

Acute rheumatic fever and rheumatic heart disease

Jonathan R. Carapetis^{1,2}, Andrea Beaton³, Madeleine W. Cunningham⁴,
Luiza Guilherme^{5,6}, Ganesan Karthikeyan⁷, Bongani M. Mayosi⁸, Craig Sable³,
Andrew Steer^{9,10}, Nigel Wilson^{11,12}, Rosemary Wyber¹ and Liesl Zühlke^{8,13}

Abstract | Acute rheumatic fever (ARF) is the result of an autoimmune response to pharyngitis caused by infection with group A *Streptococcus*. The long-term damage to cardiac valves caused by ARF, which can result from a single severe episode or from multiple recurrent episodes of the illness, is known as rheumatic heart disease (RHD) and is a notable cause of morbidity and mortality in resource-poor settings around the world. Although our understanding of disease pathogenesis has advanced in recent years, this has not led to dramatic improvements in diagnostic approaches, which are still reliant on clinical features using the Jones Criteria, or treatment practices. Indeed, penicillin has been the mainstay of treatment for decades and there is no other treatment that has been proven to alter the likelihood or the severity of RHD after an episode of ARF. Recent advances — including the use of echocardiographic diagnosis in those with ARF and in screening for early detection of RHD, progress in developing group A streptococcal vaccines and an increased focus on the lived experience of those with RHD and the need to improve quality of life — give cause for optimism that progress will be made in coming years against this neglected disease that affects populations around the world, but is a particular issue for those living in poverty.

Acute rheumatic fever (ARF) is the result of an autoimmune response to pharyngitis caused by infection with the sole member of the group A *Streptococcus* (GAS), *Streptococcus pyogenes*. ARF leads to an illness that is characterized by various combinations of joint pain and swelling, cardiac valvular regurgitation with the potential for secondary heart failure, chorea, skin and subcutaneous manifestations and fever. The clinical manifestations of ARF are summarized in the recently updated Jones Criteria for the diagnosis of ARF¹ and the most common clinical presentations are outlined in BOX 1. The acute illness can be severe, with disabling pain from arthritis, breathlessness and oedema from heart failure, high fevers and choreiform movements that impair activities of daily living. ARF is usually best managed in hospital, often for a 2–3 week period, by which time the diagnosis is confirmed and the symptoms are treated. Although most of the clinical features of ARF will resolve during this short hospital stay, the cardiac valvular damage might persist. This chronic valvular damage is known as rheumatic heart disease (RHD) and is the major cause of morbidity and mortality from ARF (BOX 2). ARF can recur as a result of subsequent GAS infections and each recurrence can worsen RHD. Thus, the priority in disease management is to

prevent ARF recurrences using long-term penicillin treatment, which is known as secondary prophylaxis.

The major advances in ARF and RHD treatment and control arose during the mid-twentieth century when these diseases were still common in North America. This period was the ‘heyday’ of ARF and RHD research and confirmed that penicillin treatment of GAS pharyngitis can prevent subsequent ARF (the basis of primary prophylaxis)² and resulted in trials confirming the efficacy of benzathine penicillin G for secondary prophylaxis³; both of these interventions remain the cornerstones of disease management. As the incidence of ARF and RHD waned in wealthy countries after the 1960s, so too did interest and research^{4,5}. As a result, by the end of the 1990s, even the WHO had minimal involvement in reducing the RHD burden. However, during this time, it became increasingly clear that ARF and RHD continued unabated in low-income and middle-income countries.

The twenty-first century has seen a resurgence of interest in ARF and RHD, sparked by a better understanding of the true burden of disease and an emerging group of clinicians and researchers from the countries most affected by the disease, particularly in sub-Saharan Africa, South Asia and Australasia. In this

Correspondence to J.R.C.
Telethon Kids Institute,
the University of Western
Australia, PO Box 855,
West Perth,
Western Australia 6872,
Australia.
[jonathan.carapetis@
telethonkids.org.au](mailto:jonathan.carapetis@telethonkids.org.au)

Article number: 15084
[doi:10.1038/nrdp.2015.84](https://doi.org/10.1038/nrdp.2015.84)
Published online 14 Jan 2016

Author addresses

¹Telethon Kids Institute, the University of Western Australia, PO Box 855, West Perth, Western Australia 6872, Australia.

²Princess Margaret Hospital for Children, Perth, Western Australia, Australia.

³Children's National Health System, Washington, District of Columbia, USA.

⁴Department of Microbiology and Immunology, Biomedical Research Center, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, USA.

⁵Heart Institute (InCor), University of São Paulo, School of Medicine, São Paulo, Brazil.

⁶Institute for Immunology Investigation, National Institute for Science and Technology, São Paulo, Brazil.

⁷Department of Cardiology, All India Institute of Medical Sciences, New Delhi, India.

⁸Department of Medicine, Groote Schuur Hospital, University of Cape Town, Cape Town, South Africa.

⁹Department of Paediatrics, the University of Melbourne, Melbourne, Victoria, Australia.

¹⁰Murdoch Childrens Research Institute, Melbourne, Victoria, Australia.

¹¹Green Lane Paediatric and Congenital Cardiac Services, Starship Hospital, Auckland, New Zealand.

¹²Department of Paediatrics, University of Auckland, Auckland, New Zealand.

¹³Department of Paediatric Cardiology, Red Cross War Memorial Children's Hospital, University of Cape Town, Cape Town, South Africa.

Primer, we outline the current understanding of ARF and RHD pathogenesis and treatment, with a particular focus on heart disease, and we highlight future research priorities.

Epidemiology Burden of disease

A 2005 systematic review, carefully designed to avoid over-estimating the disease burden of GAS infection, concluded that there were approximately 471,000 cases of ARF each year (336,000 in children aged 5–14 years), 15.6–19.6 million prevalent cases of RHD and approximately 350,000 annual deaths as a result of ARF or RHD; almost all deaths occurred in low-income and middle-income countries⁶. The Global Burden of Disease (GBD) study more recently estimated that there are 33 million prevalent cases of RHD, causing more than 9 million Disability-Adjusted Life Years lost and 275,000 deaths each year^{7–9} (FIG. 1).

Risk factors

Age. The incidence of initial cases of ARF is highest in children aged 5–14 years, although first episodes do occur in younger children, with reported cases of ARF

in those as young as 2–3 years old^{10,11}. Initial episodes can also occur in older adolescents and adults, although cases in people >30 years of age are rare. By contrast, recurrent episodes often affect slightly older children, adolescents and young adults but are rarely observed beyond the age of 35–40 years.

RHD is a chronic disease caused by accumulated heart valve damage from a single severe or, more commonly, multiple recurrent ARF episodes. This means that, although RHD occurs in children, its prevalence peaks in adulthood, usually between the ages of 25 years and 45 years¹⁰.

Sex. In most populations, ARF is equally common in males and females. However, RHD occurs more commonly in females, with a relative risk of 1.6 to 2.0 compared with males. In addition, these sex differences might be stronger in adolescents and adults than in children^{10,12}. The reasons for this association are not clear, but intrinsic factors such as greater autoimmune susceptibility, as observed in systemic lupus erythematosus¹³, and extrinsic factors such as greater exposure to GAS infection in women than in men as a result of closer involvement in child-rearing might explain this difference. In addition, women and girls might experience reduced access to primary and secondary ARF prophylaxis compared with men and boys, and this could also contribute to differences in RHD rates between females and males. Finally, RHD in pregnancy is becoming increasingly recognized. Indeed, data from South Africa and Senegal suggest that RHD is a leading cause of indirect obstetric death, which in turn accounts for 25% of all maternal deaths in developing countries^{14–16}. This effect relates to the worsening of pre-existing disease as a result of haemodynamic changes that occur during pregnancy, rather than any increase in susceptibility to ARF or RHD because of pregnancy¹⁷.

Environmental factors. The vast majority of differences in risk between populations around the world can be explained by environmental factors. The relative contribution of each of these individual risks is difficult to elucidate given that many of them overlap and most are associated with poverty and economic disadvantage^{12,18–20}. Household overcrowding is perhaps the best described risk factor and reduced overcrowding has been cited as one of the most important factors underlying the decline in ARF incidence in wealthy countries during the twentieth century²¹. Recent data clearly show an association of ARF and RHD with household crowding^{20,22,23} (see discussion on primordial prevention below).

In most studies, the risk of developing RHD is found to be highest in rural locations. For example, Indigenous Australians who live in remote communities are 3.3 times more likely to develop ARF than Indigenous Australians living in urban centres in the same region²⁴. Similar findings have been reported from other regions, although in some studies the risk has been highest of all in urban slums^{18,20}. It is likely that these locations are proxy measures of other risk factors such as household crowding — which is greatest in urban slums but often

Box 1 | Most common clinical presentations of ARF*

- Large joint arthritis and/or arthralgia, usually with fever, and sometimes with pansystolic murmur of mitral regurgitation
- Acute fever, tiredness and breathlessness from cardiac failure, with or without other manifestations (most commonly joint pain and/or swelling) and pansystolic murmur of mitral regurgitation
- Choreiform movements, commonly with behavioural disturbance but often without other manifestations
- Gradual onset of tiredness and breathlessness, which is indicative of cardiac failure, without fever or other manifestations, and pansystolic murmur of mitral regurgitation, which indicates the insidious onset of carditis

*Skin manifestations (erythema marginatum and subcutaneous nodules) are less commonly observed in acute rheumatic fever (ARF).

Box 2 | Key terms

Acute rheumatic fever

An acute illness caused by an autoimmune response to infection with group A *Streptococcus*, leading to a range of possible symptoms and signs affecting any or all of heart, joints, brain, skin and subcutaneous tissues. Acute rheumatic fever is diagnosed according to the Revised Jones Criteria and has a tendency to recur with subsequent group A streptococcal infections.

Rheumatic carditis

Active inflammation of the heart tissues, most importantly the mitral and/or the aortic valves, caused by acute rheumatic fever. Rheumatic carditis can lead to chronic damage that remains after the acute inflammatory episode has resolved.

Rheumatic heart disease

The persistent damage to heart valves resulting in mitral and/or aortic regurgitation, or in long-standing cases stenosis, that remains as a result of acute rheumatic fever with rheumatic carditis. Complications of rheumatic heart disease include heart failure, embolic stroke, endocarditis and atrial fibrillation.

high in poor, rural communities — and access to medical services. There have been several studies, dating back to some carried out in the United States during the 1960s and 1970s, that have shown lower rates of ARF in settings that had improved access to medical care than in communities in which access to care was lower²⁵. In several regions, including the French Caribbean and Cuba, a reduction in ARF rates was associated with comprehensive medical programmes that included a range of education and health promotions as well as medical strategies targeting ARF and RHD. As a result, it is difficult to isolate the specific component of access to medical care that contributes to ARF and RHD reduction^{26,27}.

Other individual associations of environmental factors with ARF and RHD, such as under-nutrition, have been occasionally shown but the evidence linking them to the diseases is not strong¹⁸. Conversely, there is little doubt that the major associations with ARF and RHD relate to poverty and that these are classic diseases of social injustice¹⁹. Indeed, recent data from the Central Asian republics highlight how RHD can rapidly emerge in settings of social disruption, which suggests that social instability and wars play a major part in fostering ARF and RHD, probably through displacement, crowding and poor living conditions²⁸. Of all of the environmental risk factors, overcrowded housing is the best-described factor that is amenable to improvement.

Mechanisms/pathophysiology**Overview**

After GAS infection of the pharynx, neutrophils, macrophages and dendritic cells phagocytose bacteria and present antigen to T cells. Both B and T cells respond to the GAS infection, initially by antibody production (IgM and IgG) and subsequently through T cell activation (mainly CD4⁺ cells). In susceptible individuals, the host response against GAS will trigger autoimmune reactions against host tissues (for example, the heart, brain, joints and/or skin) mediated by both *Streptococcus* spp.-specific antibodies and T cells through a process called molecular mimicry (FIG. 2). Molecular mimicry is the sharing of antibody or T cell epitopes between the host and the microorganism — infections generate

antibodies or T cells against the infectious pathogen to clear the infection from the host and these antibodies and T cells also recognize host antigens. In the case of ARF, these host antigens are located in tissues such as the heart and the brain^{29–40}.

The cross-reactive immune response results in transient migratory polyarthritides as a result of the formation of immune complexes (FIG. 3), leads to Sydenham's chorea as the antibodies bind to basal ganglia and neuronal cells (FIG. 4), causes erythema marginatum and subcutaneous nodules in the skin as antibodies bind to keratin (FIG. 5) and leads to inflammation of both heart valves and the myocardium (FIG. 6). Although the myocardium heals following this inflammation, there can be permanent damage to the valves, which leads to RHD. Diversification of the immune response against an immunodominant epitope leads to its amplification (epitope spreading), which favours the recognition of several self antigens and facilitates tissue damage⁴¹. In this section, we describe rheumatic carditis (inflammation of the heart) and Sydenham's chorea (inflammation of the basal ganglia). The rarer skin manifestation erythema marginatum might be due to antibodies against group A carbohydrate cross-reacting with keratin^{42,43} and the subcutaneous nodules that sometimes form in ARF might be granulomatous lesions that develop in the dermis of the skin as a result of delayed hypersensitivity against GAS antigens. Moreover, the formation of these nodules might be driven by similar mechanisms to Aschoff bodies, which are granulomatous lesions that form in the heart valve.

Genetic susceptibility and group A *Streptococcus*

Both the features of host susceptibility and the genetic makeup of the streptococcal strain are crucial to the host–streptococcal interactions that result in autoimmunity and in the development of ARF. This has been shown by the changing characteristics of ARF over time. For instance, GAS strains isolated during ARF epidemics of the World War II era were rich in M protein, heavily encapsulated by hyaluronic acid and highly virulent in mice⁴⁴. These strains, notable for their highly mucoid-appearing colonies, primarily infected the throat rather than the skin and were also detected during ARF outbreaks in Utah in the United States towards the end of the twentieth century⁴⁵. GAS strains isolated more recently in tropical climates do not share these characteristics. Indeed, molecular epidemiological studies suggest a greater diversity of GAS strains in tropical regions, with skin-associated strains dominating, raising the possibility that skin-associated strains are also linked to cases of ARF^{46–50}.

This change in the association of particular strains of GAS with ARF could be due to selective pressures acting on both the host and the organism. The evolution of GAS strains over years of penicillin therapy and prophylaxis might have led to ARF cases that were caused by GAS strains that do not have the same characteristics that were reported in previous ARF outbreaks in the United States many decades ago. In addition, the host might have evolved over this period, as many children

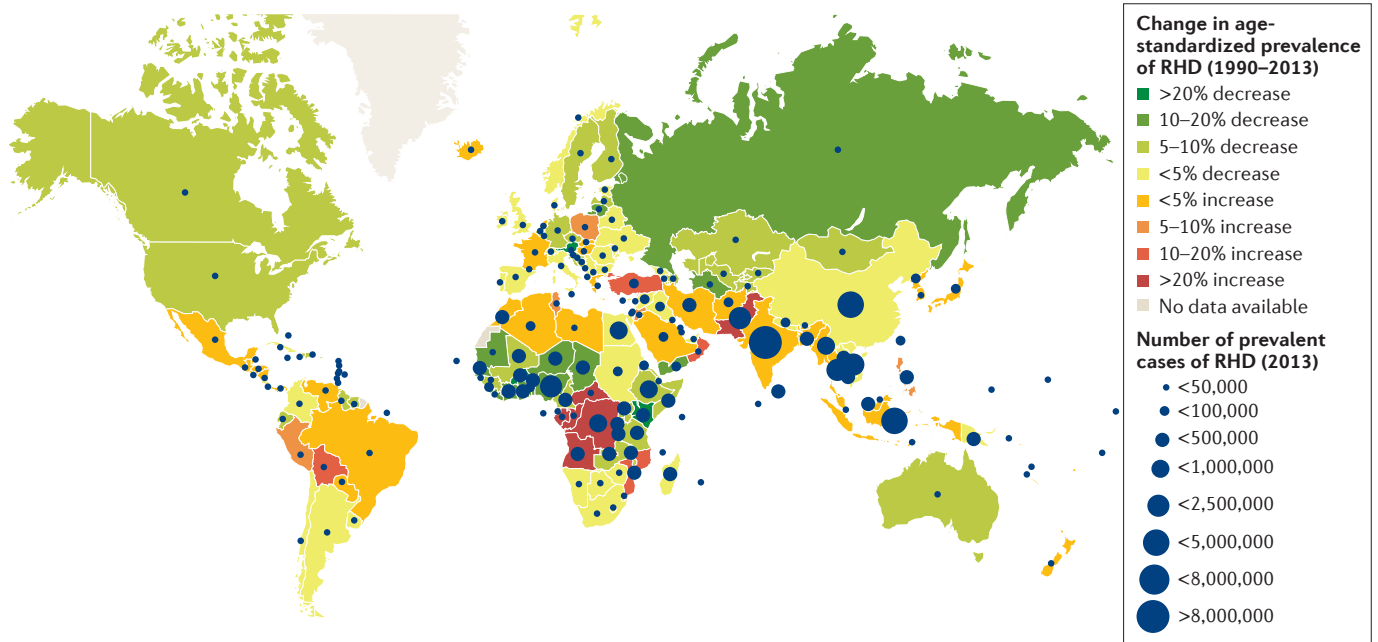


Figure 1 | **The global burden of RHD.** Number of prevalent cases of rheumatic heart disease (RHD) in 2013 by country, as well as the change in age-standardized RHD prevalence from 1990 to 2013. Data from REF. 9. Image courtesy of R. Seth, Telethon Kids Institute, Perth, Australia.

who contracted the disease in industrialized countries in the ARF epidemics of the early to mid-twentieth century did not survive or were not physically able to bear offspring. In this context, the most severe genetic predispositions for ARF susceptibility might have been transferred to the next generation at a much lower frequency than they were in non-epidemic settings. These changes over the past 100 years might have changed the bacterium and the host and, together with reduced exposure to GAS as a result of improved living conditions, might have been responsible for the decline in overall rates and the reduction in epidemics of ARF in industrialized countries.

How these factors may have influenced ARF in developing countries is even more uncertain. The extreme rates of RHD seen in the poorest countries have only become evident in recent decades, although high rates of ARF and post-streptococcal glomerulonephritis were well documented in Trinidad as far back as the 1960s⁵¹ and population prevalence rates of RHD between 0.5% and 2.2% were documented in the same period in India, Pakistan and Iran (reviewed in REF. 5). It seems likely that high rates of ARF and RHD have been mainly unreported in developing countries for at least half a century, and the lack of availability of treatment for severe RHD means that premature mortality from RHD is high⁵². Given the ongoing high rates of ARF and RHD in developing countries, any selective pressure on host susceptibility caused by premature mortality seems not to have had a substantial effect in these places. However, it is quite possible that selective pressures on organism factors in developing countries might be affected by those in industrialized nations, given emerging evidence of mobility of GAS strains on a global scale⁵³.

Genetics of host susceptibility are also important. Studies of families with individuals who were susceptible to ARF found that this susceptibility was heritable and that the associated loci had limited penetrance. In addition, phenotypic concordance among dizygotic twins suggests that susceptibility to ARF has an inherited component but that this inheritance does not follow a classic Mendelian pattern⁵⁴. Polymorphisms in several genes coding for immune-related proteins have been associated with ARF and RHD susceptibility. These proteins include mannose-binding protein C 2 (encoded by *MBL2*), ficolin 2 (encoded by *FCN2*), low-affinity immunoglobulin- γ Fc region receptor IIa (encoded by *FCGR2A*), Toll-like receptor 2 (encoded by *TLR2*), tumour necrosis factor (encoded by *TNF*), interleukin-1 receptor antagonist (encoded by *IL1RN*), transforming growth factor β 1 (encoded by *TGF β 1*) and cytotoxic T lymphocyte protein 4 (encoded by *CTLA4*)^{55–81} (TABLE 1).

Class II human leukocyte antigen (HLA) molecules are expressed on the surface of antigen-presenting cells (APCs) and are crucial for triggering adaptive immune responses via the T cell receptor. HLA class II alleles have been associated with ARF and RHD around the world; the DR7 allele is the most frequently associated with the conditions^{54,82} (TABLE 1). In addition, the class I HLA allele *HLA *B5* is associated with developing ARF and the formation of immune complexes during ARF⁸³. These associations indicate that genetic alterations of the Fc receptor (FcR) genes and the potential for failure of clearance of immune complexes might play an important part in disease pathogenesis. Further understanding of genetic susceptibility to ARF is likely to come from large multi-ethnic genome studies rather than studies from a single region.

