

NATIONAL CENTER FOR CONTROL OF RHEUMATIC FEVER AND HEART DISEASES, SHER-E-BANGLA NAGAR, DHAKA, BANGLADESH
Guideline for Diagnosis, Prophylaxis and Follow-up of Streptococcal Pharyngitis and Rheumatic Fever Patients

Disease	Diagnosis	Drug (any one)	Duration	Follow-up
Streptococcal pharyngitis	Clinical and epidemiological features, and positive rapid antigen detection test (RADT) and/or group A beta-hemolytic streptococci (GABHS) on throat culture	1. BPG 600000 U <30 kg, 1200000 U \geq 30 kg body weight, or 2. PPV 250 mg 2-3 times daily for <30 kg, 500 mg 2-3 times daily for \geq 30 kg body weight 3. For individuals allergic to penicillin ERN 40 mg/kg/day 2-3 times daily (max. 1g/day)	Once 10 days 10 days	None
RF₁ : RF without carditis	Updated Jones criteria ^a	1. BPG 600000 U <30 kg, 1200000 U \geq 30 kg body weight every 3 weeks, or 2. PPV 250 mg twice daily, or 3. SDZ 0.5 g oral once daily < 30 kg, 1.0 g once daily \geq 30 kg body weight, or 4. For individuals allergic to penicillin and SDZ ERN 250 mg twice daily	Up to 22 years of age or 5 years from last attack (whichever is longer)	Once a year for delayed development of valve lesion, or Anytime for recurrence of RF
RF₂ : RF with carditis but no residual valvular lesion	Updated Jones criteria	As above	Up to 30 years of age or 10 years from last attack (whichever is longer)	As above
RF₃ : RF with carditis and residual valvular lesion (including those with artificial valve)	Clinical and echocardiographic evidence	As above	Lifelong	Once a year to monitor valve lesion, or Anytime for recurrence of RF

BPG indicates benzathene penicillin G; PPV, phenoxymethyl penicillin V; ERN, erythromycin; SDZ, sulphadiazine.

^aIf supported by evidence of preceding GABHS infection (positive throat culture/RADT and/or **anti-streptolysin O ? 300 IU/ml for children [\geq 200 for adults] or rise/decline in titer between acute and convalescent samples drawn 3-4 weeks apart), the presence of two major manifestations (carditis, polyarthritis, chorea, erythema marginatum, and subcutaneous nodules) or of one major and two minor manifestations (arthralgia, fever \geq 39°C, abnormal acute phase response [**erythrocyte sedimentation rate \geq 30 mm Westergren 1 hour or positive C reactive protein**], prolonged PR interval) indicates a high probability of acute rheumatic fever. Exceptions to Jones criteria are isolated chorea, indolent carditis and some recurrent attacks. It is important to note that some patients who fulfill the Jones criteria are not RF patients and, conversely, some patients who do not fulfill the criteria are RF patients. Sometimes, a distinction between arthritis and arthralgia remains difficult because of a long time interval from the onset of illness to visiting the physician or because of uncertain information on salicylate/steroid medication (i.e., signs of arthritis may have disappeared or could not be fully developed). Thus, the possibility of polyarthritis can not be excluded with certainty. These patients may be marked as “**possible RF**” (**RF₄**) and secondary prophylaxis may be given. However, other possibilities should carefully be excluded. Early administration of salicylate/steroid should be avoided to allow the clinical picture fully developed.**

Rheumatic Fever Expert Committee for Revision of the Guideline

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