Background: A 19-year-old female Division I softball player began having pain in her fingers, wrists, and knees at age 16. There was a gradual onset of symptoms that included minor sleep disturbances and weight loss of approximately five to six pounds. She had no personal or familial history of autoimmune diseases. The athlete sought treatment from her primary care physician, who ordered laboratory tests. The results of the laboratory tests were abnormal. Differential Diagnosis: Tenopathy, Lyme Disease, Sjogren’s Syndrome, Systemic Lupus  Treatment: The athlete was referred to a rheumatologist by her primary care physician, who performed a physical assessment to find the cause of the athlete’s pain and joint swelling. Slight synovial joint thickening was noted at her left second metacarpophalangeal (MCP) joint and at the right second and third MCP joints on x-ray. She experienced pain at the end ranges of motion in her second and third MCP joints, as well as in her shoulder. The rheumatologist ordered laboratory tests which included a rheumatoid factor and sedimentation rate. The rheumatoid factor level was 470 units, normal is less than 30, and the sedementation rate was 50 mm/hour, normally 0-20. All radiographs were negative for decreased joint space. The athlete was diagnosed with Juvenile Rheumatoid Arthritis (JRA), confirmed by laboratory test findings, after excluding similar conditions. The athlete was prescribed non-steroidal antiinflamitory drugs (Ibuprofen), Cox-2 inhibitors (Celebrex), and disease-modifying antirheumatic drugs (Enbrel and Methotrexate), to control swelling and pain. She continues to take these medications, depending on the severity of her symptoms, and has x-rays periodically to assess the progression of the disease. Uniqueness: Juvenile Rheumatoid Arthritis is an autoimmune disease, which causes one’s own white blood cells (WBC) to lose the ability to distinguish between “self” and “invaders”. As a result of the inability of the WBC to distinguish between types of cells, there is a destruction of a person’s healthy cells rather than destroying “invaders” such as bacterial and viral cells. This destruction of healthy cells affects the chondrocytes in cartilage throughout the body, including synovial joints. Rheumatoid Arthritis has been shown to affect 25-50 per 100,000 people per year, but the juvenile form of the disease affects about 50,000 children each year. Overall, only 0.5-1.0% of the population have some form of Rheumatoid Arthritis. This athlete faces a unique challenge by playing collegiate softball, while having a disease that involves inflammation and deterioration of joints. The demands on joints from playing an intercollegiate sport are immense, coupled with a disease such as Juvenile Rheumatoid Arthritis makes participation very challenging and painful. Juvenile Rheumatoid Arthritis is a unique childhood disease that will require continuous care throughout her life. Because it is an autoimmune disease, she must maintain a healthy lifestyle in order to prevent other illnesses. Conclusion: The athlete continues to take medication to control the symptoms, and occasionally experiences an increase in joint pain and stiffness. She continues to be examined by a physician every few months to monitor any changes in her condition. Currently, she is playing Division I intercollegiate softball despite pain, joint stiffness and swelling.