Humoral immune response

The humoral (antibody-mediated) immune response to GAS is mainly responsible for initiating rheumatic carditis. This carditis is followed by cellular infiltration of the endocardium and valve tissues, which results in further damage that leads to RHD^{35,84,85}. The humoral response can also lead to Sydenham's chorea, which involves lymphocytic perivascular cuffing of vessels in the brain and which may occur with or without carditis⁸⁶. Antibodies against *Streptococcus* spp. that cross-react with antigens found in the heart or in the brain have been identified in the sera of patients with ARF and in the sera of rabbits and mice that had been immunized against streptococcal infection^{29–40}. The method for producing monoclonal antibodies (mAbs) enables production and identification of cross-reactive *Streptococcus* spp.-specific mAbs derived from mice and humans with ARF that are heart-specific and brain-specific. These developments facilitated the discovery of the pathogenetic mechanisms that are mediated by autoantibodies produced during ARF, including their effects on proteins in the heart and the brain.

The hypothesis of molecular mimicry occurring between GAS, heart and brain antigens is supported by evidence from studies using human mAbs^{35,38}, human serum IgG antibodies and both peripheral³³ and intralésional³⁴ T cell clones from patients with ARF and RHD³². A model of ARF affecting both the heart and the brain was developed in Lewis rats and studies using this model have shown that immunization with GAS antigens leads to valvulitis⁸⁷ or behaviours similar to those in

Sydenham's chorea³⁰. The investigation of *Streptococcus* spp.-specific mouse mAbs⁴⁰ and human mAbs derived from those with rheumatic carditis³⁵ and Sydenham's chorea³⁸ has supported the hypothesis that antibodies against the group A carbohydrate epitope *N*-acetyl- β -D-glucosamine recognize cross-reactive structures on heart valve endothelium and/or endocardium and on neuronal cells, which could cause carditis or Sydenham's chorea, respectively.

Sydenham's chorea. Sydenham's chorea is the neurological manifestation of ARF and is characterized by chorea and neuropsychiatric symptoms⁸⁸. In Sydenham's chorea, neuron-specific antibodies (immunoglobulin G (IgG)) target basal ganglia³⁶ and cause the release of excess dopamine from neuronal cells in culture³⁸. Human mAbs derived from patients with Sydenham's chorea³⁸ react by molecular mimicry with the group A carbohydrate epitope *N*-acetyl- β -D-glucosamine and a group of antigens found in the basal ganglia including the D1 and D2 dopamine receptors³¹, lysoganglioside³⁸ and tubulin³⁷. The cross-reactive neuron-specific antibodies are generated by the response against the group A streptococcal carbohydrate and recognize both host and microbial antigens, which share a structure that is similar enough for the antibody to cross-react. Although the reasons for antibody targeting of the basal ganglia are not well known, specific antibody targeting might be due to the presence of dopamine D2 receptors on dopaminergic neurons in the substantia nigra and ventral tegmental area that project to the striatum⁸⁹. Localization of such targeted neurons was observed when a human Sydenham's chorea-derived mAb was expressed in transgenic mice³¹.

A general theme in immunological mimicry by antibodies is the recognition of an intracellular antigen that is a biomarker; by contrast, antigens at the cell surface control disease mechanisms, such as cell signalling or complement-dependent cytotoxicity. Indeed, there is evidence that cross-reactive antibodies generated during ARF can have functional, and potentially pathogenic, consequences for neuronal cells. Antigens such as lysoganglioside and dopamine receptors in the neuronal cell membrane bind antibody and change cellular biochemistry and signalling through activation of calcium/calmodulin-dependent protein kinase type II (CAMK2), which leads to an increase in tyrosine hydroxylase and dopamine release^{31,39,90}. This altered signalling might function as a mechanism in disease^{90,91} (FIG. 4). For instance, human mAbs, serum IgG antibodies and/or cerebrospinal fluid from patients with Sydenham's chorea activate CAMK2 (REF. 38) in human neuronal cells and increase ³H-dopamine release from human neuronal cells³⁹. CAMK2 activation in neuronal cells was also shown using patient serum, and removal of IgG from the serum abrogated CAMK2 activation^{30,38}, which indicates that this neuronal signalling is antibody dependent. In addition, a human mAb derived from a patient with Sydenham's chorea induced tyrosine hydroxylase activity in dopaminergic neurons after passive transfer into rat brains³⁹, which suggests that the

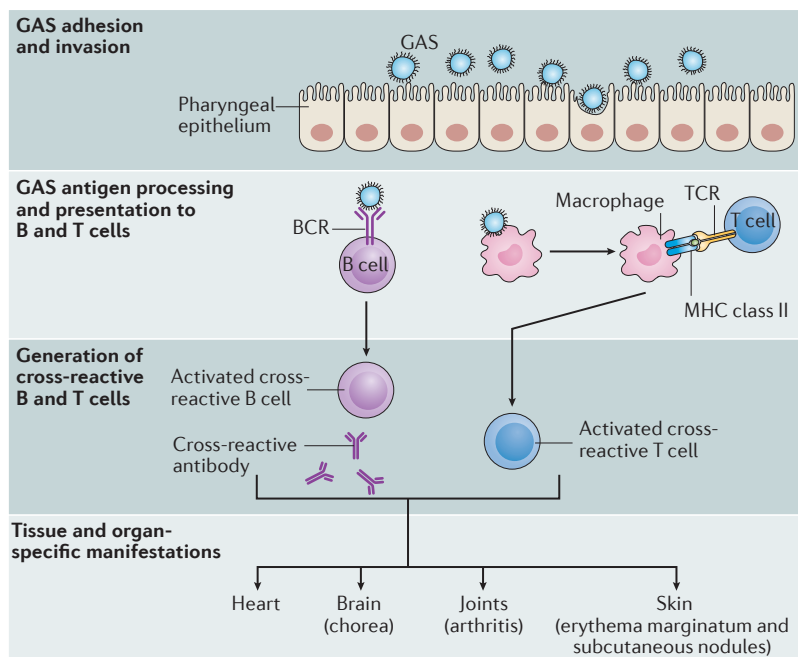


Figure 2 | Generation of a cross-reactive immune response in ARF. Following group A *Streptococcus* (GAS) adhesion to and invasion of the pharyngeal epithelium, GAS antigens activate both B and T cells. Molecular mimicry between GAS group A carbohydrate or serotype-specific M protein and the host heart, brain or joint tissues can lead to an autoimmune response, which causes the major manifestations of acute rheumatic fever (ARF). BCR, B cell receptor; TCR, T cell receptor.

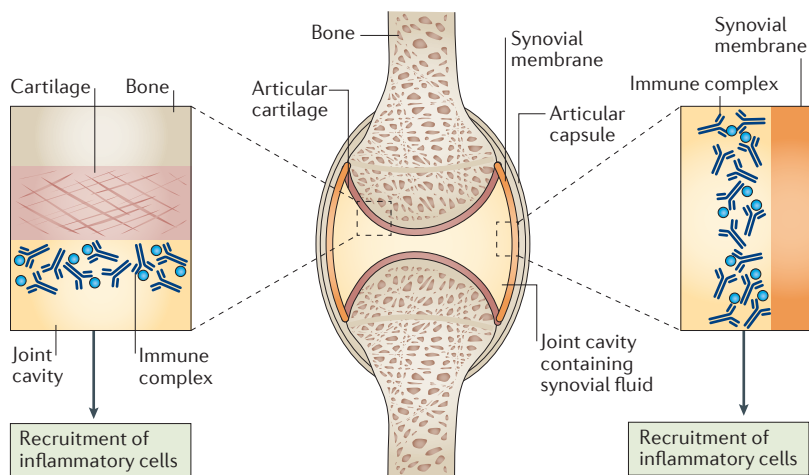


Figure 3 | **Manifestations of ARF in the joints.** Arthritis might be the result of the formation of immune complexes that bind to the synovial membrane and/or collagen in joints, which leads to recruitment of inflammatory cells. ARF, acute rheumatic fever.

neuron-specific antibodies formed in Sydenham's chorea might lead to neuronal changes and manifestations of disease. Furthermore, one study showed that when variable genes encoding a mAb derived from a patient with Sydenham's chorea, mAb 24.3.1, were expressed in transgenic mice, the resulting antibodies targeted dopaminergic tyrosine hydroxylase-expressing neurons in basal ganglia³¹ (FIG. 7). In addition, the whole mAb 24.3.1 and the source serum reacted with and signalled through the human dopamine D2 receptor³¹. Other antibodies have been found to react with the human D1 dopamine receptor and the ratio of dopamine D1 receptor-specific to dopamine D2 receptor-specific antibodies in Sydenham's chorea correlates with a measure of symptom severity²⁹. Finally, plasmapheresis, in which patients with Sydenham's chorea receive plasma from healthy donors, leads to the improvement of symptoms^{92,93}. This finding strongly suggests that disease pathogenesis is antibody-mediated and that patients would, therefore, respond to immunotherapy or corticosteroids, a prediction that has been recently validated in clinical studies^{93–98}.

Studies using rat³⁰ and mouse⁹¹ models support conclusions drawn from human studies. Exposure of rats to GAS antigens during immunization with GAS cell walls or plasma membranes leads to behaviours that are characteristic of Sydenham's chorea³⁰. Immunized rats could not hold a food pellet or traverse a narrow beam and showed compulsive grooming behaviour³⁰. These rats had IgG deposits in striatum, thalamus and frontal cortex with concomitant alterations in dopamine and glutamate levels in cortex and basal ganglia. In addition, sera from *Streptococcus* spp.-immunized rats have been shown to activate CAMK2 in a human neuronal cell line³⁰, results which are similar to those obtained using sera from patients with Sydenham's chorea³⁸. Removal of IgG from sera in these studies greatly diminished the CAMK2 activation in neuronal cells. In a mouse model, immune responses against GAS were also associated with motor and behavioural

disturbances⁹¹. In both models, passive transfer of *Streptococcus* spp.-specific antibodies directly into naive animals led to antibody deposits in the brain and concomitant behavioural changes^{90,99}. A study using the rat model has also addressed the effects of antibiotic therapy on behaviour and neurochemical changes. In this study, ampicillin treatment prevented the emergence of the motor symptoms and some of the behavioural alterations that were induced by GAS antigen exposure¹⁰⁰.

Rheumatic carditis. Cross-reactive antibodies have also been implicated in the pathogenesis of rheumatic carditis and recognize a variety of cardiac epitopes. Studies from the 1960s showed antibody deposition in human valve and myocardial tissues from patients who had died as a result of ARF or RHD⁸⁴. These findings were later confirmed using mouse^{40,101} and human mAbs^{32,35} against GAS that reacted with both myocardial and valvular tissues. The human mAbs targeted striations in the myocardium and the endothelium of the valve, a finding that had been previously reported in studies using sera from patients with ARF or from animals immunized with GAS antigens^{84,102–104}. In support of the molecular mimicry hypothesis¹⁰⁵, the targets of cross-reactive antibodies were cardiac myosin in the myocardium and laminin³⁵ in the valve endothelium and basement membrane, and these antibodies cross-reacted with the group A carbohydrate or streptococcal M protein^{35,40,101}.

The cross-reactive antibodies might also recognize glycosylated proteins or carbohydrate epitopes on the valve, which supports previous findings¹⁰⁶ showing an immunological relationship between GAS polysaccharide and the structural glycoproteins of the heart valve¹⁰⁶. This could help to explain why, in one study, the persistence of elevated group A carbohydrate-specific antibody responses in rheumatic carditis correlated with a poor prognosis of valvular heart disease¹⁰⁷. Antibodies that target valve surfaces lead to inflammation and cellular infiltration through the valve surface endocardium and/or endothelium⁸⁵.

The α -helical protein structures found in streptococcal M proteins, cardiac myosin, keratin and laminin are involved in cross-reactivity with antibodies that react to the group A carbohydrate epitope *N*-acetyl- β -D-glucosamine^{42,101}. In addition, mutations in the α -helical M1 protein that stabilize irregularities in its α -helical coiled coil structure diminish its ability to be recognized by *Streptococcus* spp.-specific antibodies that cross-react with M protein and cardiac myosin¹⁰⁸. This evidence suggests that α -helical protein epitopes and group A carbohydrate epitope *N*-acetyl- β -D-glucosamine are important targets of cross-reactive antibodies in ARF.

Active inflammation in rheumatic carditis is associated with humoral responses against specific epitopes of the S2 fragment of human cardiac myosin heavy chain¹⁰⁹ and these responses can be used to monitor disease progression and the effects of treatment¹¹⁰. S2 epitopes are similar among populations in which rheumatic carditis is endemic worldwide¹⁰⁹, regardless of

which M protein gene sequence (*emm* type) the GAS in the region carries. Repeated GAS throat (and possibly skin) infections are important in generating molecular mimicry, breaking immune tolerance and inducing epitope spreading, which leads to recognition of more epitopes in cardiac myosin and potentially other heart proteins. For example, epitopes shared among different streptococcal *emm* types in the B or C repeat regions of the streptococcal M proteins might prime the immune system against the heart during repeated streptococcal exposure and might eventually lead to RHD in susceptible individuals^{87,111–113}. The A repeat regions of the GAS M proteins that are responsible for the type-specific protection against infection from each serotype are not shared with other M types and are not cross-reactive. Sequences from the A repeat regions of the M protein serotypes have been used in group A streptococcal vaccines that show no evidence of cross-reactivity in animal and human trials^{32,114}.

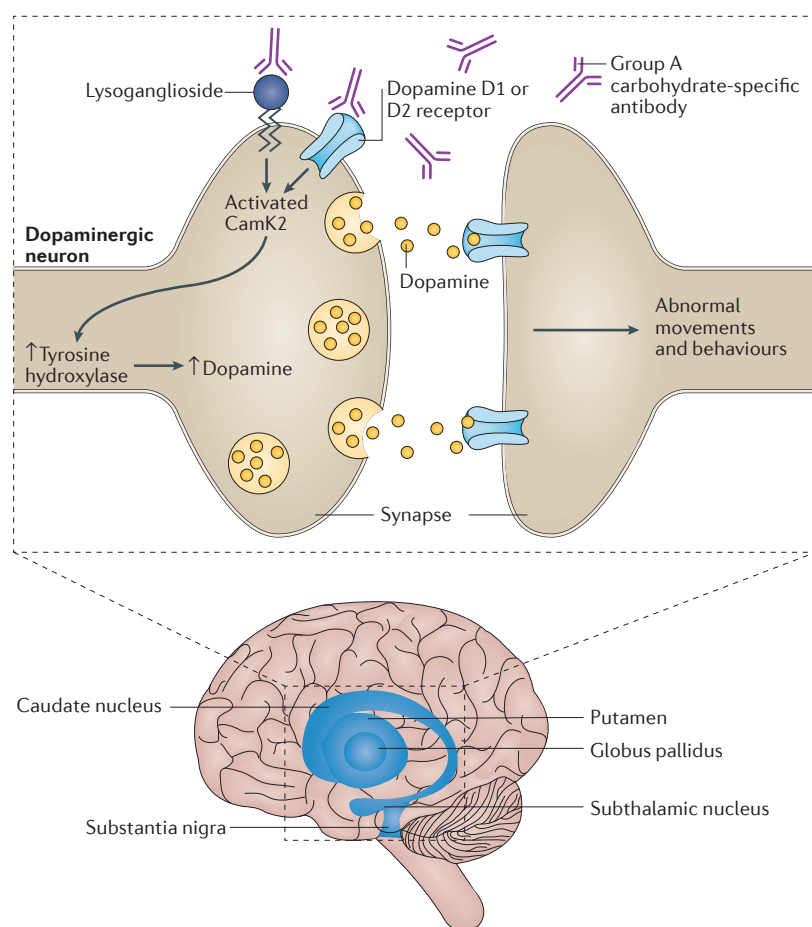


Figure 4 | Molecular and cellular basis of Sydenham's chorea. In Sydenham's chorea, neurons in the basal ganglia are attacked by antibodies against the group A carbohydrate of *Streptococcus* spp. that react with the surface of the neuron. This reaction activates signalling through calcium/calmodulin-dependent protein kinase type II (CAMK2), which involves an increase in tyrosine hydroxylase in dopaminergic neurons. Receptors, such as the D1 and D2 dopamine receptors, and lysoganglioside might be autoantibody targets on the neuronal cell. This targeting could lead to altered cell signalling and increased levels of dopamine, in turn leading to abnormal movements and behaviours.

Collagen is an important structural protein in the heart valve and autoantibodies against collagen I are produced in ARF¹¹⁵, but these antibodies are not cross-reactive. They might be produced as a result of immune responses against collagen after aggregation of collagen by certain streptococcal serotypes^{116,117}. Alternatively, they might also be due to the release of collagen from damaged valves during RHD¹¹⁶. Streptococcal proteins with similarity to collagen have been reported^{118,119}, although no immunological cross-reactivity has been observed. This absence of cross-reactivity raises the possibility of an alternative pathogenetic pathway in ARF that produces an antibody-mediated response to collagen in the valve that does not rely on molecular mimicry. As only cardiac myosin and M protein, but not collagen, have been shown to induce valvulitis in animal models^{87,120}, it is likely that molecular mimicry is important for breaking immune tolerance and for the initiation of rheumatic carditis, whereas the response to collagen probably occurs after this initial damage, as a result of exposure of the immune system to collagen — a process that continues during RHD.

Cellular immune responses in rheumatic carditis

The cellular autoimmune response in rheumatic carditis involves production of autoreactive T cells that infiltrate the valve and the myocardium, the activation of the valvular endothelium and the formation of Aschoff nodules in the valve.

Valvular endothelial activation. IgG antibodies that react with valve endothelium lead to the upregulation of vascular cell adhesion protein 1 (VCAM1) on the endothelial surface, which promotes infiltration of T cells through the activated endothelium into the valve^{85,116,121} (FIGS 6, 8). This endothelial activation also involves loss of normal endothelial cell arrangement and modifications to valvular collagen, which have been observed using scanning electron microscopy¹²². Both CD4⁺ and CD8⁺ T cells infiltrate the valves in ARF¹²³ but the CD4⁺ T cell subset predominates in the inflamed rheumatic valve⁸⁵ (FIG. 9). Only autoreactive T cells that are continually activated by antigen (that is, valve proteins) survive and remain in the valve to produce inflammatory cytokines and to cause valve injury. In ARF and RHD, lesions called Aschoff nodules or bodies can occur underneath the endocardium near to or at the valve but may also be seen directly in the myocardium, which usually heals in rheumatic carditis. These nodules are sites of granulomatous inflammation that contain both T cells and macrophages and they are formed as a result of an intense inflammatory process that is mainly mediated by CD4⁺ T cells¹²⁴.

VCAM1 also interacts with and upregulates numerous other cell adhesion molecules, chemokines and their receptors. These include integrin $\alpha 4\beta 1$ (also known as VLA4), intracellular adhesion molecule 1 (ICAM1), P-selectin, CC-chemokine ligand 3 (CCL3; also known as MIP1 α), CCL1 (also known as I309) and CXC-chemokine ligand 9 (CXCL9; also known as MIG)^{85,113}. The autoimmune reaction in the valves is associated with

elevated levels of heart tissue proteins vimentin and lumican and elevated apolipoprotein A1 levels, whereas collagen VI, haptoglobin-related protein, prolargin, biglycan and cartilage oligomeric matrix protein are reduced¹²⁵. This imbalance results in a loss of structural integrity of valve tissue and, consequently, in valve dysfunction.

Autoreactive T cells. Autoreactive T cells that infiltrate the myocardium and valves recognize myocardium-derived and valve-derived proteins and have an oligoclonal profile — they are derived from only a few individual T cell clones — in patients with both acute carditis and chronic RHD¹²⁶. These autoreactive T cells taken from rheumatic valves proliferate and express TNF and interferon- γ (IFN γ) (T_H1 subsets), whereas only a few T cells taken from rheumatic valves secrete the regulatory cytokine IL-4, which might explain the progression of valvular lesions in some cases¹²⁷. The granulomatous T_H1 cell response and the presence of IFN γ have been reported in rheumatic valves¹²⁷. Although less is known about T_H17 cell responses in RHD, T_H17 cells are important in GAS infections and have been identified in nasopharyngeal and tonsillar lymphoid tissues in streptococcal infection animal models^{128–130}. In ARF and RHD, elevated numbers of T_H17 cells, high IL-17A levels and decreased T regulatory cells were reported in peripheral blood¹³¹. IL-17 triggers effective immune responses against extracellular bacteria, such as promoting neutrophil responses^{132,133}.

