policy makers on rheumatic disease in children. The fellow members of the SORh were queried to develop a list of diagnostic and management decisions that have resulted in misuse of laboratory studies and resources. Through a series of votes, the fellow members developed the list into five statements to address the most common misconceptions seen when encountering pediatric autoimmune conditions. The fellows involved in this project are: Kathleen Collins, Brian Dizon, Suhas Ganguli, Miriah Gillispie, Marla Guzman, Michael B. Nelson, Onengiya Harry, Meiqian Ma, MaiLan Nguyen, Amir Orandi, Amanda Schlefman, Laura Tasan, and Erin Treemarcki. The list was shared with membership of the SORh Executive Committee for feedback and then finalized by collaboration. These five clinical issues are the result. Various expert committees and sections of the AAP reviewed and approved the list. The AAP Executive Committee granted final approval of the list.

AAP’s disclosure and conflict of interest policy can be found at www.aap.org.


