

**Acute rheumatic fever – Clinical vigilance is essential for primary prevention to be successful and avoid lifelong rheumatic heart disease (Editorial)**

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# Acute rheumatic fever

*Clinical vigilance is essential for primary prevention to be successful and avoid lifelong rheumatic heart disease*

**Janelle Speed**, Stephen A Margolis

**AS WE SLOWLY** move towards a post-COVID-19 world, it is timely to revisit the ongoing disparity in health outcomes across Australia. Aboriginal and Torres Strait Islander people continue to experience lower life expectancy and higher morbidity than other Australians.<sup>1</sup> Closing the Gap began in 2007, aiming to ‘close the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians ... by 2030’.<sup>2</sup> However, at the 10-year review in 2018, it was clear that the gap is not closing.<sup>2</sup>

Of key concern is the need for clinical problems to be identified in a timely fashion by health providers, as early recognition leads to early intervention and the opportunity for improved health outcomes. Acute rheumatic fever (ARF) leading to rheumatic heart disease (RHD) is a pivotal example of the need for early diagnosis. Delay in clinicians considering ARF within their diagnostic assessment can lead to devastating lifelong cardiac disease. Timely administration of commonplace, readily available, low-cost antibiotics can prevent lifelong cardiac disease. ARF is the stereotypical disease for which there are effective low-tech solutions readily available.

In this issue of *Australian Journal of General Practice*, the clinical approach to primary prevention of ARF in Australia is detailed by Wyber et al.<sup>3</sup>

It is extraordinary that ARF and RHD, clearly identified as primarily major public health problems for countries with developing economies, remain core clinical issues in Australia at the present time.<sup>4</sup> In 2013–17, there were 1776 ARF diagnoses among Aboriginal and/or Torres Strait

Islander Australians, most commonly at the age of 5–14 years.<sup>5</sup> This means that Aboriginal and Torres Strait Islander people in Australia have the world’s highest rates of ARF/RHD.<sup>6</sup> Of critical importance is that Aboriginal and Torres Strait Islander people are no more or less susceptible than anyone else in Australia.<sup>7</sup>

So why is our health system unable to eradicate ARF/RHD? Important issues comprise clinician cultural competency including recognising and addressing cultural bias, improved access to appropriate resources, health literacy and, importantly, a coordinated and consistent clinical approach. Successful implementation of evidence-based medicine requires framing within the cultural and structural barriers Aboriginal and Torres Strait Islander people experience.<sup>8</sup> This requires ongoing educational programs to heighten awareness and corresponding vigilance early, ensuring cases are not missed. The critical element is to ensure that clinicians understand that the risk factors for ARF are not location specific, affecting urban, metropolitan Aboriginal and Torres Strait Islander people as well as those living in more rural and remote locations.<sup>9</sup>

We encourage our readers to carefully consider the clinical issues related to ARF and include this diagnosis within their diagnostic approach. Each person’s risk needs to be assessed independently, without preconceptions, regardless of whether they are in a rural or metropolitan area, as every person treated with timely antibiotics may prevent a lifetime of cardiac disease.

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