The cross-reactive T cells taken from ARF and RHD heart valves mainly recognize three regions (residues 1–25, 81–103 and 163–177) of the amino-terminal region of M protein, several valve-derived proteins¹³⁴ and peptides of the β -chain of human cardiac light meromyosin region, which is the smaller of two subunits produced by tryptic digestion of human cardiac myosin^{33,34}. Peripheral blood and valve-infiltrating³⁴ human T cells react strongly against peptides of streptococcal M protein and human cardiac myosin. In animal models of RHD, the intact streptococcal M protein and peptides from A, B and C repeat regions of streptococcal M protein have been investigated for their potential to cause

valvular heart disease. For instance, rat T cell lines that are specific for streptococcal M5 protein epitopes such as DKLKQQRDTLSTQKET¹³⁴ passively transfer valvulitis and upregulation of VCAM1 (REF. 135) to uninfected rats.

Pathological consequences of inflammation

The inflammatory cascade in ARF has structural and functional effects on various parts of the heart valves that can lead to acute inflammatory damage and ultimately to RHD. This includes dilation of valve annuli — rings that surround the valve and that help close leaflets during systole — and elongation of chordae tendinae, which connect leaflets of the mitral and tricuspid valves to the left and right ventricles, respectively. Together these changes result in inadequate coaptation (that is, meeting) of the valve leaflets, which in turn causes regurgitation (that is, backwards leakage of blood through the valve when it closes)¹³⁶. Further inflammation leads to fibrinous vegetations in the rough zone of the anterior leaflet and scarring of leaflets, which might ultimately lead to valvular stenosis, in which the valve becomes narrowed, stationary and is unable to fully open (FIG. 6).

Diagnosis, screening and prevention

Diagnosis

The diagnosis of ARF is made using clinical criteria (the Jones Criteria) and by excluding other differential diagnoses. The Jones Criteria were first established in 1944 (REF. 137) and since then have undergone multiple modifications, revisions and updates, most recently in 2015 (REFS 1, 138–141). The criteria are divided into major and minor manifestations (TABLE 2). The diagnosis of ARF is made when the patient presents with two major manifestations or one major manifestation and at least two minor¹ manifestations. In addition, evidence of preceding infection with GAS must be shown, which is usually done using streptococcal serology. The exceptions to these criteria are patients who present with chorea or indolent carditis because these manifestations might only become apparent months after the causative streptococcal infection and, therefore, additional manifestations might not be present and streptococcal serology testing might be normal¹⁸⁸.

The most common presenting features of ARF are arthritis (75% of patients) and fever (>90% of patients). The arthritis of ARF is the most difficult diagnostic challenge because of the large number of differential diagnoses, especially in patients who present with an initial monoarthritis. In patients presenting with a single inflamed joint, it is important to exclude septic arthritis¹⁴². The arthritis of ARF is highly responsive to anti-inflammatory drugs (aspirin and NSAIDs) and if the patient does not respond within 48–72 hours alternate diagnoses should be considered. Subcutaneous nodules are small (0.5–2 cm in diameter), painless and round nodules that develop over bony prominences or extensor tendons, and erythema marginatum are bright pink, blanching macules or papules that spread outwards in a circular pattern, usually on the trunk and proximal limbs. Both are infrequent manifestations of ARF, occurring in less than 10% of patients^{24,50}.

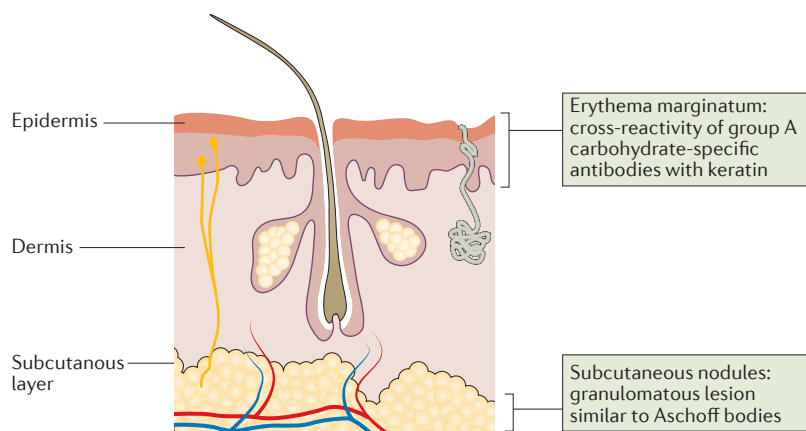


Figure 5 | Skin manifestations of ARF. Erythema marginatum might be due to antibodies against group A carbohydrates cross-reacting with keratin and subcutaneous nodules might be caused by delayed hypersensitivity against group A streptococcal antigens.

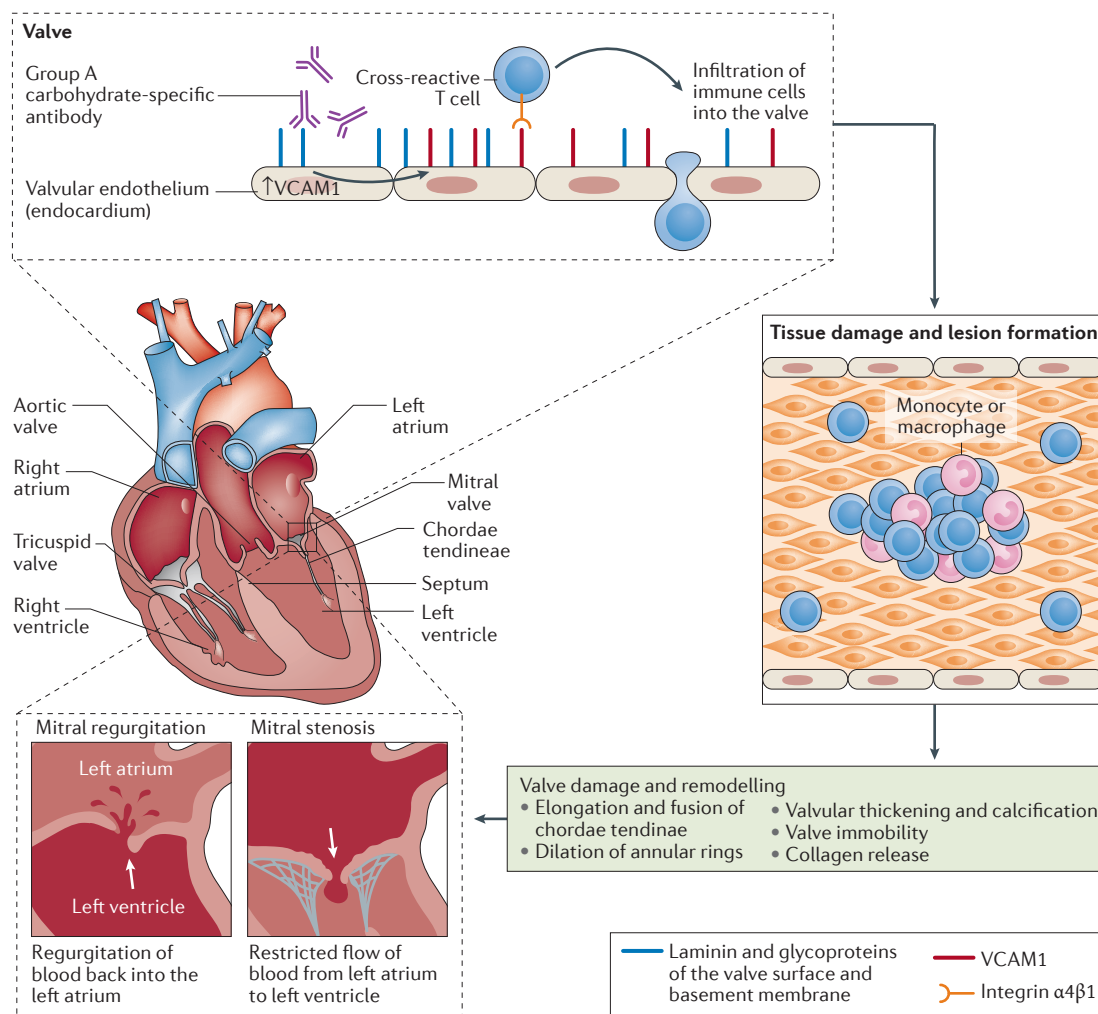


Figure 6 | The GAS cross-reactive immune response in the heart. The heart is affected by antibodies (generated by B cells) against the group A carbohydrate binding to the surface of the valve and upregulating vascular cell adhesion molecule 1 (VCAM1) on the surface of the valve endothelium. The upregulation of VCAM1 allows T cells expressing integrin $\alpha 4\beta 1$ (also known as VLA4) to adhere to the endothelium and to extravasate into the valve. The inner valve becomes infiltrated by T cells, primarily $CD4^+$ T cells, and Aschoff bodies or granulomatous lesions form underneath the endocardium. Damage to the endothelium and infiltration of T cells into the valve remodels the valve structure, including the chordae tendineae, with malformation of the valve leading to regurgitation or stenosis of the valve. Breakdown of the valve releases collagen and results in further immune-mediated damage to the valve.

Carditis occurs in >50% of patients with ARF and is predominantly characterized by valvulitis of the mitral valve (mitral regurgitation) and, less frequently, of the aortic valve (aortic regurgitation)^{143–145}. Cardiomegaly occurs when there is moderate or severe valvular regurgitation. Since publication of the previous Jones Criteria in 1992, new data have been published on the use of Doppler echocardiography in diagnosing cardiac involvement in ARF^{145–149}. On the basis of these results, echocardiographic evaluation for all patients who are suspected of having ARF is a new recommendation that has been included in the 2015 Jones Criteria. Both clinical and subclinical carditis fulfil a major criterion, even in the absence of classical auscultatory findings¹ (FIGS 10,11).

Chorea occurs in up to 30% of those who have ARF. It is characterized by involuntary and purposeless movements of the trunk, limbs and face. Chorea may

also present on its own without other features of ARF and without evidence of a recent streptococcal infection. In this scenario, it is important to exclude other potential causes of chorea including drug reactions, systemic lupus erythematosus, Wilson disease and other diseases, and to carry out an echocardiogram because chorea is strongly associated with carditis.

The 2015 revision of the Jones Criteria was undertaken by the American Heart Association in response to emerging data regarding differences in presentation of ARF between low- and moderate–high-risk cohorts. Moderate–high risk is defined as coming from a population with an ARF incidence of >2 per 100,000 school-aged children per year or an all age RHD prevalence of >1 per 1,000 people per year. In moderate–high risk populations, monoarthritis in addition to the more classic polyarthritis can fulfil a major manifestation¹. This

Table 1 | Genetic polymorphisms of immune response-related genes associated with ARF and RHD

Gene	Polymorphism	Effect of polymorphism	Population	Refs
MBL2	-221 X,Y (promoter, exon 1) A (52C, 54G, 57G), O (52T, 54A, 57A)	High production of mannose-binding protein	Brazilian	55
	A (52C, 54G, 57G), O (52T, 54A, 57A)	Low level of MBL2 in sera	Brazilian	56
FCN2	-986G>A, -602G>A, -G>A (promoter)	Low levels of FCN2	Brazilian	57
TLR2	2258A>G (exon 3), resulting in 753 Arg>Gln	Low level of pathogen recognition	Turkish	58
FCGR2A	494A>G (exon 4), resulting in 131 His>Arg	Low ability of receptor to bind human IgG2	Turkish	59
IL1RN	Variable number of tandem repeats A1, A2 A3, A4 (intron 2)	Low level of receptor expression	Egyptian and Brazilian	60,61
TNF	-308G>A (promoter)	T _H 1 and T _H 2 imbalance	Mexican, Egyptian and Brazilian	60,62, 63
	-238G>A (promoter)	High production of TNF	Turkish, Mexican and Brazilian	63,64
TGFB1	-509C>T (promoter)	T _H 1 and T _H 2 imbalance	Egyptian	65
	-509C>T (promoter)	Protection from developing RHD	Chinese	66
	869T>C (exon 1), resulting in 10 Leu>Pro	Association with elevated serum TGFβ1	Egyptian	65
IL10	-1082G>A (promoter)	T _H 1 and T _H 2 imbalance	Egyptian	60
CTLA4	49A>G (exon 1)	Transmits an inhibitory signal to T cells	Turkish	67
HLA class II	Diverse HLA-DR alleles located at short arm of chromosome six at DRB1 gene, including DR1, DR2, DR3, DR4, DR5, DR6, DR7 and DR9	Antigen recognition and antigen presentation to T cells; activation of humoral and cellular immune responses	Several ethnic populations	68–81

ARF, acute rheumatic fever; CTLA4, cytotoxic T lymphocyte-associated protein 4; FCGR2A, Fc fragment of IgG low-affinity IIa receptor; FCN2, ficolin 2; HLA, human leukocyte antigen; IL10, interleukin-10; IL1RN, interleukin-1 receptor antagonist; MBL2, mannose-binding lectin protein C 2; RHD, rheumatic heart disease; TGFB1, transforming growth factor β1; T_H, T helper; TLR2, Toll-like receptor 2; TNF, tumor necrosis factor.

change is meant to increase the sensitivity of the criteria in areas where ARF remains endemic^{24,150,151} and to maintain high specificity in low-risk areas. These modifications were previously reflected in the Australian and New Zealand guidelines, which allow for less-stringent findings among those at greatest risk^{152,153}. In many high-risk tropical areas, acute onset arthritis and fever can be caused by arboviral infections such as dengue, chikungunya and Ross River fever. These infections are important and common differential diagnoses for ARF. The risk of overdiagnosis of ARF can be reduced by testing for these and other arboviral infections if possible, ensuring that streptococcal serology is positive when making a diagnosis of ARF (preferably by comparing acute and convalescent titres) and by completing a full work-up for ARF that includes an echocardiogram.

Patients might present with established RHD rather than ARF. This is very common in resource-poor settings in which patients frequently present with late-stage RHD. For example, in a cohort of 309 patients with RHD in Uganda, none had a previous history of ARF¹⁵⁴. The presentation with *de novo* RHD is most often associated with symptoms of cardiac failure, although patients might also present with embolic stroke, infective endocarditis or arrhythmia (atrial fibrillation). There is evidence that

RHD contributes to sudden cardiac death, probably as a result of cardiac arrhythmia¹⁵⁵. RHD might also be diagnosed when a heart murmur is detected as part of routine care. Diagnosis of RHD in pregnant women is of particular importance because these patients present challenging issues in their management.

Prevention

Primordial prevention. Primordial prevention involves prophylactic strategies to avoid GAS infection. ARF is triggered by GAS pharyngitis and the GAS transmission is facilitated by close contact between people. Thus, living conditions, knowledge regarding the importance of a sore throat caused by GAS and an understanding of the mechanisms of transmission are integral, both for the lay public and for health professionals, to the control of ARF. Studies carried out in Baltimore in a low-resource inner city area outlined how the alleviation of household crowding could reduce the incidence of ARF independent of ethnic group¹⁵⁶. Older ecological studies in the British army showed that bed spacing in crowded barracks was crucial to the control of ARF¹⁵⁷. More recent studies lack analysis of the relative importance of primordial factors. However, in New Zealand, a developed country in which ARF clusters in poorer sections

of the population, there is a clear association between ARF and socioeconomic deprivation. This association is shown using the New Zealand Deprivation Index, which combines 9 variables from the most recent national census including income, education, employment, accommodation and access to car and/or telephone¹⁵⁸.

Primary prevention. Primary prevention aims to stop a GAS infection from causing ARF. ARF is preventable with appropriate healthcare by treating the preceding GAS pharyngitis with antibiotics (primary prophylaxis). As many cases of GAS pharyngitis might be asymptomatic or cause only a mild sore throat, primary prophylaxis is only possible when a patient has symptoms of a sore throat that are sufficient to lead them to seek medical attention². This presentation relies on access to healthcare with the knowledge, both on the part of the general population and the healthcare professionals, that treating a sore throat is important for ARF prevention. High-quality studies on the control of ARF through healthcare interventions such as use of long-acting depot penicillin, which is a slow-release formulation of penicillin delivered by injection, were carried out soon after penicillin became available in the United States armed forces, in which ARF was occurring at very high rates². Community-based studies are, by their nature, less rigorous and have suggested that widespread sore throat diagnosis and treatment might be effective in reducing ARF incidence in developing and developed countries, although it has yet to be definitively determined that primary prophylaxis alone will significantly reduce the incidence of ARF^{114,159,160}. A randomized controlled

trial (RCT) in New Zealand of a school-based sore throat intervention involving approximately 22,000 students determined the efficacy of active sore throat surveillance accompanied by throat swab confirmation and antibiotic treatment of GAS-positive cases. Although this trial found a 28% reduction in ARF incidence in schools in which intervention had taken place, this result failed to reach statistical significance ($P=0.27$)¹⁶¹. A large-scale effectiveness evaluation of this intervention is underway in New Zealand and might provide definitive evidence of the potential for primary prophylaxis to reduce ARF incidence at a population level.

In the vast majority of published studies on primary prevention interventions, throat swabbing was not used to separate GAS pharyngitis from the more common viral pharyngitis. Rather, most of those who presented at clinics were treated with injectable long-acting penicillin. Clinical algorithms for better precision to avoid unnecessary antibiotic treatment for a viral pharyngitis have poor prediction¹⁶². Thus, culture of a throat swab, when it is possible to do so, is the best way to accurately diagnose GAS pharyngitis and to target antibiotic treatment to patients whose sore throat is caused by a GAS infection in order to prevent ARF.

The persistence of a pharyngeal GAS is an important risk factor for the development of ARF following an acute pharyngitis episode¹⁶³. Early studies found that eradication of the microorganism can be achieved using injectable benzathine penicillin and subsequent studies have showed that satisfactory rates of eradication can also be achieved using 10 days of oral penicillin twice a day or 10 days of oral amoxicillin once a day^{164–166}.

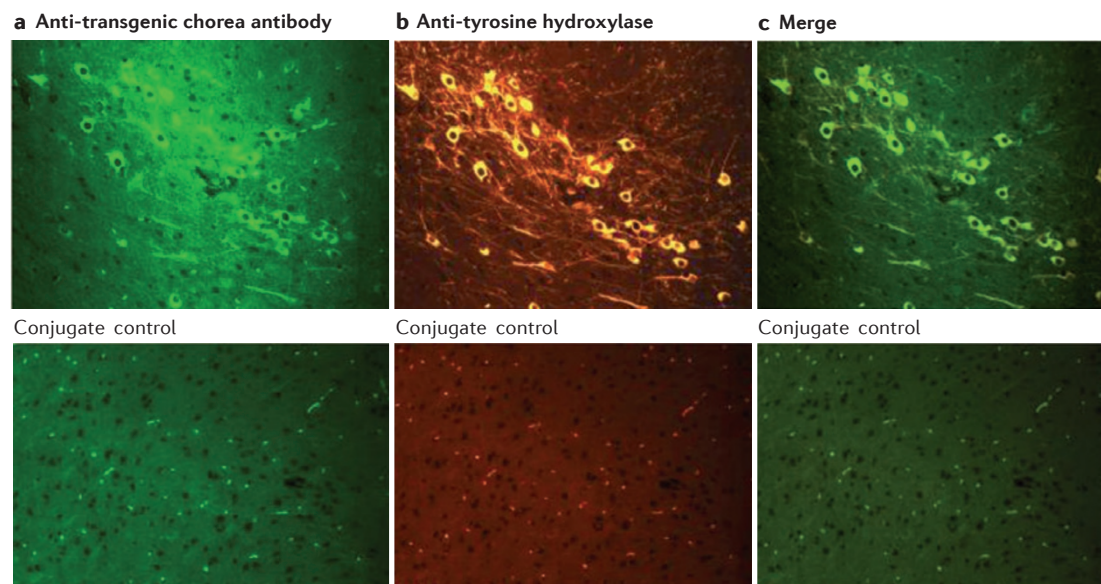


Figure 7 | Localization of Sydenham's chorea-derived antibodies and tyrosine hydroxylase in the brains of transgenic mice. Transgenic mice are shown in which genes encoding variable segments of a human monoclonal antibody derived from a patient with Sydenham's chorea are expressed. The resulting antibodies target the dopaminergic neurons in these mice, showing that these antibodies cross the blood–brain–barrier to target the neurons. **a** | Antibody penetration of basal ganglia and neurons in the substantia nigra or ventral tegmental area. Neurons are stained in green with an antibody specific for the transgenic chorea IgG1a antibody. **b** | Dopaminergic neurons are labelled in red using a tyrosine hydroxylase-specific antibody. **c** | Merged frames show the transgenic chorea antibodies target cells that express tyrosine hydroxylase. Magnification 20×. Images are reproduced, with permission, from REF. 32 © (2014) Taylor & Francis.

