

# Reumatic fever: it is still among us

*Febre reumática: ela ainda está entre nós*

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Despite evidence to the contrary [1-3], it has become commonplace to affirm that rheumatic fever and its consequent valvar cardiopathy are diseases in extinction in the civilized world and more and more rare in Brazil. In fact, on consulting specialized journals in cardiology, the scientific programs of our medical congresses or the government health policies confirm the lack of interest in respect to this disease, with specialists preferring to focus on many other illnesses.

However, there is a contradiction between this viewpoint and the real world. In 1983, we observed that the number of admittances for rheumatic cardiopathy in the Hospital das Clínicas, Federal University of Ceará and the Hospital de Messejana of the state health department, were ten times greater than hospitalizations for Chagas Disease [4]. Even today, in these hospitals, admittances for acute rheumatic fever are common, many hospital beds are occupied by sufferers of chronic rheumatic heart disease and more than one third of the heart operations in these institutions are for the correction of defective valves. Twenty years after, but rheumatic fever is still with us.

Data from the Medical Archives and Statistics Service of the Messejana Hospital, reveal that only in the latter five years of the period from 1988 to 1999 did the number of operations for coronary artery bypass grafting overtake, and even then only slightly, corrections for defective

valves. This is the main tertiary hospital for the treatment of cardiovascular diseases of Fortaleza for government health insurance patients

In 2001, during the VII Cearense Heart Congress, Brazil, we demonstrated that more than 70% of the valve disease patients operated on in this hospital were less than 50 years old, thereby strengthening the inference of a rheumatic fever etiology. Also 71.3% of valve disease patients suffered procedures involving the mitral valve, resulting in the implantation of a valvar prostheses in more than 2/3 of these patients. And finally that 20% of these patients underwent reoperations, either for prosthetic dysfunction, for re-stenosis or aggravation of mitral valve failure with the time.

Apart from the personal and economic costs of the heart surgery itself, of the necessity of reoperation and the morbidity inherent in valvar prostheses, in the Messejana Hospital during that period, valve replacement was accompanied with a 9% mortality rate which reached 14.4% at the first re-operation. These are aspects and numbers that emphasize the perverse nature of an illness in the face of which we can not wait with our arms crossed any longer, highlighting the observation by Victor [5] who affirmed that “*once the heart valve is damaged any treatment is palliative, hence all efforts should be directed towards prevention of rheumatic heart disease*”.

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Twenty years ago, we suggested an intensification of measures directed towards prevention and control of the disease in our area [4], but, from what is indicated, this was not done. Ten years after, on analyzing specifically hospital admittances for rheumatic carditis in these hospitals, we observed that 77% of the patients were victims of disease reoccurrence [6]! Only in 23% of cases was the carditis an expression of the first rheumatic aggression, a fact revealing the inefficiency of the health care related to the treatment of streptococcic pharyngitis and the secondary prevention of rheumatic fever. For a long time it has been know that this disease does not reoccur if this infection is avoided [7,8].

The origin of this so deplorable panoramic problem, apart from the unfavorable socioeconomic conditions of the majority of our population and their consequent nutritional and housing problems, is our lack of care in recognizing streptococcic pharyngotonsillitis or insufficient effort in the secondary prevention of rheumatic fever.

We believe that, as in other regions of Brazil, we are experiencing in Fortaleza, a epidemiological transition characterized by a growing prevalence of obesity, diabetes mellitus, systemic hypertension, cerebrovascular disease and arteriosclerotic coronary disease [9,10]. However, old illnesses, fed by the poverty and social inequality, continue among us. According to EISENBERG [11], *“rather than dwindling and disappearing from the world health scene, rheumatic fever is still with us in most developing areas of the world, and is actually on the ascent in some of these areas due to the effect of poverty and overcrowding.”*

At a time calling for renewed hope, the struggle against rheumatic fever also demands priority in governmental programs. We hope that the Health Ministry and its secretaries have a clear policy in relation to the problem through the Family Health Program, in which physicians, nurses, social assistants and other health workers, become involved in the detection, control and the secondary prophylaxis of the disease. That the patient has access, at home, in a convenient manner and at appropriate intervals to benzathine penicillin administered by a professional nurse, without having to travel to the health post, which is for sure one of the motives for inadequate prevention.

In relation to rheumatic fever, old lessons need to be effectively practiced.

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