Dear Sir,

Acute Rheumatic fever (ARF) is highly prevalent in India and other developing countries. The prevalence of Rheumatic heart disease is estimated to be 1.5-2/1000 in all age groups [1]. Jones criteria, which are a standard in diagnosis of ARF first described in 1944, were modified 1992 [2] and reconfirmed in principle in 2000 [3]. Over the past few years the development in various areas have led to reexamination of Jones criteria. The tremendous progress in the field of Echocardiography and Color Doppler over the past 2 decades has made these modalities integral part of cardiac diagnosis, which the Jones criteria lack up till now.[4,5] Numerous studies have suggested that echocardiography should be used more widely in diagnosing subclinical carditis [6]. Monoarticular arthritis was not addressed particularly in the Jones criteria. Level of evidence categories and Classification of Recommendations did not form the basis of previous AHA ARF recommendations, which are taken care in this revision [6].

The following are the revised Jones Criteria recommended by AHA

A. For all patient population with evidence of preceding Group A streptococci infection. Diagnosis : Initial ARF - 2 major manifestations OR 1 major + 2 minor Manifestation. Recurrent ARF – 2-major OR 1 major and 2 minor or 3 minor.

B. Major Criteria:

Low Risk Population
Carditis* -- Clinical and/or Subclinical.
Arthritis ---- Polyarthritis only.
Chorea
Erythema marginatum
Subcutaneous nodules

Keywords: Rheumatic fever; Jones Criteria

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C. Minor Criteria
Low risk Population
Polyarthralgia
Fever (>38.5°C)
ESR >60mm in the first hour and/or CRP >3mg/dl
Prolonged PR interval (unless carditis is major criteria) after accounting for age variability.

Moderate or high risk population
Major Criteria
Carditis—clinical and/or subclinical
Arthritis—Monoarthritis or polyarthritis
Polyarthralgia
Chorea
Erythema Marginatum
Subcutaneous nodules.

Minor Criteria
Monoarthralgia
Fever (>38°C)
ESR>60 mm in the first hour and or CRP>3mg/dl
Prolonged PR interval after accounting for age variability (unless carditis is major criteria)

Possible Rheumatic fever: In high incidence settings the clinical presentation may not fulfill the revised Jones criteria but the clinician may have high suspicion of ARF. This may occur where laboratory test for acute phase reactants or confirmation of preceding group A streptococcal infection is not possible or history is unreliable. In such situations clinician should use their discretion to make diagnosis and treat accordingly.

1. When there is genuine uncertainty, it is reasonable to consider offering 12 months of secondary prophylaxis followed by reevaluation which involves repeat ECHO.
2. In a patient with recurrent symptoms (particularly involving joints) who has been adherent to prophylaxis but lacks serological evidence of group A streptococcal infection and lacks echocardiographic evidence of valvulitis it is reasonable to conclude that recurrent symptom are not due to ARF and discontinuation of antibiotic prophylaxis may be appropriate.

Rheumatic fever recurrences:
1. With a reliable past history of ARF or established RHD and in the face of documented group A streptococcal infection, 2 major or 1 major with 2 or 3 minor criteria may be sufficient for a presumptive diagnosis.
2. When minor criteria alone are present the exclusion of other more likely causes of clinical presentation is recommended before a diagnosis of ARF recurrence is made.

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[ARF: Acute Rheumatic fever, ESR: Erythrocyte Sedimentation Rate, CRP: C-reactive protein
# Low risk population are those with ARF incidence <=2 per 100000 school children or all age prevalence of RHD <=1 per 1000 population per year.
+ Subclinical carditis—indicates echocardiographic valvuilitis
** Polyarthralgia should be considered a major criteria in moderate or high risk population after exclusion of other causes. Joint manifestations can either be considered as major or minor criteria but not both in the same patient.
$CRP value must be greater than the upper limit of normal for the lab. Also ESR may evolve during the course of ARF peak ESR values should be used].

REFERENCES


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