In order to reduce the risk of development of ARF, treatment of GAS pharyngitis must be initiated within 9 days of onset of a sore throat^{2,156}. There are different reasons for choosing one of each of these three modalities. Use of other antimicrobial drugs is not supported; broad-spectrum antibiotics are more expensive and, in the face of increasing resistance, not indicated for the majority of presentations. In some tropical areas where ARF is common, GAS carriage and GAS pharyngitis seem to be less common than in temperate areas, but impetigo (a superficial skin infection that results in sores and crusting) caused by GAS occurs at very high levels¹⁶⁷. In New Zealand, the GAS isolates associated with ARF come from classically skin-associated *emm* types and *emm* cluster types^{168,169}. These observations, and other data, have led to the hypothesis that GAS impetigo might contribute to the pathogenesis of ARF^{46,167}, but no definitive link has been found between the two conditions and no studies on the treatment of GAS impetigo for primary prevention of ARF have been carried out.

Secondary prevention. The importance of secondary penicillin prophylaxis for prevention of recurrent ARF and progressive RHD cannot be overemphasized. This strategy has been proven in RCTs to prevent recurrence of ARF¹⁷⁰ and remains the single most important step of management of ARF. Intramuscular benzathine penicillin (BPG) is superior to oral penicillin. There is strong evidence that secondary prophylaxis reduces the severity of RHD by preventing disease progression^{171,172}. Studies carried out in the mid-twentieth century showed that 40–60% of patients with ARF progress to RHD^{173–175} and that the rate of regression of mitral regurgitation increased from 20% to 70% after penicillin was introduced¹⁷³. More recently, Lawrence and colleagues¹⁰ studied 1,149 children with ARF (27.5% these children presented with carditis)

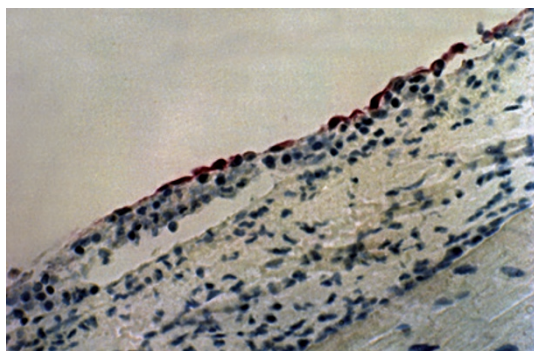


Figure 8 | Expression of VCAM1 by the valvular endothelium. Immunohistochemistry of the valvular endothelium in the context of acute rheumatic fever and valvulitis is shown. Vascular cell adhesion protein 1 (VCAM1) has been labelled with a VCAM1-specific monoclonal antibody (mAb) (red). The VCAM1-specific mAb reacted with the rheumatic valvular endothelium but not with the normal valve (not shown). That is, the antibody to anti-VCAM1 is conjugated to alkaline phosphatase and developed with fast red indicated binding of the antibody to VCAM1. Original magnification 400 \times . Image is modified, with permission, from REF. 85 © (2001) Oxford Journals.

in the Northern Territory, Australia, and reported that 35% of children with ARF developed RHD by 1 year and 61% had evidence of RHD by 10 years¹⁰. Of children that progressed to RHD, 14% showed heart failure at 1 year and 27% had heart failure at 5 years. In a multivariate analysis, the only factor found to be strongly associated with RHD incidence was age at first ARF episode (risk decreased by 2% per year of age). There was a suggestion that the risk of developing RHD after an ARF diagnosis was higher for Indigenous than for non-Indigenous people and for female than for male patients, but the confidence intervals for both hazard ratios included 1.0, which implies that there was no definitive evidence of difference in RHD risk between the groups.

Lue and colleagues¹⁷⁶ reported that patients receiving penicillin every fourth week, compared with those who received it every third week, were more likely to have undetectable serum penicillin levels between doses and were fivefold more likely to have prophylaxis failure¹⁷⁶. However, contemporary data from New Zealand showed that ARF recurrences were rare among people who were fully adherent to a 4-weekly BPG regimen — the rate of ARF recurrence in fully adherent individuals on a 28-day regimen was 0.07 cases per 100 patient years. Failure on the prophylaxis programme (that is, recurrence of ARF, including in those who were less than fully adherent) was 1.4 cases per 100 patient years¹⁷⁷. Patients without auscultation evidence of carditis are still at considerable risk of developing RHD. In one study, the prevalence of subclinical carditis following the first episode of ARF was 18% and half of the patients had persistence or deterioration of disease 2–23 months later¹⁷⁸. Studies by Araujo and colleagues¹⁷⁹ and Pekpak and colleagues¹⁸⁰ reported that the proportion of patients with subclinical ARF who had persistence of carditis at least 1 year later was 72% and 55%, respectively.

Efforts to optimize compliance with penicillin and to ensure a safe and adequate supply of the drug are crucial components of secondary prophylaxis¹⁸¹. Non-adherence to penicillin was strongly associated with recurrent ARF in a 2010 Brazilian study¹⁸². Many patients with RHD who live in developing countries seek medical attention too late to benefit from secondary prevention. For instance, one study found that Ugandan patients with RHD ($n = 309$) had a mean age of 30 years (range 15–60 years) and 85% had cardiovascular symptoms at initial presentation¹⁵⁴. In addition, half of these patients had severe complications including heart failure, atrial flutter and/or fibrillation, pulmonary hypertension and stroke. None had ever been diagnosed with ARF or taken penicillin. Mitral stenosis is also more common at initial presentation in the developing world¹⁸³.

The appropriate duration of secondary prophylaxis depends on several factors. These include the time elapsed since the last episode of ARF (ARF recurrences occur more commonly in the first 5 years since the last episode)¹⁷⁷, age (ARF recurrence is less common after the age of 25 years and uncommon after the age of 30 years)¹⁷⁷, the presence or absence of carditis at presentation and the severity of RHD at follow-up, and the environment (particularly the likelihood of ongoing

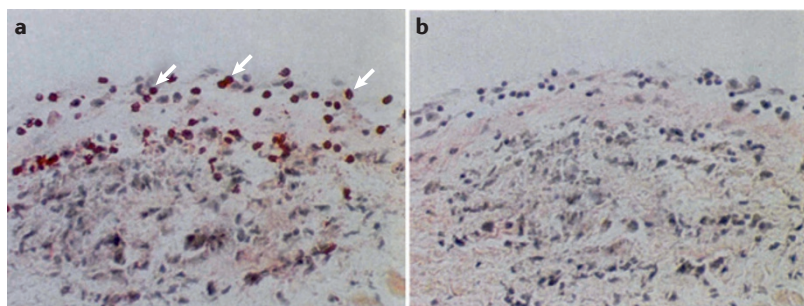


Figure 9 | Immunohistochemistry of infiltration of CD4⁺ T cells into the valve of the left atrium in ARF. In acute rheumatic fever (ARF), CD4⁺ T cells cross the valvular endothelium and infiltrate into the subendocardium, where they are involved in the formation of Aschoff's bodies. **a** | An Aschoff body, with CD4⁺ T cells in the valve (red, indicated with arrows) labelled with a primary monoclonal antibody against CD4, secondary antibody against human IgG and fast red. **b** | An IgG1 isotype control did not react with the rheumatic valve. CD4⁺ T cells are stained with the CD4-specific mAb, a secondary antibody conjugated to alkaline phosphatase and development with fast red to detect antibody binding to CD4⁺ T cells. Magnification 200 \times . Image is modified, with permission, from REF. 87 © (2001) American Society for Microbiology.

exposure to GAS such as having young children in the household). On the basis of these factors, the recommended duration of secondary prophylaxis is usually for a minimum of 10 years after the most recent episode of ARF or until age 18–21 years (whichever is longer)¹⁸⁴. Recent guidelines recommend that those with moderate RHD continue prophylaxis until age 30–35 and those with severe RHD continue until age 40 (REFS 184, 185).

Screening for RHD

Developing an effective screening strategy that could bridge the gap between the large number of patients with RHD who would benefit from secondary prophylaxis and the relatively small proportion of those who have a known ARF history has the potential to result in significant reduction of disease morbidity and mortality. Portable echocardiography machines have made large-scale field echocardiography screening possible, even in remote settings. Multiple studies of school-aged children have shown a significant (fivefold to fiftyfold) increase in detection of RHD by echocardiography screening compared with auscultation^{186–195}. The prevalence of RHD in these studies ranged from 8–57 out of 1,000 children screened; if all of these cases represented true RHD, the disease might affect 62–78 million people worldwide and cause up to 1.4 million annual deaths¹⁹⁶. Beaton and colleagues¹⁹² found associations between lower socioeconomic status and older age with higher RHD prevalence. No patients with screening-detected RHD recalled a history of ARF, underscoring the importance of screening as perhaps the only tool for early case detection in settings in which ARF is uncommonly diagnosed and RHD presentations occur late in the illness. The World Heart Federation (WHF) published standardized screening guidelines in 2012 for the use of echocardiography without auscultation¹⁹⁷. Using the WHF criteria, no definite RHD cases were found in a low-risk group of Australian children and borderline RHD was more common in high-risk than in low-risk children, suggesting that definite RHD

is likely to represent true disease and borderline RHD includes many children with true RHD¹⁹⁸.

Smartphone-size hand-held echocardiography (HHE) offers hope for more efficient, mobile and cost-effective screening. Beaton and colleagues¹⁹⁹ reported that HHE was highly sensitive and specific for distinguishing between healthy individuals and those with RHD in a retrospective study of 125 Ugandan patients¹⁹⁹. Moreover, HHE had good sensitivity (79%) and specificity (87%) for RHD detection, being most sensitive for definite RHD (97.9%) in a large prospective study of 1420 children in four schools in Gulu, Uganda²⁰⁰.

Although few would argue against putting those with definite RHD on prophylaxis, management of borderline patients is unclear, given the risks associated with penicillin and the stigma of being labelled with a chronic disease²⁰¹. The population of patients with borderline RHD is heterogeneous and includes patients who are likely to have physiological mitral regurgitation and patients who are likely to develop progressive carditis²⁰². There are no long-term follow-up data regarding this patient population. In four studies looking at short-term follow-up, 331 patients with subclinical RHD were followed for 4–27 months^{186,188,203,204}. Approximately two-thirds of patients had no change and one-third had improvement or resolution. One study found disease progression in 10% of cases¹⁸⁸. There was insufficient data on secondary prophylaxis or recurrence but one study that used prophylaxis for all patients found no disease progression²⁰⁴.

Training frontline medical personnel is necessary for better access to screening. In Fiji, echocardiographic screening by two nurses had good sensitivity and specificity in detecting mitral regurgitation²⁰⁵. Screening children who do not attend school, older children and young adults²⁰⁶, and pregnant woman¹⁴ might yield an even higher burden of disease. Studies are needed to determine if echocardiography screening can be cost effective¹⁹⁶. A study using a Markov model found that echocardiography screening and secondary prophylaxis for patients with early evidence of RHD might be more cost effective than primary prophylaxis²⁰⁷.

A public health approach that combines multiple modalities could result in a highly sensitive and specific screen that is affordable and could greatly affect resource allocation for prevention of ARF. The addition of biomarkers to echocardiography screening programmes, such as B-type natriuretic peptides and antibodies against *Streptococcus* spp., that are specific for cardiac involvement and immunological assays might result in more specific and sensitive screening programmes.

Management

ARF

High suspicion in geographic areas where ARF is endemic is vital. In any child or young person with an acutely painful and swollen joint, ARF should be considered in addition to septic arthritis and injury as well as rarer causes of their symptoms. Use of NSAIDs might mask the usual progression from this initial disease stage to polyarthritis, which is a hallmark of ARF. The major priority in the first few days after presentation with ARF

Table 2 | The Jones Criteria 2015 for the diagnosis of rheumatic fever

Criteria	Patient population*	Manifestations
Major	Low risk [†]	<ul style="list-style-type: none"> • Carditis[§] (clinical and/or subclinical[§]) • Arthritis (polyarthritis only) • Chorea • Erythema marginatum • Subcutaneous nodules
	Moderate and high risk	<ul style="list-style-type: none"> • Carditis (clinical and/or subclinical) • Arthritis (including monoarthritis, polyarthritis or polyarthralgia) • Chorea • Erythema marginatum • Subcutaneous nodules
Minor	Low risk [†]	<ul style="list-style-type: none"> • Polyarthralgia • Fever (≥ 38.5 °C) • An ESR of ≥ 60 mm per hour and/or CRP of ≥ 3.0 mg per dL • Prolonged PR interval, after accounting for age variability (unless carditis is a major criterion)
	Moderate and high risk	<ul style="list-style-type: none"> • Monoarthralgia • Fever (≥ 38 °C) • An ESR of ≥ 30 mm per hr and/or CRP of ≥ 3.0 mg per dL • Prolonged PR interval, after accounting for age variability (unless carditis is a major criterion)

As in the past Jones Criteria versions, it should be recalled that erythema marginatum and subcutaneous nodules are rarely 'stand alone' major criteria. In addition, joint manifestations can only be considered in either the major or minor categories but not both in the same patient. ARF, acute rheumatic fever; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; RHD, rheumatic heart disease. *For all patient populations with evidence of preceding group A *Streptococcus* infection, diagnosis of initial ARF requires two major manifestations or one major plus two minor manifestations. Diagnosis of recurrent ARF requires either two major manifestations, one major and two minor manifestations or three minor manifestations. [†]Annual ARF incidence of ≤ 2 per 100,000 school-aged children or all age RHD prevalence of ≤ 1 per 1,000 people per year. [§]Defined as echocardiographic valvulitis. ^{||}Polyarthralgia should only be considered as a major manifestation in moderate and high risk populations after exclusion of other causes. [¶]CRP value must be greater than the normal laboratory upper limit. In addition, as the ESR might evolve during the course of ARF, peak ESR values should be used.

is confirmation of the diagnosis. Ideally, all patients with suspected ARF should be hospitalized, primarily for an echocardiogram and other investigations as needed, such as a needle aspiration of the joint if septic arthritis is a possibility, inflammatory markers and a search for a preceding streptococcal throat infection (preferably by measuring streptococcal titres). A search for other causes of polyarthritis that are dependent on the geographic area, for example arboviral infections in the tropics, might be helpful if the echocardiogram remains normal for 3 weeks or more after the initial presentation. Hospitalization also provides an ideal opportunity for education about ARF, especially the need for secondary prophylaxis. The priorities in management of ARF relate to eradication of GAS from the throat, symptomatic treatment of arthritis and/or arthralgia and management of carditis and/or heart failure (BOX 3).

To reliably eradicate GAS²⁰⁸, intramuscular BPG as a single dose or a full 10 days of oral penicillin or amoxicillin should be given. The first dose of intramuscular BPG should also be given in hospital in association with education about the importance of secondary prophylaxis, as the majority of patients are children²⁰⁹. Controlled studies have failed to show that treating ARF with penicillin affects the outcome of rheumatic valvular lesions 1 year later^{210,211}.

In the pre-penicillin era, prolonged bed rest in those with rheumatic carditis was associated with shorter duration of carditis, fewer relapses and less cardiomegaly²¹². In the absence of contemporary studies, ambulation should be gradual and as tolerated in patients with severe acute valve disease, especially during the first 4 weeks, or until the serum C-reactive protein level has normalized and the erythrocyte sedimentation rate has normalized or significantly reduced. Those with milder or no carditis should only remain in bed as long as necessary to manage arthritis and other symptoms¹⁵³.

Carditis. Long-term morbidity and mortality from ARF are mainly due to RHD, which in turn is mostly a function of the extent of acute cardiac involvement of ARF and the incidence of subsequent episodes of recurrent ARF. Corticosteroids reduce the inflammatory markers of ARF, especially fever and elevated acute phase reactants and are widely used in severe acute carditis with heart failure, even though there is little objective data to prove that they augment the usual strategies such as bed rest, fluid restriction and cardiac medications^{213,214}. There is no evidence that corticosteroid use alters the severity of chronic valvular heart disease 1 year after ARF^{213,214}. However, previous studies of corticosteroid therapy for the treatment of ARF were mainly carried out in the 1950s and 1960s, before the advent of echocardiography²¹³⁻²¹⁵. Valvular outcomes, which were primarily based on the presence of an apical systolic murmur, at 12-month follow-up were not significantly improved and inflammation tended to rebound once steroid therapy was withdrawn. Despite this, corticosteroids are frequently used to treat severe carditis around the world^{215,216}. Intravenous immunoglobulin has been used in a RCT treatment study of ARF but no benefit was shown²¹⁶. There are no reliable data to support the use of other inflammatory modulators.

There is a strong argument for the need to carry out a multicentre RCT of corticosteroids versus placebo for ARF using echocardiographic end points for acute carditis (at 6 weeks) and chronic valvular disease (at 6 months to 1 year)²¹⁴. Such a study would need to be powered to account for the natural improvement of carditis after the acute phase²¹⁶ but would provide an evidence-based approach to corticosteroid therapy for active rheumatic carditis. Similar multicentre studies of other immunomodulators, informed by an expanded understanding of ARF immunopathogenesis, could eventually be considered but there is no role for small, underpowered studies²¹⁷.

Heart failure. An urgent echocardiogram and cardiology assessment are recommended for all patients with heart failure. Diuretics and fluid restriction are the mainstay of treatment. Angiotensin-converting enzyme (ACE) inhibitors are recommended for some patients with aortic regurgitation²⁰⁹. ACE inhibitors improve haemodynamics by increasing cardiac output in patients with aortic regurgitation. They are indicated if there are symptoms or if there is left ventricular dysfunction, but should not be a substitute for surgery²¹⁸.

Cardiac surgery is usually deferred until the acute inflammation has subsided so that the repair is technically easier and a more durable repair can be achieved. Rarely, chordae tendinae rupture leads to a flail leaflet, by which the unsecured section of the valve results in severe regurgitation and acute pulmonary oedema owing to a rapid rise in left atrial pressure. This condition is often misdiagnosed as pneumonia as the pulmonary venous congestion is often unilateral. Such cases require emergency life-saving surgery to repair the flail leaflet²¹⁹. Even in the absence of a flail leaflet, urgent surgery might be indicated owing to torrential mitral or aortic regurgitation or both. The philosophy for cardiac surgery in the young should always be to repair rather than to replace the mitral valve²²⁰. A recent retrospective report of 81 patients aged 3–19 years showed not only lower morbidity (less endocarditis and no thromboembolism) for repairs but also that the need for reoperation was not increased compared with the mitral valve replacement group¹⁹⁷.

Sydenham's chorea. Sydenham's chorea can be self-limiting with resolution within weeks to months but some case series report the persistence of symptoms beyond 2 years²²¹. Mild or moderate chorea does not require any specific treatment, aside from rest and a calm environment.

As chorea is often benign and self-limiting and medications against chorea medications are potentially toxic, treatment should only be considered if the movements interfere substantially with normal activities, place the person at risk of injury or are extremely distressing to the patient, their family and their friends²⁰⁹. Aspirin therapy has no significant effect on rheumatic chorea²¹². Valproic acid and carbamazepine are now preferred to haloperidol, which was previously considered to be the first-line medical treatment for chorea^{222,223}. Valproic acid enhances neurotransmitters and stabilizes mood, and carbamazepine is a benzodiazepine anti-convulsant and analgesic. A small, prospective comparison of these three agents concluded that valproic acid was the most effective²²⁴. However, because of the small potential for liver toxicity with valproic acid, it is recommended that carbamazepine be used initially for severe chorea requiring treatment and that valproic acid be considered for refractory cases²⁰⁹. Recent evidence from case series, a retrospective analysis and a single RCT suggest that corticosteroids can reduce symptom intensity and the time to remission in chorea, therefore short courses of prednisolone treatment can be considered for severe or refractory cases^{93–98}. The onset of chorea during pregnancy (chorea gravidarum) can be caused by ARF but there are many other causes of chorea that begin in pregnancy.

