29. Medicines for diseases of joints

29.2. Disease-modifying anti-rheumatic drugs (DMARDs)

**Azathioprine**

**Indication**
Rheumatoid arthritis, serology unspecified

**ICD11 code**
FA20.Z

**ATC codes**
L04AX01

**Essential medicine status**

**Medicine type**
Chemical agent

**List type**
Complementary

**Formulations**
Oral > Solid: 50 mg

**EML status history**
First added in 1997 (TRS 882)
Changed in 2003 (TRS 920)
Changed in 2011 (TRS 965)

**Sex**
All

**Age**
Adolescents and adults

**Therapeutic alternatives**
The recommendation is for this specific medicine

**Patent information**
Patents have expired in most jurisdictions
Read more about patents.

**Wikipedia**
Azathioprine

**DrugBank**
Azathioprine

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**Summary of evidence and Expert Committee recommendations**

At its 2009 meeting, the Committee had requested a review of the medicines needed for the treatment of juvenile idiopathic arthritis (JIA) in children, as it did not endorse any of the medicines currently listed. A review was prepared by P Gowdie (Royal Children’s Hospital, Melbourne, Australia) to identify priority rheumatic conditions in children, treatment options, evidence for efficacy and safety, and to make recommendations for the inclusion of medicines. The Committee noted that the most frequent condition in children is JIA, with three main forms: systemic onset, polyarticular, and oligo-monoarticular. Other conditions of interest are juvenile dermatomyositis/polymyositis (JDM), and systemic lupus erythematosus (SLE), but these are infrequent in children. Other chronic arthritic diseases affecting children such as acute rheumatic fever, Lyme disease, post-streptococcal reactive arthritis, Kawasaki disease, and other vasculitides were not discussed in the application. The Committee noted the lack of specific data in children affected by chronic arthritis or inflammatory systemic diseases in developing countries.

The Committee evaluated the evidence provided in the review for each of the medicines. A summary of the considerations is provided in Table 1 (page 14, TRS 965) and full details of the clinical evidence are in the application. Despite the recommendation made in the review, the Committee considered that the evidence supporting the use of sulfasalazine and
Azathioprine in JIA was too limited and indicated poor tolerance and the need for regular monitoring to detect potentially serious adverse effects. The Committee did not recommend the inclusion of azathioprine on the EMLc for rheumatoid disorders.