Table 7.2. Priorities in managing ARF in the acute setting

| Admission to hospital | Determining the diagnosis
| Admit all patients suspected to have ARF | The diagnosis is determined based on:
- Understanding of epidemiological risk
- History obtained from primary care staff and/or patient and their family
- Clinical observation prior to anti-inflammatory treatment: use paracetamol (first line) during this time if required for fever or joint pain
- Investigations (Error! Reference source not found.)
- Follow up findings:
  - The final diagnosis may not be clear until several months after the acute episode; e.g. if Jones criteria are not met for a diagnosis of definite ARF but a follow up echocardiogram confirms rheumatic valvular changes not visible at the outset, then the diagnosis shifts from possible or probable to definite ARF

| Treatment |
| All cases | Provision of supportive, culturally safe care
- Antibiotic management using pain avoidance techniques for delivery of intramuscular injection (Error! Reference source not found.)
- Influenza vaccine - annual influenza vaccination is part of the long-term care plan but needs to be considered acutely as a strategy to reduce the risk of Reye’s syndrome for children receiving aspirin

| Arthritis and fever | Paracetamol (first line) until diagnosis confirmed
- Naproxen, ibuprofen or aspirin once diagnosis confirmed, if arthritis or severe arthralgia present
- Mild arthralgia and fever may respond to paracetamol alone

| Sydenham’s chorea | No pharmacological treatment for mild cases
- Anticonvulsant such as carbamazepine or sodium valproate if symptoms are debilitating or impacting significantly on function (Error! Reference source not found.)
- Stepwise use of other agents as per text below (Error! Reference source not found.). Evidence base is limited

| Carditis/heart failure | Bed rest, with mobilisation as symptoms permit
- Anti-failure medication as required (Error! Reference source not found.)
- Corticosteroids for severe carditis or pericarditis with effusion (Error! Reference source not found. and Error! Reference source not found.)
- Valve surgery for life-threatening acute carditis (rare)

| Long-term preventive measures and discharge planning |

Prepare for discharge to primary-care facility and follow-up:
- Notify case to the jurisdictional ARF/RHD register (where it exists) (Table 13.1)
- Contact the patient’s local primary care service and community pharmacist
- Provide a discharge letter to the patient or family, the primary care service and community pharmacist including information about:
  - ARF diagnosis (possible, probable, definite)
  - priority classification of RHD if also present (Priority 1, 2 or 3) (Table 11.2)
  - a recommended care summary based on disease priority classification (Error! Reference source not found.)
  - date of last BPG administration
  - required frequency of BPG, and the due date of next dose
  - date of next medical appointment
  - date of next echocardiogram
  - information about vaccinations administered in hospital
- relevant contraception information and/or pregnancy planning for women
- Arrange dental review and ongoing dental care to reduce risk of endocarditis

Family and community engagement:
- Involve family in care
- Engage interpreters for patients and families whose first language is not English
- Provide education that is culturally appropriate and age-appropriate
- With consent from family, notify school (for school-aged children) to encourage support for ongoing care
- Acknowledge the significance of a chronic disease diagnosis in childhood, including the need for linkage with peer-support networks, psychological support, ongoing education, transition care as the individual ages, and self-management support. Where indicated, engage adolescent support services (Table 11.4).