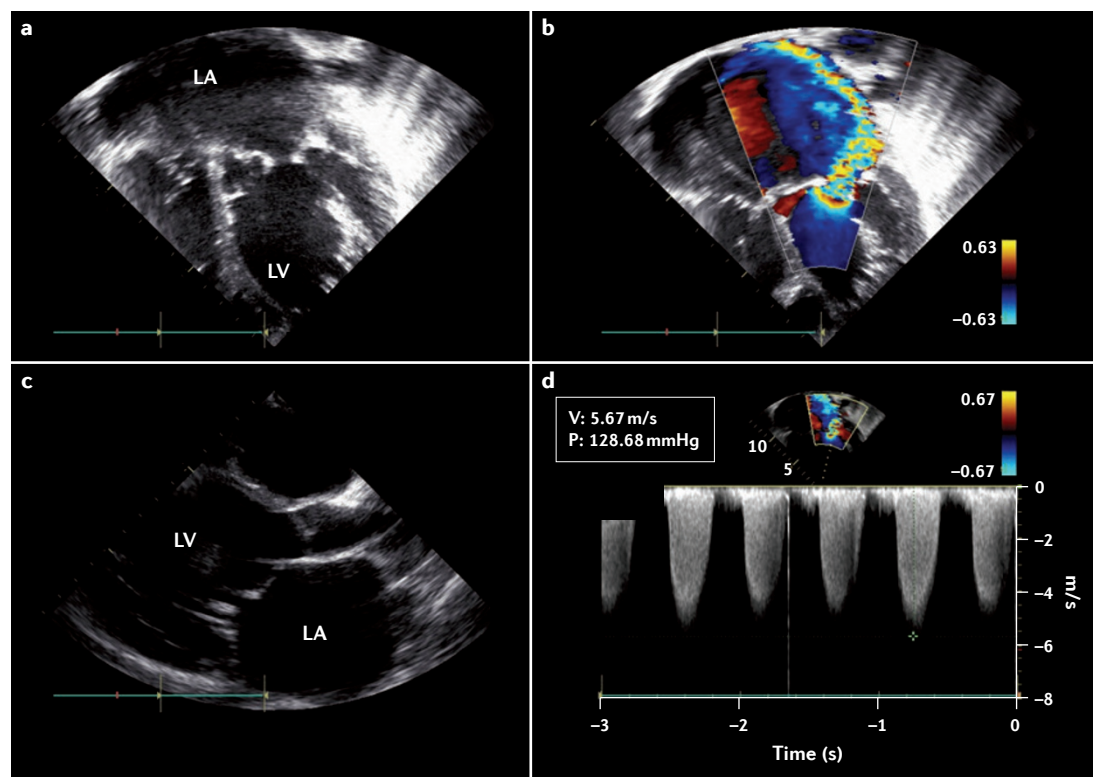


Figure 10 | Echocardiogram from child with severe mitral regurgitation. This echocardiogram was produced as part of an echocardiography screening programme. **a** | Apical four-chamber view in black and white Doppler. **b** | Apical four-chamber view in colour Doppler. The colour jet extends to the back of the left atrium. **c** | A parasternal long-axis view. The mitral valve is thickened with excessive leaflet tip motion and lack of coaptation. The left atrium is severely dilated and the left ventricle is moderately dilated. **d** | Pan-systolic spectral Doppler of mitral regurgitation. LA, left atrium; LV, left ventricle; P, pressure; V, volume.

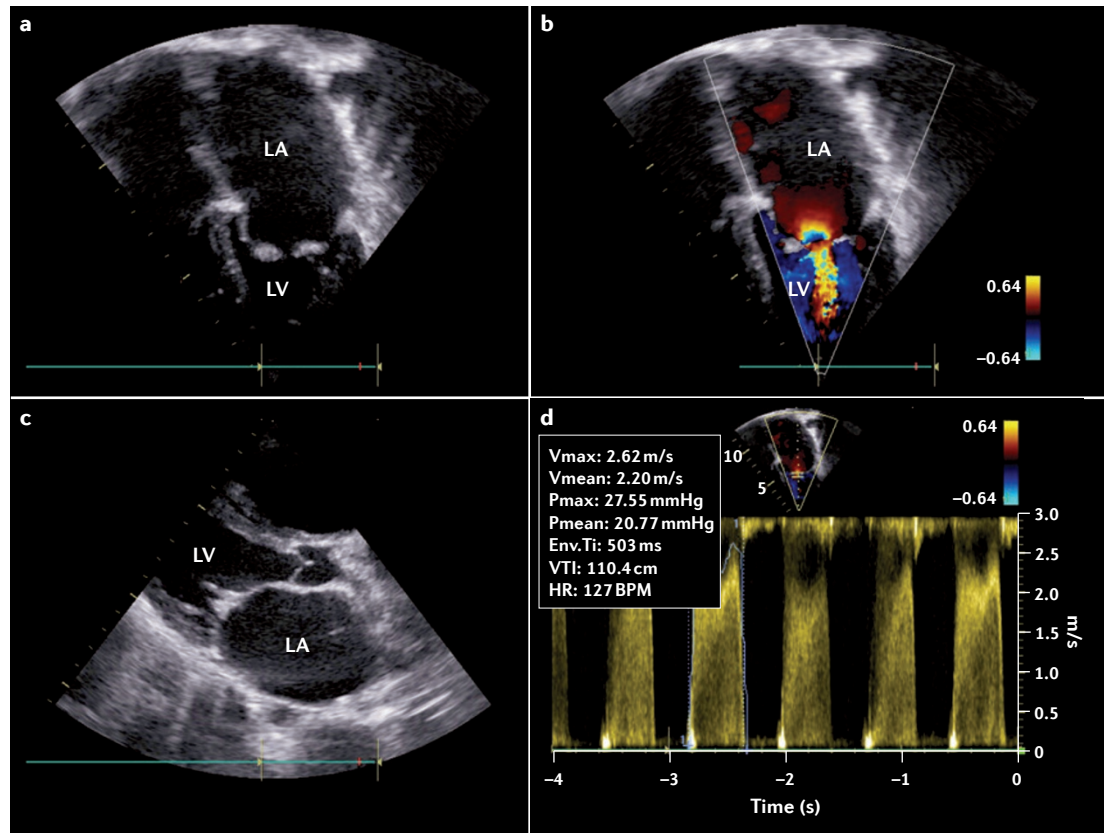


Figure 11 | **Echocardiogram from child with severe mitral stenosis.** This echocardiogram was produced as part of an echocardiography screening programme. **a** | Apical four-chamber view in black and white Doppler. **b** | Apical four-chamber view in colour Doppler. The colour jet reveals turbulence in diastole. **c** | A parasternal long-axis view. The mitral valve is thickened with limited motion and the chordae are thickened and fused. The left atrium is severely dilated. **d** | Pan-diastolic spectral Doppler of with severe mitral stenosis mean gradient (mean 21 mmHg). Env. Ti, envelope time; HR, heart rate; LA, left atrium; LV, left ventricle; Pmax, maximum pressure gradient; Pmean, mean pressure gradient; Vmax, maximum velocity; VTI, velocity time integral.

Arthritis. The pain of mild arthritis or arthralgia and fever might respond to paracetamol alone, which should be used if the diagnosis is not confirmed (as early use of NSAIDs might mask the evolution of the typical migratory polyarthritis). This is particularly important in areas in which echocardiography is unavailable, as the typical evolution of migratory polyarthritis is a hallmark of ARF. Aspirin has been the mainstay of treatment for decades, although published evidence also supports naproxen as an alternative for control of the arthritis of ARF. There is no similar published evidence for the use of other NSAIDs, although expert opinion supports the use of ibuprofen and this, as well as other NSAIDs and paracetamol, are recommended in guidelines for first-line treatment of arthritis pain²⁰⁹. Naproxen has similar analgesic potency as aspirin but, unlike aspirin^{225,226}, does not have the risk of the rare complication of Reye's syndrome, which is associated with multiorgan failure when aspirin is used to treat in viral infections in children. Aspirin and NSAIDs quickly control joint symptoms so they should be stopped as quickly as possible — while acknowledging that there is sometimes a need to prolong treatment somewhat to avoid 'rebound' joint symptoms on weaning — as there is no evidence that they have an influence on carditis.

Erythema marginatum and subcutaneous nodules. Erythema marginatum and subcutaneous nodules are painless and transient manifestations. There is no specific treatment for either but local treatment might be required for ulceration that might rarely occur when the skin overlying the nodules is damaged.

RHD

Best practice RHD care involves secondary prevention with penicillin prophylaxis, timely reviews by a specialist experienced in RHD management, access to echocardiography to serially assess left ventricular function and valve function, adequate monitoring of anticoagulation therapy in patients with atrial fibrillation and/or mechanical prosthetic valves, access to oral healthcare and timely referral for heart surgery²⁰⁹.

The fundamental goals of long-term management of RHD are to prevent ARF recurrences (which lead to the progression of valve disease) and to monitor left ventricular size and function. In many patients with mild or moderate RHD, in which the left ventricle is not at risk of failing, resolution of RHD is observed over time^{227–229}. By contrast, in those with severe RHD, disease might progress owing to the irreversible damage of the valves.

This damage leads to impaired left ventricular function as a result of longstanding left ventricular overload, even without recurrences of ARF. Echocardiography has become an essential tool for grading the severity of valvular disease and for assessing left ventricular size and systolic function. Mitral stenosis usually occurs many years after the initial episode of ARF. The pathogenesis and progression of stenosis with valvular, subvalvular fibrosis and calcification is often associated with silent ARF recurrences causing symptoms before the age of 20 years²³⁰.

Pregnancy and childbirth. Ideally, women with known RHD should have a complete cardiac assessment before pregnancy¹⁴². In women who are already symptomatic with considerable RHD, consideration should be given to cardiac surgery before pregnancy to avoid severe morbidity or even mortality as a result of the physiological changes of pregnancy on cardiac work. Mitral stenosis is particularly hazardous. Percutaneous balloon mitral valvotomy may be considered in women with anything more than mild mitral stenosis.

Women with moderate and severe RHD are at risk of obstetric complications such as preterm delivery and fetal complications such as fetal growth restriction. Cardiac complications can be compounded if pregnancy disorders such as pre-eclampsia or obstetric haemorrhage develop. Pregnant women with RHD should ideally be under the care of a multidisciplinary team with an obstetrician in collaboration with a cardiologist and/or an obstetric physician. Women with severe RHD should have their delivery at a referral centre that has onsite cardiology and intensive-care facilities.

Anticoagulation. Warfarin, a vitamin K antagonist, is the drug of choice for anticoagulation for patients with prosthetic heart valves, including those with both RHD and non-rheumatic valve disease. As the absorption of warfarin is affected by diet, the international normalized ratio must be measured on a regular basis with adjustments of the dose as required. Newer anticoagulants have been developed that dose-dependently inhibit thrombin or activated factor X (such as dabigatran), but the efficacy and the safety of these newer agents are still being studied in patients with prosthetic valves and these agents are currently not recommended for use in this situation²⁰⁹. Anticoagulation is also indicated for those who develop atrial fibrillation.

Infective endocarditis. Although the American Heart Association guidelines no longer list RHD as an indication for antibiotic prophylaxis to prevent infective endocarditis, in other regions of the world where RHD and endocarditis are common, it is recommended that persons with established RHD or prosthetic valves should receive antibiotic prophylaxis before procedures expected to produce bacteraemia, especially for *Viridans streptococci*^{142,209,231}. Individuals who have a history of ARF but no valvular damage do not require antibiotic prophylaxis²⁰⁹.

Indications for cardiac surgery. Referral for cardiac surgery is indicated in adults with severe mitral regurgitation, severe aortic regurgitation or severe mitral stenosis²¹⁸. Specific indications are evidence-based²¹⁸; valve regurgitation is assessed on the basis of symptoms and left ventricular size, and mitral stenosis is assessed on the basis of symptoms and valve gradient. Concomitant valve surgery for tricuspid regurgitation might be required. The body of evidence for the threshold for cardiac surgery in children is minimal compared with the adult literature and is mainly based on published experience from New Zealand^{220,232–235}. If the valve is judged to have a high likelihood of repair, surgery can be recommended for moderate to severe mitral regurgitation with normal left ventricular size and function.

Mitral valve repair is the operation of choice for mitral regurgitation because of lower mortality and morbidity²³⁶. In adults, mitral valve repair has a higher reoperation rate than replacement²³⁷. When it is considered feasible to offer further surgery in the future, repair avoids the potentially fatal consequences of thromboembolism with a prosthetic valve²³⁸. If the mitral valve is not suitable for repair, the option is valve replacement with either a mechanical valve prosthesis or a bioprosthetic valve. Women of childbearing age who are planning a pregnancy should be offered a bioprosthetic valve rather than a prosthetic valve, even though the reoperation rate will be higher, because the risk of warfarin to the fetus and the risk of heparin regimens to the patient remain high²³⁹.

In most cases, referral for cardiac surgery or valvuloplasty is indicated for severe disease with symptoms and increasingly for asymptomatic disease with evidence of moderate to severe disease (TABLE 3). An exercise test

Box 3 | Priorities in management of ARF

Key management priorities in acute rheumatic fever (ARF) and the main actions used to address them include:

Diagnosis

- Hospitalization for assessment and investigations, including echocardiography, acute phase reactants, streptococcal serology and tests for other differential diagnoses

Eradication of group A *Streptococcus* from the throat

- Single dose benzathine penicillin G

Symptomatic treatment of joint involvement and fever

- Nonsteroidal anti-inflammatory drugs (paracetamol may be used until diagnosis has been confirmed)

Management of heart failure

- Bed rest, fluid restriction and cardiac medications
- Corticosteroids may be considered for severe heart failure
- Deferral of surgery, if possible, until acute inflammation has subsided

Management of chorea

- Rest and calm environment
- For severe or refractory cases, administration of valproic acid, carbamazepine or corticosteroids may be considered

Commencement of long-term care

- Education and registration for long-term care
- First dose of benzathine penicillin G (to eradicate group A *Streptococcus* from the throat)

can help to define if ‘asymptomatic’ patients do in fact have restricted capacity. Early referral should be considered in younger patients as they have a better chance of successful mitral valvuloplasty than older patients. Combined severe mitral regurgitation and severe aortic regurgitation are the most deleterious to long-term ventricular function²³³.

Quality of life

The WHO has defined quality of life as “individuals’ perception of their position in life in the context of the culture and values systems in which they live and in relation to their goals, expectations, standards and concerns” (REF. 240). However, health-related quality of life (HRQOL) is a function of a wide range of social and cultural factors making measurement and evaluation of HRQOL difficult. A small number of quantitative (using standardized scoring tools) and qualitative approaches have been applied to understand the effect of RHD on HRQOL.

In Sao Paulo, Brazil, a Portuguese translation of the Pediatric Quality of Life Inventory core and cardiac module was used to investigate the quality of life of 109 young people with RHD and their parents²⁴¹. Results indicated global impairment of quality of life in physical, emotional, social, school and psychosocial domains. Similarly, in Egypt, a sample of 400 parents of children with heart disease (32.5% with RHD) was compared with 400 parents of children with minor illness with an Arabic version of a standardized quality of life questionnaire (SF-36)²⁴². The parents of children with heart disease reported that their children had significantly ($P < 0.001$) different HRQOL with a reduction in general health and physical functioning and with role limitations as a result of physical, emotional and social problems. Factors determining HRQOL included age, severity of

illness and the financial situation of families. An Arabic version of the Pediatric Quality of Life Inventory was also used to investigate the quality of life of 100 school-aged Egyptian children with ARF. The majority of children recorded a neutral HRQOL and these results correlated well with maternal reports²⁴³. In Queensland, Australia, the parent-reported CHQ-PF28 tool was used to score the quality of life outcomes of an RHD echocardiography screening programme²⁴⁴. The study identified an adverse effect on quality of life in children with an abnormal screening result in the domains of ‘general health perception’ and ‘parental impact — emotional’. Further work to use the PedsQL approach for young people identified with asymptomatic RHD in Nepal is underway²⁴⁵.

A small number of qualitative studies support quantitative HRQOL data. Anxiety about the medical, social, marital and financial outcomes of people living with RHD is a prominent theme worldwide^{246,247}. Studies investigating determinants of adherence to secondary prophylaxis have identified a range of logistical, relational and educational factors with the potential to influence both HRQOL and health-seeking behaviour^{248,249}. Strong themes expressed by patients in these studies are lack of empowerment, social and integrative challenges and poor coping mechanisms that are exacerbated by ill health.

The paucity of HRQOL data suggests that the non-medical effect of RHD has been underexplored relative to the severity and the burden of disease worldwide. One of the greatest challenges in the control of RHD is supporting people living with the disease to engage with ongoing prophylactic and therapeutic intervention. Greater attention to the lived experience of children, adults and communities with RHD has recently been prioritized by the RHD clinical and

Table 3 | Indications for cardiac surgery in RHD

Condition	Patient group	Criteria
Severe mitral regurgitation	Adults	<ul style="list-style-type: none"> Severe mitral regurgitation with symptoms (NYHA class 2–4) and an LVEF of >30% Asymptomatic mitral regurgitation and one of the following: LVESD of ≥ 40 mm, impaired left ventricular function with an LVEF of >30% and <60%, pulmonary hypertension of >50 mmHg or new onset atrial fibrillation Moderate to severe mitral regurgitation with an LVEF of >60% and an LVESD of <40 mm, and only if the valve is judged to have a high likelihood of repair
	Children	<ul style="list-style-type: none"> Severe mitral regurgitation with symptoms of breathlessness Asymptomatic mitral regurgitation and one of the following: impaired left ventricular function of <60%, an LVESD z-score of ≥ 2.5 mm or pulmonary hypertension of >50 mmHg
Mitral stenosis*	Adults and children	<ul style="list-style-type: none"> Severe mitral stenosis with symptoms (NYHA class 2–4) Asymptomatic severe mitral stenosis and one of the following: paroxysmal atrial fibrillation, a mitral valve area of <1.5 cm², pulmonary hypertension of >50 mmHg or thromboembolism
Severe aortic regurgitation	Adults	<ul style="list-style-type: none"> Symptoms NYHA class 2–4 Asymptomatic severe aortic regurgitation and one of the following: an LVESD of ≥ 50 mm, impaired left ventricular function with an LVEF of <50% or a LVEDD of >65 mm
	Children	<ul style="list-style-type: none"> Symptoms Asymptomatic severe aortic regurgitation with an LVESV z-score of >4 and impaired left ventricular function with an LVEF of <50%

LVEDD, left ventricular end-diastolic dimension; LVEF, left ventricular ejection fraction; LVESD, left ventricular end-systolic dimension; LVESV, left ventricular end-systolic volume; NYHA, New York Heart Association; RHD, rheumatic heart disease.

*Mitral valvuloplasty or cardiac surgery is recommended.

Box 4 | Research priorities on quality of life in RHD

- Understanding the social, cultural and economic effect of rheumatic heart disease (RHD) on communities with an endemic burden of disease
- Investigating the effect of therapeutic interventions — including echocardiography screening, secondary prophylaxis and cardiac surgery — on people living with RHD using comprehensive quality of life assessments
- Investigating the acceptability and quality of life influence of new RHD interventions, including reformulated antibiotics for secondary prophylaxis and potential group A streptococcal vaccines

research community²⁵⁰. Priorities for further research are outlined in BOX 4. Improving the depth and the breadth of QOL studies is a crucial manifestation of this commitment and ultimately an opportunity to optimize clinical care for people living with RHD.

Outlook

With a few exceptions²²⁷, research into RHD has not received the backing of researchers from high-resource countries who are supported by dedicated funding and contemporary methodological and technological tools. However, there has recently been a sustained increase in the focus on RHD among researchers in RHD-endemic countries^{251–253}. We believe that these efforts will contribute to a reduction in ARF and/or RHD burden if they can be coordinated around three broad themes: effective implementation of known, evidence-based interventions, generation of new knowledge and interventions for RHD prevention and treatment, and advocacy of RHD control efforts (BOX 5). Although these represent distinct areas of focus, there is much overlap between these strategies and their integration into one concerted effort will be crucial to the success of ARF and/or RHD control.

