

ARF & RHD IN THE NORTHERN TERRITORY

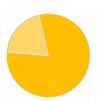
2016 - 2020

9, % of the ARF

reported in the Northern Territory [g] Ua cbg Aboriginal and Torres Strait Islander people







80%

of people diagnosed with RHD have NO prior ARF diagnosis recorded



of people diagnosed with ARF are FEMALE

In the *NT* the incidence of ARF is approximately 344 per 100,000 among Aboriginal and Torres Strait Islander people compared with 2.5 per 100,000 for other Australians.



ARF
is most
common in
YOUNG
PEOPLE
aged
5-14 YEARS

36% of people with ARF have heart involvement



The rate of ARF
RECURRENCES
decreased between
2016 and 2020



Most
HEART VALVE
SURGERIES
occur among people

aged 25-34 YEARS





Acute rheumatic fever and rheumatic heart disease are PREVENTABLE and MANAGEABLE

MORE 3800
PEOPLE IN THE
NORTHERN TERRITORY
ARE LIVING WITH ARF OR
RHD



10% of people have SEVERE disease at FIRST RHD diagnosis



We acknowledge that these numbers represent people living with ARF and RHD, and that this disease impacts on individuals, families, and communities.

Reference: Australian Institute of Health and Welfare. (2022). Northern Territory: ARF and RHD facts. Retrieved from https://www.aihw.gov.au/reports/indigenous-australians/nt-arf-rhd







THINGS YOU NEED TO KNOW



IN AUSTRALIA

- ARF and RHD occur almost exclusively among Aboriginal and Torres Strait Islander peoples particularly those living across northern and central Australia.
- New Zealand Māori and other Pacific Islander peoples also experience high rates of ARF and RHD



DISEASE CONTROL

- RHD control programs use disease registers to coordinate care for people with ARF and RHD.
- The Australian ARF/RHD Guideline includes recommendations and guidance to support best practice care that is clinically sound and culturally safe.



GLOBAL SIGNIFICANCE

- ARF is a sensitive marker of childhood disadvantage.
- ARF is most common among children aged 5-14 years.
- RHD is the most common form of acquired heart disease in children and young adults.
- ARF and RHD are notifiable conditions in some Australian states and territories.



PATHOGENESIS

- ARF is an autoimmune illness which develops after a bacterial Group A streptococcal (Strep A) infection. Not all people with Strep A infections develop ARF.
- RHD is damage to the heart valves following ARF. The valves are not able to function normally which leads to leaking or blockage of blood as it moves through the heart.



PRIMARY PREVENTION

 Prompt treatment of Strep A throat and skin infections with penicillin prevents ARF.



DIAGNOSIS OF ARF

- Diagnosis requires a specific combination of symptoms plus evidence of a recent Strep A infection.
- Symptoms may include fever, red, painful, swollen joints, choreiform movements (chorea), rashes, or lumps under the skin, chest pain or palpitations.
- Heart involvement is identified by ECG changes and echocardiographic changes.
- Everyone suspected to have ARF should be admitted to hospital under the care of a medical specialist.



TREATMENT FOR ARF

- For everyone: penicillin to treat the underlying Strep A infection.
- For symptoms: analgesia to relieve pain and fever, supportive care for sore joints, consider corticosteroids for severe carditis, anti-epileptics for severe chorea.



RECURRENCE

- ARF tends to recur with subsequent Strep A infections.
- Intramuscular penicillin given every 21 to 28 days during the period of high risk prevents recurrent ARF.



DIAGNOSIS OF RHD

- Echocardiography is the international standard for diagnosing RHD.
- The mitral and aortic valves are most commonly affected.
- Signs of progressing RHD include breathlessness on exertion or when lying down, fatigue, swelling of the legs and feet, and palpitations.



PRIMORDIAL PREVENTION

 ARF and RHD can be eliminated by ending socioeconomic disadvantage, avoiding household crowding, and ensuring timely access to quality health services.

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