Implementation of evidence-based interventions

It is now well known that there is poor use of established preventive and control strategies in populations with RHD. As an example, recent data indicate that

just more than half of eligible patients were receiving secondary antibiotic prophylaxis⁵², an intervention proven to reduce the recurrence of ARF¹⁷⁰. The barriers to uptake of simple, inexpensive treatments such as penicillin are numerous but mainly reflect the lack of systems to identify and to track patients with RHD in the community. Establishment of ARF and RHD registers for this purpose has been advocated as an important step towards disease control. However, there are currently only two countries (Australia and New Zealand) that have widespread register-based RHD control programmes, perhaps reflecting the barriers to establishing disease-specific vertical control programmes in resource-poor countries. Integration of ARF and RHD control efforts into existing disease prevention and control programmes is likely to be a more feasible option in these countries. Case-finding, referral and treatment monitoring as part of school health or other child health programmes is possible with education of providers and little additional funding. For example, RHD is one of the many diseases earmarked for screening and referral under a national child health-focused programme in India (the Rashtriya Bal Swasthya Karyakram initiative)²⁵⁴. It might be possible to include the provision and the monitoring of secondary prophylaxis, and perhaps even sore throat detection and treatment, under this and similar schemes.

Generation of new knowledge and interventions

This is the most resource-intensive of the three outlined strategies and until recently has been the purview of researchers in high-resource countries. In general, funding for neglected diseases is poor (<2%^{218,255} of healthcare research and development spending) and ARF and RHD research receives a mere 0.7% of these funds, the bulk of which (>90%) comes from public and philanthropic donors²⁵⁶. Thus, an essential first step in generating new knowledge is to convince funders (including the philanthropic arms of industry) to increase allocation to ARF and RHD research.

We believe that there are six key areas of research that will advance ARF and RHD control. First, contemporary descriptions of the epidemiology of ARF and RHD are needed to identify demographic predispositions, to determine the rates of disease progression and adverse outcomes and to identify shortfalls and barriers to effective care. Such efforts are already underway^{52,253}. Second, there are little data on the place of tools, such as screening echocardiography and rapid streptococcal antigen tests, and strategies, such as blanket treatment of sore throats¹⁶⁰, in diagnosis and management algorithms. Formal assessment of these health technologies and practices, and their economic evaluation, are urgently needed for efficient resource allocation. Third, the development of a safe and effective vaccine against GAS will revolutionize the primary prevention of ARF and RHD. Efforts to accelerate the development of candidate vaccines are ongoing but will need greater coordination and funding²⁵⁷. Polyvalent vaccines based on type-specific M protein antigens and some vaccines based on the conserved regions of the GAS M protein seem promising^{257,258}. Fourth, the strong

Box 5 | Potential strategies for ARF and RHD control**Effective implementation of known evidence-based treatments**

- Integration of acute rheumatic fever (ARF) and rheumatic heart disease (RHD) control efforts into existing child-health programmes
- Disease-specific and register-based case finding, treatment and tracking (where feasible)

Generation of new knowledge and interventions

- Contemporary data on disease characteristics and outcomes
- Health technology assessment and economic evaluation
- Vaccine development
- Genetic studies
- Plasma and tissue proteomic studies
- Development of longer acting penicillin formulations

Advocacy

- Reliable data on disease burden and effects on populations
- Adaptation of elements from advocacy models of the 'big three' diseases

genetic predisposition to the development of RHD²⁵⁹ has led investigators to design large genome-wide association studies to identify potential genetic markers. At least three large studies are underway and are likely to contribute to our understanding of the genetics of ARF and RHD. Fifth, the use of contemporary tissue and plasma proteomic techniques might enhance our understanding of the development and the progression of RHD and might help to identify pathophysiological pathways that are amenable to therapeutic modification^{260,261}. Finally, development of longer acting formulations of penicillin might improve adherence to secondary prophylaxis. Awareness of this need has stimulated partnerships between academic researchers, industry and government, which are likely to lead to the development of marketable products in the near future.

Advocacy of ARF and RHD control efforts

Advocacy is of crucial importance in the case of ARF and RHD. RHD predominantly affects the poor and underprivileged in society, the very people whose voices are unlikely to be heard in the absence of strong

advocates of their cause. Furthermore, in many RHD-endemic countries, there is an increasingly common perception that ARF and RHD are on the decline. This perception might be based on incomplete and often skewed data²⁶² and might potentially damage control efforts by understating the public health importance of the disease to policy makers. Accurate data on the burden of the disease in the community and its effects on quality of life and loss of productivity are needed to make advocacy more credible and effective. Advocacy should therefore also place equal emphasis on raising awareness about the need for establishing systems for reliable assessment of disease burden. Finally, the highly successful advocacy campaigns directed at the 'big three' diseases (HIV, tuberculosis and malaria) involved a large number of people and organizations beyond those in the health-care profession. By contrast, advocacy for ARF and RHD control is mainly done by the few healthcare professionals working on the disease. Broader societal engagement in advocacy efforts, with the involvement of citizens' groups and nongovernmental organizations, is needed for the success of the ARF and RHD control agenda.

- Gewitz, M. H. *et al.* Revision of the Jones Criteria for the diagnosis of acute rheumatic fever in the era of Doppler echocardiography: a scientific statement from the American Heart Association. *Circulation* **131**, 1806–1818 (2015). **The 2015 revision of the Jones Criteria provides, for the first time, differing criteria for low and high disease incidence settings.**
- Denny, F. W., Wannamaker, L. W., Brink, W. R., Rammelkamp, C. H. Jr & Custer, E. A. Prevention of rheumatic fever; treatment of the preceding streptococcal infection. *J. Am. Med. Assoc.* **143**, 151–153 (1950).
- Stollerman, G. H., Rusoff, J. H. & Hirschfeld, I. Prophylaxis against group A streptococci in rheumatic fever; the use of single monthly injections of benzathine penicillin G. *N. Engl. J. Med.* **252**, 787–792 (1955).
- Carapetis, J. R. The stark reality of rheumatic heart disease. *Eur. Heart J.* **36**, 1070–1073 (2015).
- Quinn, R. W. Comprehensive review of morbidity and mortality trends for rheumatic fever, streptococcal disease, and scarlet fever: the decline of rheumatic fever. *Rev. Infect. Dis.* **11**, 928–953 (1989). **This paper describes the first attempt to quantify the global disease burden resulting from ARF. Although the estimates did not incorporate many data from developing countries, this paper set the scene for subsequent disease burden estimates.**
- Carapetis, J. R., Steer, A. C., Mulholland, E. K. & Weber, M. The global burden of group A streptococcal diseases. *Lancet Infect. Dis.* **5**, 685–694 (2005). **This article outlines the most definitive attempt to quantify the global disease burden due to GAS infections, including ARF and RHD. This study proved to be pivotal for advocacy efforts and also highlighted major gaps in data, particularly from developing countries.**
- Murray, C. J. *et al.* Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* **380**, 2197–2223 (2012).
- GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* **385**, 117–171 (2015).
- Global Burden of Disease Study 2013 Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* **386**, 743–800 (2015). **The GBD study has attempted to update RHD burden estimates, and this is one of many papers from that study. The methodology continues to be refined, so estimates are still not sufficiently robust, but most researchers in the RHD community believe the GBD estimates are moving us closer to understanding the true burden of RHD.**
- Lawrence, J. G., Carapetis, J. R., Griffiths, K., Edwards, K. & Condon, J. R. Acute rheumatic fever and rheumatic heart disease: incidence and progression in the Northern Territory of Australia, 1997 to 2010. *Circulation* **128**, 492–501 (2013).
- Parnaby, M. G. & Carapetis, J. R. Rheumatic fever in indigenous Australian children. *J. Paediatr. Child Health* **46**, 527–533 (2010).
- Rothenbuhler, M. *et al.* Active surveillance for rheumatic heart disease in endemic regions: a systematic review and meta-analysis of prevalence among children and adolescents. *Lancet Glob. Health* **2**, e717–e726 (2014).
- Yacoub Wasef, S. Z. Gender differences in systemic lupus erythematosus. *Gen. Med.* **1**, 12–17 (2004).
- Diao, M. *et al.* Pregnancy in women with heart disease in sub-Saharan Africa. *Arch. Cardiovasc. Dis.* **104**, 370–374 (2011).
- Say, L. *et al.* Global causes of maternal death: a WHO systematic analysis. *Lancet Glob. Health* **2**, e323–e333 (2014).
- Soma-Pillay, P., MacDonald, A. P., Mathivha, T. M., Bakker, J. L. & Mackintosh, M. O. Cardiac disease in pregnancy: a 4-year audit at Pretoria Academic Hospital. *S. Afr. Med. J.* **98**, 553–556 (2008).
- Sawhney, H. *et al.* Maternal and perinatal outcome in rheumatic heart disease. *Int. J. Gynaecol. Obstetr.* **80**, 9–14 (2003).
- Steer, A. C., Carapetis, J. R., Nolan, T. M. & Shann, F. Systematic review of rheumatic heart disease prevalence in children in developing countries: the role of environmental factors. *J. Paediatr. Child Health* **38**, 229–234 (2002).
- Brown, A., McDonald, M. I. & Calma, T. Rheumatic fever and social justice. *Med. J. Aust.* **186**, 557–558 (2007).
- Riaz, B. K. *et al.* Risk factors of rheumatic heart disease in Bangladesh: a case-control study. *J. Health Popul. Nutr.* **31**, 70–77 (2013).
- Quinn, R. W. Epidemiology of group A streptococcal infections — their changing frequency and severity. *Yale J. Biol. Med.* **55**, 265–270 (1982).
- Jaine, R., Baker, M. & Venugopal, K. Acute rheumatic fever associated with household crowding in a developed country. *Pediatr. Infect. Dis. J.* **30**, 315–319 (2011).
- Okello, E. *et al.* Socioeconomic and environmental risk factors among rheumatic heart disease patients in Uganda. *PLoS ONE* **7**, e45917 (2012).
- Carapetis, J. R. & Currie, B. J. Rheumatic fever in a high incidence population: the importance of monoarthritis and low grade fever. *Arch. Dis. Child* **85**, 223–227 (2001).
- Gordis, L. Effectiveness of comprehensive-care programs in preventing rheumatic fever. *N. Engl. J. Med.* **289**, 331–335 (1973).
- Bach, J. F. *et al.* 10-year educational programme aimed at rheumatic fever in two French Caribbean islands. *Lancet* **347**, 644–648 (1996).
- Nordet, P., Lopez, R., Duenas, A. & Sarmiento, L. Prevention and control of rheumatic fever and rheumatic heart disease: the Cuban experience. *Cardiovasc. J. Afr.* **19**, 135–140 (2008).
- Omurzakova, N. A. *et al.* High incidence of rheumatic fever and rheumatic heart disease in the republics of Central Asia. *Int. J. Rheum. Dis.* **12**, 79–83 (2009).
- Ben-Pazi, H., Stoner, J. A. & Cunningham, M. W. Dopamine receptor autoantibodies correlate with symptoms in Sydenham's chorea. *PLoS ONE* **8**, e73516 (2013).
- Brimberg, L. *et al.* Behavioral, pharmacological, and immunological abnormalities after streptococcal exposure: a novel rat model of Sydenham chorea and related neuropsychiatric disorders. *Neuropsychopharmacology* **37**, 2076–2087 (2012).
- Cox, C. J. *et al.* Brain human monoclonal autoantibody from sydenham chorea targets dopaminergic neurons in transgenic mice and signals dopamine D2 receptor: implications in human disease. *J. Immunol.* **191**, 5524–5541 (2013).
- Cunningham, M. W. Rheumatic fever, autoimmunity, and molecular mimicry: the streptococcal connection. *Int. Rev. Immunol.* **33**, 314–329 (2014).
- Ellis, N. M. J., Li, Y., Hildebrand, W., Fischetti, V. A. & Cunningham, M. W. T cell mimicry and epitope specificity of cross-reactive T cell clones from rheumatic heart disease. *J. Immunol.* **175**, 5448–5456 (2005).
- Fae, K. C. *et al.* Mimicry in recognition of cardiac myosin peptides by heart-intralesional T cell clones from rheumatic heart disease. *J. Immunol.* **176**, 5662–5670 (2006).

References 33 and 34 outline the investigation of cross-reactive T cell clones from the blood and heart of patients with rheumatic carditis and describe the identification of T cell clone cross-reactivity with human cardiac myosin and the group A streptococcal M protein.

35. Galvin, J. E., Hemric, M. E., Ward, K. & Cunningham, M. W. Cytotoxic monoclonal antibody from rheumatic carditis reacts with human endothelium: implications in rheumatic heart disease. *J. Clin. Invest.* **106**, 217–224 (2000).
36. Husby, G., van de Rijn, I., Zabriskie, J. B., Abdin, Z. H. & Williams, R. C. Antibodies reacting with cytoplasm of subthalamic and caudate nuclei neurons in chorea and acute rheumatic fever. *J. Exp. Med.* **144**, 1094–1110 (1976).
37. Kirvan, C. A., Cox, C. J., Swedo, S. E. & Cunningham, M. W. Tubulin is a neuronal target of autoantibodies in Sydenham's chorea. *J. Immunol.* **178**, 7412–7421 (2007).
38. Kirvan, C. A., Swedo, S. E., Heuser, J. S. & Cunningham, M. W. Mimicry and autoantibody-mediated neuronal cell signaling in Sydenham chorea. *Nat. Med.* **9**, 914–920 (2003).
- This study of human mAbs derived from Sydenham's chorea showed that antibodies in chorea were cross-reactive with the group A carbohydrate antigen N-acetyl- β -D-glucosamine and brain antigens such as lysoganglioside and could alter signalling activity in human neuronal cell cultures. Together these data provided strong evidence for a role for cross-reactivity between group A streptococci and brain tissues and molecular mimicry in this manifestation of ARF.**
39. Kirvan, C. A., Swedo, S. E., Kurahara, D. & Cunningham, M. W. Streptococcal mimicry and antibody-mediated cell signaling in the pathogenesis of Sydenham's chorea. *Autoimmunity* **39**, 21–29 (2006).
40. Krisher, K. & Cunningham, M. W. Myosin: a link between streptococci and heart. *Science* **227**, 413–415 (1985).
- Using mAbs from mice immunized with group A streptococcal wall-membrane antigens, this study found that antibodies against the group A streptococci reacted with both heart and streptococcal antigens and that the target heart antigen was myosin. This study thus showed for the first time the roles of cross-reactivity and molecular mimicry in ARF.**
41. Lehmann, P. V., Forsthuber, T., Miller, A. & Sercarz, E. E. Spreading of T-cell autoimmunity to cryptic determinants of an autoantigen. *Nature* **358**, 155–157 (1992).
42. Shikhman, A. R. & Cunningham, M. W. Immunological mimicry between N-acetyl-beta-D-glucosamine and cytokeratin peptides. Evidence for a microbially driven anti-keratin antibody response. *J. Immunol.* **152**, 4375–4387 (1994).
43. Swerlick, R. A., Cunningham, M. W. & Hall, N. K. Monoclonal antibodies cross-reactive with group A streptococci and normal and psoriatic human skin. *J. Invest. Dermatol.* **87**, 367–371 (1986).
44. Stollerman, G. H. Rheumatic fever in the 21st century. *Clin. Infect. Dis.* **33**, 806–814 (2001).
45. Veasy, L. G. *et al.* Temporal association of the appearance of mucoid strains of *Streptococcus pyogenes* with a continuing high incidence of rheumatic fever in Utah. *Pediatrics* **113**, 168–172 (2004).
46. McDonald, M., Currie, B. J. & Carapetis, J. R. Acute rheumatic fever: a chink in the chain that links the heart to the throat? *Lancet Infect. Dis.* **4**, 240–245 (2004).
47. Bessen, D. E. *et al.* Contrasting molecular epidemiology of group A streptococci causing tropical and nontropical infections of the skin and throat. *J. Infect. Dis.* **182**, 1109–1116 (2000).
48. Erdem, G. *et al.* Group A streptococcal isolates temporally associated with acute rheumatic fever in Hawaii: differences from the continental United States. *Clin. Infect. Dis.* **45**, e20–e24 (2007).
49. Smeesters, P. R. *et al.* Differences between Belgian and Brazilian group A *Streptococcus* epidemiologic landscape. *PLoS ONE* **1**, e10 (2006).
50. Steer, A. C. *et al.* Acute rheumatic fever and rheumatic heart disease in Fiji: prospective surveillance, 2005–2007. *Med. J. Aust.* **190**, 133–135 (2009).
51. Potter, E. V. *et al.* Relationship of acute rheumatic fever to acute glomerulonephritis in Trinidad. *J. Infect. Dis.* **125**, 619–625 (1972).
52. Zuhlke, L. *et al.* Characteristics, complications, and gaps in evidence-based interventions in rheumatic heart disease: the Global Rheumatic Heart Disease Registry (the REMEDY study). *Eur. Heart J.* **36**, 1115–1122 (2015).
53. Towers, R. J. *et al.* Extensive diversity of *Streptococcus pyogenes* in a remote human population reflects global-scale transmission rather than localised diversification. *PLoS ONE* **8**, e73851 (2013).
54. Bryant, P. A., Robins-Browne, R., Carapetis, J. R. & Curtis, N. Some of the people, some of the time. Susceptibility to acute rheumatic fever. *Circulation* **119**, 742–753 (2009).
55. Messias-Reason, I. J., Schafranski, M. D., Jensenius, J. C. & Steffensen, R. The association between mannose-binding lectin gene polymorphism and rheumatic heart disease. *Hum. Immunol.* **67**, 991–998 (2006).
56. Ramasawmy, R. *et al.* Association of mannose-binding lectin gene polymorphism but not of mannose-binding serine protease 2 with chronic severe aortic regurgitation of rheumatic etiology. *Clin. Vaccine Immunol.* **15**, 932–936 (2008).
57. Messias-Reason, I. J., Schafranski, M. D., Kremsner, P. G. & Kun, J. F. Ficolin 2 (*FCN2*) functional polymorphisms and the risk of rheumatic fever and rheumatic heart disease. *Clin. Exp. Immunol.* **157**, 395–399 (2009).
58. Berdeli, A., Celik, H. A., Ozyürek, R., Dogrusoz, B. & Aydin, H. H. *TLR-2* gene Arg753Gln polymorphism is strongly associated with acute rheumatic fever in children. *J. Mol. Med. (Berl.)* **85**, 535–541 (2005).
59. Yee, A. M., Phan, H. M., Zuniga, R., Salmon, J. E. & Musher, D. M. Association between Fc γ RIIa-R131 allotype and bacteremic pneumococcal pneumonia. *Clin. Infect. Dis.* **30**, 25–28 (2000).
60. Settini, A., Abdel-Hady, H., El-Baz, R. & Saber, I. Gene polymorphisms of *TNF- α* ³⁰⁸, *IL-10*⁻¹⁰⁸², *IL-6*⁻¹⁷⁴, and *IL-1Ra*^{NTIR} related to susceptibility and severity of rheumatic heart disease. *Pediatr. Cardiol.* **28**, 363–371 (2007).
61. Azevedo, P. M. *et al.* Interleukin-1 receptor antagonist gene (*IL1RN*) polymorphism possibly associated to severity of rheumatic carditis in a Brazilian cohort. *Cytokine* **49**, 109–113 (2010).
62. Hernández-Pacheco, G. *et al.* Tumor necrosis factor- α promoter polymorphisms in Mexican patients with rheumatic heart disease. *J. Autoimmun.* **21**, 59–63 (2003).
63. Ramasawmy, R. *et al.* Association of polymorphisms within the promoter region of the tumor necrosis factor- α with clinical outcomes of rheumatic fever. *Mol. Immunol.* **44**, 1873–1878 (2007).
64. Sallakki, N. *et al.* TNF α -G-308A polymorphism is associated with rheumatic fever and correlates with increased TNF α production. *J. Autoimmun.* **25**, 150–154 (2005).
65. Kamal, H. *et al.* Transforming growth factor- β 1 gene C-509T and T869C polymorphisms as possible risk factors in rheumatic heart disease in Egypt. *Acta Cardiol.* **65**, 177–183 (2010).
66. Chou, H. T., Chen, C. H., Tsai, C. H. & Tsai, F. J. Association between transforming growth factor- β 1 gene C-509T and T869C polymorphisms and rheumatic heart disease. *Am. Heart J.* **148**, 181–186 (2004).
67. Düzgün, N., Duman, T., Haydardeoglu, F. E. & Tutkac, H. Cytotoxic T lymphocyte-associated antigen-4 polymorphism in patients with rheumatic heart disease. *Tissue Antigens* **74**, 539–542 (2009).
68. Maharaj, B., Hammond, M. G., Appadoo, B., Leary, W. P. & Pudifin, D. J. HLA-A, B, DR, and DQ antigens in black patients with severe chronic rheumatic heart disease. *Circulation* **76**, 259–261 (1987).
69. Monplaisir, N., Valette, I. & Bach, J. F. HLA antigens in 88 cases of rheumatic fever observed in Martinique. *Tissue Antigens* **28**, 209–213 (1986).
70. Donadi, E. A., Smith, A. G., Louzada-Júnior, P., Voltarelli, J. C. & Nepom, G. T. HLA class I and class II profiles of patients presenting with Sydenham's chorea. *J. Neurol.* **247**, 122–128 (2000).
71. Ayoub, E. M., Barrett, D. J., Maclaren, N. K. & Krischer, J. P. Association of class II human histocompatibility leukocyte antigens with rheumatic fever. *J. Clin. Invest.* **77**, 2019–2026 (1986).
72. Hernández-Pacheco, G. *et al.* MHC class II alleles in Mexican patients with rheumatic heart disease. *Int. J. Cardiol.* **92**, 49–54 (2003).
73. Jhinghan, B. *et al.* HLA, blood groups and secretor status in patients with established rheumatic fever and rheumatic heart disease. *Tissue Antigens* **27**, 172–178 (1986).
74. Ozkan, M. *et al.* HLA antigens in Turkish race with rheumatic heart disease. *Circulation* **87**, 1974–1978 (1993).
75. Anastasiou-Nana, M. I., Anderson, J. L., Carlquist, J. F. & Nanas, J. N. HLA-DR typing and lymphocyte subset evaluation in rheumatic heart disease: a search for immune response factors. *Am. Heart J.* **112**, 992–997 (1986).
76. Rajapakse, C. N., Halim, K., Al-Orainey, I., Al-Nozha, M. & Al-Aska, A. K. A genetic marker for rheumatic heart disease. *Br. Heart J.* **58**, 659–662 (1987).
77. Guilherme, L., Weidenbach, W., Kiss, M. H., Snitcowdsky, R. & Kalil, J. Association of human leukocyte class II antigens with rheumatic fever or rheumatic heart disease in a Brazilian population. *Circulation* **83**, 1995–1998 (1991).
78. Visentainer, J. E. *et al.* Association of HLA-DR7 with rheumatic fever in the Brazilian population. *J. Rheumatol.* **27**, 1518–1520 (2000).
79. Guédez, Y. *et al.* HLA class II associations with rheumatic heart disease are more evident and consistent among clinically homogeneous patients. *Circulation* **99**, 2784–2790 (1999).
80. Stanevicha, V. *et al.* HLA class II associations with rheumatic heart disease among clinically homogeneous patients in children in Latvia. *Arthritis Res. Ther.* **5**, R340–R346 (2003).
81. Olmez, U. *et al.* Association of HLA class I and class II antigens with rheumatic fever in a Turkish population. *Scand. J. Rheumatol.* **22**, 49–52 (1993).
82. Guilherme, L., Köhler, K. F. & Kalil, J. Rheumatic heart disease: mediation by complex immune events. *Adv. Clin. Chem.* **53**, 31–50 (2011).
83. Yoshinoya, S. & Pope, R. M. Detection of immune complexes in acute rheumatic fever and their relationship to HLA-B5. *J. Clin. Invest.* **65**, 136–145 (1980).
84. Kaplan, M. H., Bolande, R., Ratika, L. & Blair, J. Presence of bound immunoglobulins and complement in the myocardium in acute rheumatic fever. *N. Engl. J. Med.* **271**, 637 (1964).
85. Roberts, S. *et al.* Pathogenic mechanisms in rheumatic carditis: focus on valvular endothelium. *J. Infect. Dis.* **183**, 507–511 (2001).
86. Greenfield, J. G. & Wolfson, J. M. The pathology of Sydenham's chorea. *Lancet* **2**, 603–606 (1922).
87. Quinn, A., Kosanke, S., Fischetti, V. A., Factor, S. M. & Cunningham, M. W. Induction of autoimmune valvular heart disease by recombinant streptococcal M protein. *Infect. Immun.* **69**, 4072–4078 (2001).
88. Taranta, A. & Stollerman, G. H. The relationship of Sydenham's chorea to infection with group A streptococci. *Am. J. Med.* **20**, 170–175 (1956).
89. Meador-Woodruff, J. H. *et al.* Comparison of the distributions of D1 and D2 dopamine receptor mRNAs in rat brain. *Neuropsychopharmacology* **5**, 231–242 (1991).
90. Lotan, D. *et al.* Behavioral and neural effects of intra-striatal infusion of anti-streptococcal antibodies in rats. *Brain Behav. Immun.* **38**, 249–262 (2014).
91. Hoffman, K. L., Hornig, M., Yaddanapudi, K., Jabado, O. & Lipkin, W. I. A murine model for neuropsychiatric disorders associated with group A β -hemolytic streptococcal infection. *J. Neurosci.* **24**, 1780–1791 (2004).
92. Perlmutter, S. J. *et al.* Therapeutic plasma exchange and intravenous immunoglobulin for obsessive-compulsive disorder and tic disorders in childhood. *Lancet* **354**, 1153–1158 (1999).
93. Garvey, M. A., Snider, L. A., Leitman, S. F., Werden, R. & Swedo, S. E. Treatment of Sydenham's chorea with intravenous immunoglobulin, plasma exchange, or prednisone. *J. Child Neurol.* **20**, 424–429 (2005).
94. Barash, J., Margalith, D. & Matitiah, A. Corticosteroid treatment in patients with Sydenham's chorea. *Pediatr. Neurol.* **32**, 205–207 (2005).
95. Cardoso, F., Maia, D., Cunningham, M. C. & Valenca, G. Treatment of Sydenham chorea with corticosteroids. *Mov. Disord.* **18**, 1374–1377 (2003).
96. Fusco, C., Uchino, V., Frattini, D., Pisani, F. & Della Giustina, E. Acute and chronic corticosteroid treatment of ten patients with paralytic form of Sydenham's chorea. *Eur. J. Paediatr. Neurol.* **16**, 373–378 (2012).
97. Paz, J. A., Silva, C. A. & Marques-Dias, M. J. Randomized double-blind study with prednisone in Sydenham's chorea. *Pediatr. Neurol.* **34**, 264–269 (2006).
98. Walker, A. R. *et al.* Rheumatic chorea: relationship to systemic manifestations and response to corticosteroids. *J. Pediatr.* **151**, 679–683 (2007).

99. Yaddanapudi, K. *et al.* Passive transfer of streptococcus-induced antibodies reproduces behavioral disturbances in a mouse model of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection. *Mol. Psychiatry* **15**, 712–726 (2009).
100. Lotan, D., Cunningham, M. & Joel, D. Antibiotic treatment attenuates behavioral and neurochemical changes induced by exposure of rats to group A streptococcal antigen. *PLoS ONE* **9**, e101257 (2014).
101. Cunningham, M. W. Pathogenesis of group A streptococcal infections. *Clin. Microbiol. Rev.* **13**, 470–511 (2000).
102. Zabriskie, J. B. Mimetic relationships between group A streptococci and mammalian tissues. *Adv. Immunol.* **7**, 147–188 (1967).
103. Zabriskie, J. B. & Freimer, E. H. An immunological relationship between the group A streptococcus and mammalian muscle. *J. Exp. Med.* **124**, 661–678 (1966).
104. Zabriskie, J. B., Hsu, K. C. & Seegal, B. C. Heart-reactive antibody associated with rheumatic fever: characterization and diagnostic significance. *Clin. Exp. Immunol.* **7**, 147–159 (1970).
105. Cunningham, M. W. Streptococcus and rheumatic fever. *Curr. Opin. Rheumatol.* **24**, 408–416 (2012).
106. Goldstein, I., Halpern, B. & Robert, L. Immunological relationship between streptococcus A polysaccharide and the structural glycoproteins of heart valve. *Nature* **213**, 44–47 (1967).
107. Dudding, B. A. & Ayoub, E. M. Persistence of streptococcal group A antibody in patients with rheumatic valvular disease. *J. Exp. Med.* **128**, 1081–1098 (1968).
108. McNamara, C. *et al.* Coiled-coil irregularities and instabilities in group A streptococcus M1 are required for virulence. *Science* **319**, 1405–1408 (2008).
109. Ellis, N. M. J. *et al.* Priming the immune system for heart disease: a perspective on group A streptococci. *J. Infect. Dis.* **202**, 1059–1067 (2010).
110. Gorton, D. E. *et al.* Cardiac myosin epitopes for monitoring progression of rheumatic fever. *Pediatr. Infect. Dis. J.* **30**, 1015–1016 (2011).
111. Cunningham, M. W., Antone, S. M., Smart, M., Liu, R. & Kosanke, S. Molecular analysis of human cardiac myosin-cross-reactive B- and T-cell epitopes of the group A streptococcal M5 protein. *Infect. Immun.* **65**, 3913–3923 (1997).
112. Cunningham, M. W. *et al.* Human and murine antibodies cross-reactive with streptococcal M protein and myosin recognize the sequence GLN-LYS-SER-LYS-GLN in M protein. *J. Immunol.* **143**, 2677–2683 (1989).
113. Faé, K. C. *et al.* CXCL9/MIG mediates T cells recruitment to valvular tissue lesions of chronic rheumatic heart disease patients. *Inflammation* **36**, 800–811 (2013).
114. Dale, J. B., Penfound, T. A., Chiang, E. Y. & Walton, W. J. New 30-valent M protein-based vaccine evokes cross-opspecific antibodies against non-vaccine serotypes of group A streptococci. *Vaccine* **29**, 8175–8178 (2011).
115. Martins, T. B. *et al.* Comprehensive analysis of antibody responses to streptococcal and tissue antigens in patients with acute rheumatic fever. *Int. Immunol.* **20**, 445–452 (2008).
116. Tandon, R. *et al.* Revisiting the pathogenesis of rheumatic fever and carditis. *Nat. Rev. Cardiol.* **10**, 171–177 (2013).
117. Dinkla, K. *et al.* Streptococcus pyogenes recruits collagen via surface-bound fibronectin: a novel colonization and immune evasion mechanism. *Mol. Microbiol.* **47**, 861–869 (2003).
118. Lukomski, S. *et al.* Identification and characterization of the *scl* gene encoding a group A Streptococcus extracellular protein virulence factor with similarity to human collagen. *Infect. Immun.* **68**, 6542–6553 (2000).
119. Lukomski, S. *et al.* Identification and characterization of a second extracellular collagen-like protein made by group A Streptococcus: control of production at the level of translation. *Infect. Immun.* **69**, 1729–1738 (2001).
120. Galvin, J. E. *et al.* Induction of myocarditis and valvulitis in Lewis rats by different epitopes of cardiac myosin and its implications in rheumatic carditis. *Am. J. Pathol.* **160**, 297–306 (2002).
- This study of mAbs from human rheumatic carditis explain the mimicry between group A streptococcal antigens and the heart valves and myocardium. Specific cross-reactive antigens included the group**
- A carbohydrate and α -helical proteins such as cardiac myosin in the myocardium and laminin in the endocardium of the valve.**
121. Chopra, P., Narula, J., Kumar, A. S., Sachdeva, S. & Bhatia, M. L. Immunohistochemical characterisation of Aschoff nodules and endomyocardial inflammatory infiltrates in left atrial appendages from patients with chronic rheumatic heart disease. *Int. J. Cardiol.* **20**, 99–105 (1988).
122. Chopra, P. & Narula, J. P. Scanning electron microscope features of rheumatic vegetations in acute rheumatic carditis. *Int. J. Cardiol.* **30**, 109–112 (1991).
123. Roberts, S. *et al.* Immune mechanisms in rheumatic carditis: focus on valvular endothelium. *J. Infect. Dis.* **183**, 507–511 (2001).
124. Aschoff, L. Myocarditisfrage. *Verh. Dtsch. Path. Ges.* **8**, 46–53 (1906).
125. Martins, C. de O. *et al.* Distinct mitral valve proteomic profiles in rheumatic heart disease and myxomatous degeneration. *Clin. Med. Insights Cardiol.* **8**, 79–86 (2014).
126. Guilherme, L. *et al.* Molecular evidence for antigen-driven immune responses in cardiac lesions of rheumatic heart disease patients. *Int. Immunol.* **12**, 1063–1074 (2000).
127. Guilherme, L. *et al.* Rheumatic heart disease: proinflammatory cytokines play a role in the progression and maintenance of valvular lesions. *Am. J. Pathol.* **165**, 1583–1591 (2004).
128. Dileepan, T. *et al.* Robust antigen specific Th17 T cell response to group A Streptococcus is dependent on IL-6 and intranasal route of infection. *PLoS Pathog.* **7**, e1002252 (2011).
129. Pepper, M. *et al.* Different routes of bacterial infection induce long-lived T_H1 memory cells and short-lived T_H17 cells. *Nat. Immunol.* **11**, 83–89 (2010).
130. Wang, B. *et al.* Induction of TGF β 1 and TGF β 1-dependent predominant T_H17 differentiation by group A streptococcal infection. *Proc. Natl Acad. Sci. USA* **107**, 5937–5942 (2010).
131. Bas, H. D. *et al.* A shift in the balance of regulatory T and T helper 17 cells in rheumatic heart disease. *J. Invest. Med.* **62**, 78–83 (2014).
132. Weaver, C. T., Hatton, R. D., Mangan, P. R. & Harrington, L. E. IL-17 family cytokines and the expanding diversity of effector T cell lineages. *Annu. Rev. Immunol.* **25**, 821–852 (2007).
133. Peck, A. & Mellins, E. D. Precarious balance: T_H17 cells in host defense. *Infect. Immun.* **78**, 32–38 (2010).
134. Guilherme, L. *et al.* Human heart-infiltrating T-cell clones from rheumatic heart disease patients recognize both streptococcal and cardiac proteins. *Circulation* **92**, 415–420 (1995).
135. Kirvan, C. A., Galvin, J. E., Hill, S., Kosanke, S. & Cunningham, M. W. Identification of streptococcal M-protein cardiopathogenic epitopes in experimental autoimmune valvulitis. *J. Cardiovasc. Transl. Res.* **7**, 172–181 (2013).
136. Veasy, L. G. & Tani, L. Y. A new look at acute rheumatic mitral regurgitation. *Cardiol. Young* **15**, 568–577 (2005).
137. Jones, T. D. The diagnosis of rheumatic fever. *J. Am. Med. Assoc.* **126**, 481–484 (1944).
138. [No authors listed.] Jones Criteria (revised) for guidance in the diagnosis of rheumatic fever. *Circulation* **69**, 204A–208A (1984).
139. [No authors listed.] Guidelines for the diagnosis of rheumatic fever. Jones Criteria, 1992 update. Special Writing Group of the Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease of the Council on Cardiovascular Disease in the Young of the American Heart Association. *JAMA* **268**, 2069–2073 (1992).
140. [No authors listed.] Jones criteria (modified) for guidance in the diagnosis of rheumatic fever; report of the Committee on Standards and Criteria for programs of care. *Circulation* **13**, 617–620 (1956).
141. [No authors listed.] Jones Criteria (revised) for guidance in the diagnosis of rheumatic fever. *Circulation* **32**, 664–668 (1965).
142. Australia (ARF/RHD Writing Group), National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. *Australian Guideline for Prevention, Diagnosis and Management of Acute Rheumatic Fever and Rheumatic Heart Disease* 2nd edn (Menzies School of Health Research, 2012).
143. Veasy, L. G., Tani, L. Y. & Hill, H. R. Persistence of acute rheumatic fever in the intermountain area of the United States. *J. Pediatr.* **124**, 9–16 (1994).
144. Veasy, L. G. *et al.* Resurgence of acute rheumatic fever in the intermountain area of the United States. *N. Engl. J. Med.* **316**, 421–427 (1987).
145. Vijayalakshmi, I., Vishnuabrahmu, R. O. & Chitra, N. The efficacy of echocardiographic criteria for the diagnosis of carditis in acute rheumatic fever. *Cardiol. Young* **18**, 586–592 (2008).
146. Narula, J. & Kaplan, E. L. Echocardiographic diagnosis of rheumatic fever. *Lancet* **358**, 2000 (2001).
147. Abernethy, M. *et al.* Doppler echocardiography and the early diagnosis of carditis in acute rheumatic fever. *Aust. N. Z. J. Med.* **24**, 530–535 (1994).
148. Figueroa, F. E. *et al.* Prospective comparison of clinical and echocardiographic diagnosis of rheumatic carditis: long term follow up of patients with subclinical disease. *Heart* **85**, 407–410 (2001).
149. Minich, L., Tani, L. Y. & Pagotto, L. T. Doppler echocardiography distinguishes between physiologic and pathologic 'silent' mitral regurgitation in patients with rheumatic fever. *Clin. Cardiol.* **20**, 924–926 (1997).
150. Padmavati, S. & Gupta, V. Reappraisal of the Jones criteria: the Indian experience. *N. Z. Med. J.* **101**, 391–392 (1988).
151. Pereira, B. A. F. *et al.* Jones Criteria and underdiagnosis of rheumatic fever. *Indian J. Pediatr.* **74**, 117–121 (2007).
152. National Heart Foundation of New Zealand & the Cardiac Society of Australia and New Zealand. *Evidence-based, best practice New Zealand Guidelines for Rheumatic Fever 1. Diagnosis, Management and Secondary Prevention* (National Heart Foundation of New Zealand, 2006).
153. National Heart Foundation of Australia (RF/RHD Guideline Development Working Group) & the Cardiac Society of Australia and New Zealand. *Diagnosis and Management of Acute Rheumatic Fever and Rheumatic Heart Disease in Australia — an Evidence-Based Review* (National Heart Foundation of New Zealand, 2006).
154. Okello, E. *et al.* Cardiovascular complications in newly diagnosed rheumatic heart disease patients at Mulago Hospital, Uganda. *Cardiovasc. J. Afr.* **24**, 80–85 (2013).
155. Singh, P. I., Carapetis, J. R., Buadromo, E. M., Samberkar, P. N. & Steer, A. C. The high burden of rheumatic heart disease found on autopsy in Fiji. *Cardiol. Young* **18**, 62–69 (2008).
156. Gordis, L., Lienfield, A. & Rodriguez, R. Studies in the epidemiology and preventability of rheumatic fever. I. Demographic factors and the incidence of acute attacks. *J. Chronic Dis.* **21**, 645–654 (1969).
157. Glover, J. A. Milroy lectures on the incidence of rheumatic diseases. *Lancet* **215**, 499–505 (1930).
158. Salmond, C., Crampton, P. & Atkinson, J. *NZDep2006 Index of Deprivation* (Department of Public Health, 2007).
159. Kerdemelidis, M., Lennon, D. R., Arroll, B., Peat, B. & Jarman, J. The primary prevention of rheumatic fever. *J. Paediatr. Child Health* **46**, 534–548 (2010).
160. Irlam, J., Mayosi, B. M., Engel, M. & Gaziano, T. A. Primary prevention of acute rheumatic fever and rheumatic heart disease with penicillin in South African children with pharyngitis: a cost-effectiveness analysis. *Circul. Cardiovasc. Qual. Outcomes* **6**, 343–351 (2013).
161. Lennon, D., Stewart, J., Farrell, E., Palmer, A. & Mason, H. School-based prevention of acute rheumatic fever: a group randomized trial in New Zealand. *Pediatr. Infect. Dis. J.* **28**, 787–794 (2009).
162. LeMarechal, F., Martnot, A., Duhamel, A., Pruvost, I. & Dubos, F. Streptococcal pharyngitis in children: a meta-analysis of clinical decision rules and their clinical variables. *BMJ Open* **3**, e001482 (2013).
163. Catanzaro, F. J., Rammelkamp, C. H. Jr & Chamovitz, R. Prevention of rheumatic fever by treatment of streptococcal infections. *N. Engl. J. Med.* **259**, 53–57 (1958).
164. Bass, J. W., Crast, F. W., Knowles, C. R. & Onufer, C. N. Streptococcal pharyngitis in children. A comparison of four treatment schedules with intramuscular penicillin G benzathine. *JAMA* **235**, 1112–1116 (1976).
165. Lennon, D. R., Farrell, E., Martin, D. R. & Stewart, J. M. Once-daily amoxicillin versus twice-daily penicillin V in group A β -haemolytic streptococcal pharyngitis. *Arch. Dis. Child* **93**, 474–478 (2008).
166. Clegg, H. W. *et al.* Treatment of streptococcal pharyngitis with once-daily compared with twice-daily amoxicillin: a noninferiority trial. *Pediatr. Infect. Dis. J.* **25**, 761–767 (2006).

167. Parks, T., Smeesters, P. R. & Steer, A. C. Streptococcal skin infection and rheumatic heart disease. *Curr. Opin. Infect. Dis.* **25**, 145–153 (2012).
168. Martin, D. R., Voss, L. M., Walker, S. J. & Lennon, D. Acute rheumatic fever in Auckland, New Zealand: spectrum of associated group A streptococci different from expected. *Pediatr. Infect. Dis. J.* **13**, 264–269 (1994).
169. Williamson, D. A. *et al.* M-protein analysis of *Streptococcus pyogenes* isolates associated with acute rheumatic fever in New Zealand. *J. Clin. Microbiol.* **53**, 3618–3620 (2015).
170. Manyemba, J. & Mayosi, B. M. Penicillin for secondary prevention of rheumatic fever. *Cochrane Database Syst. Rev.* **3**, CD002227 (2002).
171. Tompkins, D. G., Boxerbaum, B. & Liebman, J. Long-term prognosis of rheumatic fever patients receiving regular intramuscular benzathine penicillin. *Circulation* **45**, 543–551 (1972).
172. Taranta, A. Factors influencing recurrent rheumatic fever. *Annu. Rev. Med.* **18**, 159–172 (1967).
173. Bland, E. F. & Duckett Jones, T. Rheumatic fever and rheumatic heart disease; a twenty year report on 1000 patients followed since childhood. *Circulation* **4**, 836–843 (1951).
174. Ash, R. Rheumatic infection in childhood; 15 to 20 year follow-up. *Am. J. Dis. Child* **76**, 46–52 (1948).
175. Wilson, M. G. & Lubschez, R. Longevity in rheumatic fever; based on the experience of 1,042 children observed over a period of 30 years. *J. Am. Med. Assoc.* **138**, 794–798 (1948).
176. Lue, H. C., Wu, M. H., Wang, J. K., Wu, F. F. & Wu, Y. N. Long-term outcome of patients with rheumatic fever receiving benzathine penicillin G prophylaxis every three weeks versus every four weeks. *J. Pediatr.* **125**, 812–816 (1994).
177. Spinetto, H., Lennon, D. & Horsburgh, M. Rheumatic fever recurrence prevention: a nurse-led programme of 28-day penicillin in an area of high endemicity. *J. Paediatr. Child Health* **47**, 228–234 (2011).
178. Tubridy-Clark, M. & Carapetis, J. R. Subclinical carditis in rheumatic fever: a systematic review. *Int. J. Cardiol.* **119**, 54–58 (2007).
179. Araujo, F. D., Goulart, E. M. & Meira, Z. M. Prognostic value of clinical and Doppler echocardiographic findings in children and adolescents with significant rheumatic valvular disease. *Ann. Pediatr. Cardiol.* **5**, 120–126 (2012).
180. Pekpak, E. *et al.* Rheumatic silent carditis: echocardiographic diagnosis and prognosis of long-term follow up. *Pediatr. Int.* **55**, 685–689 (2013).
181. Remenyi, B. *et al.* Position statement of the World Heart Federation on the prevention and control of rheumatic heart disease. *Nat. Rev. Cardiol.* **10**, 284–292 (2013).
182. Pelajo, C. F., Lopez-Benitez, J. M., Torres, J. M. & de Oliveira, S. K. Adherence to secondary prophylaxis and disease recurrence in 536 Brazilian children with rheumatic fever. *Pediatr. Rheumatol. Online J.* **8**, 22 (2010).
183. Tadele, H., Mekonnen, W. & Tefera, E. Rheumatic mitral stenosis in children: more accelerated course in sub-Saharan patients. *BMC Cardiovasc. Disord.* **13**, 95 (2013).
184. Heart Foundation of New Zealand. New Zealand guidelines for rheumatic fever: diagnosis, management and secondary prevention of acute rheumatic fever and rheumatic heart disease: 2014 update. *Heart Foundation of New Zealand* [online], http://www.heartfoundation.org.nz/uploads/HF2227A_Rheumatic_Fever_Guideline_v3.pdf (2014). **This is an evidence-based guideline highlighting the importance of hospitalization for patients with ARF to facilitate echocardiography, education and commencement of secondary prophylaxis.**
185. Nishimura, R. A. *et al.* 2014 AHA/ACC guideline for the management of patients with valvular heart disease: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* **129**, e521–e643 (2014).
186. Saxena, A. *et al.* Prevalence and outcome of subclinical rheumatic heart disease in India: the RHEUMATIC (Rheumatic Heart Echo Utilisation and Monitoring Actuarial Trends in Indian Children) study. *Heart* **97**, 2018–2022 (2011).
187. Webb, R. H. *et al.* Optimising echocardiographic screening for rheumatic heart disease in New Zealand: not all valve disease is rheumatic. *Cardiol. Young* **21**, 436–443 (2011).
188. Paar, J. A. *et al.* Prevalence of rheumatic heart disease in children and young adults in Nicaragua. *Am. J. Cardiol.* **105**, 1809–1814 (2010).
189. Bhaya, M., Panwar, S., Beniwal, R. & Panwar, R. B. High prevalence of rheumatic heart disease detected by echocardiography in school children. *Echocardiography* **27**, 448–453 (2010).
190. Carapetis, J. R. *et al.* Evaluation of a screening protocol using auscultation and portable echocardiography to detect asymptomatic rheumatic heart disease in Tongan schoolchildren. *Nat. Clin. Pract. Cardiovasc. Med.* **5**, 411–417 (2008).
191. Marijon, E. *et al.* Prevalence of rheumatic heart disease detected by echocardiographic screening. *N. Engl. J. Med.* **357**, 470–476 (2007).
192. Beaton, A. *et al.* Echocardiography screening for rheumatic heart disease in Ugandan schoolchildren. *Circulation* **125**, 3127–3132 (2012).
193. Roberts, K., Colquhoun, S., Steer, A., Remenyi, B. & Carapetis, J. Screening for rheumatic heart disease: current approaches and controversies. *Nat. Rev. Cardiol.* **10**, 49–58 (2013).
194. Miranda, L. P., Camargos, P. A., Torres, R. M. & Meira, Z. M. Prevalence of rheumatic heart disease in a public school of Belo Horizonte. *Arq. Bras. Cardiol.* **103**, 89–97 (2014).
195. Roberts, K. V., Brown, A. D., Maguire, G. P., Atkinson, D. N. & Carapetis, J. R. Utility of auscultatory screening for detecting rheumatic heart disease in high-risk children in Australia's Northern Territory. *Med. J. Aust.* **199**, 196–199 (2013).
196. Zuhlke, L. & Mayosi, B. M. Echocardiographic screening for subclinical rheumatic heart disease remains a research tool pending studies of impact on prognosis. *Curr. Cardiol. Rep.* **15**, 343 (2013).
197. Remenyi, B. *et al.* World Heart Federation criteria for echocardiographic diagnosis of rheumatic heart disease — an evidence-based guideline. *Nat. Rev. Cardiol.* **9**, 297–309 (2012). **This article provides guidance on the Doppler and two-dimensional echocardiographic findings that are consistent with RHD. The criteria are based on consensus international expert opinion and available evidence and have been crucial for the field in standardizing diagnosis across centres.**
198. Roberts, K. *et al.* Echocardiographic screening for rheumatic heart disease in high and low risk Australian children. *Circulation* **129**, 1953–1961 (2014).
199. Beaton, A. *et al.* The utility of handheld echocardiography for early diagnosis of rheumatic heart disease. *J. Am. Soc. Echocardiogr.* **27**, 42–49 (2014).
200. Beaton, A. *et al.* Utility of handheld echocardiography for early rheumatic heart disease diagnosis: a field study. *Eur. Heart J. Cardiovasc. Imaging* **16**, 475–482 (2015).
201. Tani, L. Y. Echocardiographic screening for rheumatic heart disease. *Circulation* **129**, 1912–1913 (2014).
202. Colquhoun, S. M. *et al.* Echocardiographic screening in a resource poor setting: borderline rheumatic heart disease could be a normal variant. *Int. J. Cardiol.* **173**, 284–289 (2014).
203. Beaton, A. *et al.* Latent rheumatic heart disease: outcomes 2 years after echocardiographic detection. *Pediatr. Cardiol.* **35**, 1259–1267 (2014).
204. Bhaya, M., Beniwal, R., Panwar, S. & Panwar, R. B. Two years of follow-up validates the echocardiographic criteria for the diagnosis and screening of rheumatic heart disease in asymptomatic populations. *Echocardiography* **28**, 929–933 (2011).
205. Colquhoun, S. M. *et al.* Pilot study of nurse-led rheumatic heart disease echocardiography screening in Fiji — a novel approach in a resource-poor setting. *Cardiol. Young* **23**, 546–552 (2013).
206. Kane, A. *et al.* Echocardiographic screening for rheumatic heart disease: age matters. *Int. J. Cardiol.* **168**, 888–891 (2013).
207. Manji, R. A. *et al.* Cost-effectiveness analysis of rheumatic heart disease prevention strategies. *Expert Rev. Pharmacoecon. Outcomes Res.* **13**, 715–724 (2013).
208. Catanzaro, F. J. *et al.* The role of the streptococcus in the pathogenesis of rheumatic fever. *Am. J. Med.* **17**, 749–756 (1954).
209. New Zealand Heart Foundation. New Zealand guidelines for rheumatic fever 1: diagnosis, management and secondary prevention. *Heart Foundation of New Zealand* [online], <http://www.waikatodhb.health.nz/assets/for-health-professionals/Primary-care-management-guidelines/Guidelines-for-Rheumatic-Fever-1-Diagnosis-Management-and-Secondary-Prevention.pdf> (2006).
210. Carter, M. E., Bywaters, E. G. & Thomas, G. T. Rheumatic fever treated with penicillin in bactericidal dosage for six weeks. Report of a small controlled trial. *Br. Med. J.* **1**, 965–967 (1962).
211. Mortimer, E. A. Jr *et al.* The effect of penicillin on acute rheumatic fever and valvular heart disease. *N. Engl. J. Med.* **260**, 101–112 (1959).
212. Markowitz, M. & Gordis, L. Rheumatic fever. *Major Probl. Clin. Pediatr.* **11**, 1–309 (1972).
213. Albert, D. A., Harel, L. & Karrison, T. The treatment of rheumatic carditis: a review and meta-analysis. *Medicine (Baltimore)* **74**, 1–12 (1995).
214. Cilliers, A., Manyemba, J., Adler, A. J. & Saloojee, H. Anti-inflammatory treatment for carditis in acute rheumatic fever. *Cochrane Database Syst. Rev.* **6**, CD003176 (2012). **This systematic review confirms that there is no evidence-based medical treatment that alters the outcome of carditis in ARF.**
215. Rheumatic Fever Working Party of the Medical Research Council of Great Britain and the Subcommittee of Principal Investigators of the American Council on Rheumatic Fever and Congenital Heart Disease, American Heart Association. Treatment of acute rheumatic fever in children a co-operative clinical trial of A.C.T.H., cortisone and aspirin. *Circulation* **11**, 343–377 (1955).
216. Voss, L. M. *et al.* Intravenous immunoglobulin in acute rheumatic fever: a randomized controlled trial. *Circulation* **103**, 401–406 (2001).
217. Azevedo, P. M., Pereira, R. R. & Guilherme, L. Understanding rheumatic fever. *Rheumatol. Int.* **32**, 1113–1120 (2012).
218. Nishimura, R. A. *et al.* 2014 AHA/ACC guideline for the management of patients with valvular heart disease: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J. Am. Coll. Cardiol.* **63**, e57–e185 (2014). **This article provides a clear guideline outlining that indications for cardiac surgery in adults are based on extensive evidence of management of adults with valvular heart disease.**
219. Anderson, Y., Wilson, N., Nicholson, R. & Finucane, K. Fulminant mitral regurgitation due to ruptured chordae tendinae in acute rheumatic fever. *J. Paediatr. Child Health* **44**, 134–137 (2008).
220. Finucane, K. & Wilson, N. Priorities in cardiac surgery for rheumatic heart disease. *Glob. Heart* **8**, 213–220 (2013).
221. Cardoso, F., Vargas, A. P., Oliveira, L. D., Guerra, A. A. & Amaral, S. V. Persistent Sydenham's chorea. *Mov. Disord.* **14**, 805–807 (1999).
222. Genel, F., Arslanoglu, S., Uran, N. & Saylan, B. Sydenham's chorea: clinical findings and comparison of the efficacies of sodium valproate and carbamazepine regimens. *Brain Dev.* **24**, 73–76 (2002).
223. Daoud, A. S., Zaki, M., Shakir, R. & al-Saleh, O. Effectiveness of sodium valproate in the treatment of Sydenham's chorea. *Neurology* **40**, 1140–1141 (1990).
224. Pena, J., Mora, E., Cardozo, J., Molina, O. & Montiel, C. Comparison of the efficacy of carbamazepine, haloperidol and valproic acid in the treatment of children with Sydenham's chorea: clinical follow-up of 18 patients. *Arq. Neuropsiquiatr.* **60**, 374–377 (2002).
225. Hashkes, P. J. *et al.* Naproxen as an alternative to aspirin for the treatment of arthritis of rheumatic fever: a randomized trial. *J. Pediatr.* **143**, 399–401 (2003).
226. Uziel, Y. *et al.* The use of naproxen in the treatment of children with rheumatic fever. *J. Pediatr.* **137**, 269–271 (2000).
227. Carapetis, J. R., McDonald, M. & Wilson, N. J. Acute rheumatic fever. *Lancet* **366**, 155–168 (2005).
228. World Health Organization. *Report of a WHO Expert Consultation on Rheumatic Fever and Rheumatic Heart Disease* (WHO, 2001).
229. Wilson, N., Voss, L. M. & Neutze, J. M. in *Proceedings of the Second World Congress of Pediatric Cardiology and Cardiac Surgery* (eds Imai, Y. & Momma, K.) 971–972 (Futura Publishing Co., 1998).
230. Walsh, W. F. Medical management of chronic rheumatic heart disease. *Heart Lung Circ.* **19**, 289–294 (2010).

231. Nishimura, R. A. *et al.* ACC/AHA 2008 Guideline update on valvular heart disease: focused update on infective endocarditis: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines endorsed by the Society of Cardiovascular Anesthesiologists, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons. *J. Am. Coll. Cardiol* **52**, 676–685 (2008).
232. Cheung, M. M., Sullivan, I. D., de Leval, M. R., Tsang, V. T. & Redington, A. N. Optimal timing of the Ross procedure in the management of chronic aortic incompetence in the young. *Cardiol. Young* **13**, 253–257 (2003).
233. Gentles, T. L. *et al.* Normalized end-systolic volume and pre-load reserve predict ventricular dysfunction following surgery for aortic regurgitation independent of body size. *JACC Cardiovasc. Imaging* **5**, 626–633 (2012).
234. Remenyi, B. *et al.* Improved long-term survival for rheumatic mitral valve repair compared to replacement in the young. *World J. Pediatr. Congenit. Heart Surg.* **4**, 155–164 (2013).
235. Gentles, T. L., Finucane, A. K., Remenyi, B., Kerr, A. R. & Wilson, N. J. Ventricular function before and after surgery for isolated and combined regurgitation in the young. *Ann. Thorac. Surg.* **100**, 1383–1389 (2015).
236. Enriquez-Sarano, M., Akins, C. W. & Vahanian, A. Mitral regurgitation. *Lancet* **373**, 1382–1394 (2009).
237. DiBardino, D. J. *et al.* Four decades of experience with mitral valve repair: analysis of differential indications, technical evolution, and long-term outcome. *J. Thorac. Cardiovasc. Surg.* **139**, 76–83; discussion 83–74 (2010).
238. Antunes, M. J., Magalhaes, M. P., Colsen, P. R. & Kinsley, R. H. Valvuloplasty for rheumatic mitral valve disease. A surgical challenge. *J. Thorac. Cardiovasc. Surg.* **94**, 44–56 (1987).
239. Sadler, L. *et al.* Pregnancy outcomes and cardiac complications in women with mechanical, bioprosthetic and homograft valves. *BJOG* **107**, 245–253 (2000).
240. The WHOQOL Group. The World Health Organization Quality of Life Assessment (WHOQOL): position paper from the World Health Organization. *Soc. Sci. Med.* **41**, 1403–1409 (1995).
241. do Nascimento Moraes, A. Health related quality of life in children with rheumatic heart diseases: reliability of the Brazilian version of the pediatric quality of life inventory cardiac module scale. *Health Qual. Life Outcomes* **11**, 198 (2013).
242. Arafa, M., Zaher, S., El-Dowaty, A. & Moneeb, D. Quality of life among parents of children with heart disease. *Health Qual. Life Outcomes* **6**, 91 (2008).
243. Essaway, M., Bahgat, Z. & Kassem, H. Health-related quality of life of school-aged children with rheumatic fever. *J. Egypt. Publ. Health Assoc.* **85**, 205–222 (2010).
244. Wark, E., Hodder, Y., Woods, C. & Maguie, G. Patient and health-care impact of a pilot rheumatic heart disease screening program. *J. Paediatr. Child Health* **49**, 297–302 (2013).
245. Pilgrim, T. *et al.* Protocol for a population-based study of rheumatic heart disease prevalence and cardiovascular outcomes among school children in Nepal. *BMJ Open* **2**, e001320 (2012).
246. Koech, M. & Ngeno, T. Perception of parents whose children have rheumatic heart disease at a referral hospital, Kenya. *Bas. Res. J. Med. Clin. Sci.* **3**, 67–73 (2014).
247. Atnafe, L. *The Experience of Married Women with Rheumatic Heart Disease*. Thesis, Addis Ababa University (2011).
248. Harrington, Z., Thomas, D., Currie, B. & Bulkanhawuy, J. Challenging perceptions of non-compliance with rheumatic fever prophylaxis in a remote Aboriginal community. *Med. J. Aust.* **184**, 514–517 (2006).
249. Petricca, K., Mamo, Y., Haileamlk, A., Seid, E. & Parry, E. Barriers to effective follow-up treatment for rheumatic heart disease in Jimma, Ethiopia: a grounded theory analysis of the patient experience. *Ethiopian J. Health Sci.* **19**, 39–44 (2009).
250. Johnson, T. D. *et al.* The 5 × 5 path towards rheumatic heart disease control: outcomes from the third rheumatic heart disease forum. *Glob. Heart* **10**, 75–78 (2014).
251. Guilherme, L. & Kalil, J. Rheumatic fever and rheumatic heart disease: cellular mechanisms leading to autoimmune reactivity and disease. *J. Clin. Immunol.* **30**, 17–23 (2010).
252. Mayosi, B. *et al.* The Drakensberg declaration on the control of rheumatic fever and rheumatic heart disease in Africa. *S. Afr. Med. J.* **96**, 246 (2006).
253. Karthikeyan, G. *et al.* Rationale and design of a Global Rheumatic Heart Disease Registry: the REMEDY study. *Am. Heart J.* **163**, 535–540 (2012).
254. Ministry of Health and Family Welfare & Government of India Rashtriya Bal Swasthya Karyakram. Child Health Screening and Early Intervention Services under NRHM. *National Health Mission* [online], http://nrhm.gov.in/images/pdf/programmes/RBSK/Resource_Documents/RBSK%20Resource%20Material.pdf (2013).
255. Nishimura, R. A. *et al.* 2014 AHA/ACC guideline for the management of patients with valvular heart disease: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J. Am. Coll. Cardiol.* **63**, 2438–2488 (2014).
256. Moran, M. *et al.* Neglected disease research and development: how much are we really spending? *PLoS Med.* **6**, e30 (2009).
257. Dale, J. B. *et al.* Group A streptococcal vaccines: paving a path for accelerated development. *Vaccine* **31**, B216–B222 (2013).
258. Guerino, M. T. *et al.* HLA class II transgenic mice develop a safe and long lasting immune response against StrepTnCor, an anti-group A streptococcus vaccine candidate. *Vaccine* **29**, 8250–8256 (2011).
259. Engel, M. E., Stander, R., Vogel, J., Adeyemo, A. A. & Mayosi, B. M. Genetic susceptibility to acute rheumatic fever: a systematic review and meta-analysis of twin studies. *PLoS ONE* **6**, e25326 (2011).
260. Fae, K. C. *et al.* PDIA3, HSPA5 and vimentin, proteins identified by 2-DE in the valvular tissue, are the target antigens of peripheral and heart infiltrating T cells from chronic rheumatic heart disease patients. *J. Autoimmun.* **31**, 136–141 (2008).
261. Gao, G. *et al.* Identification of altered plasma proteins by proteomic study in valvular heart diseases and the potential clinical significance. *PLoS ONE* **8**, e72111 (2013).
262. Ramakrishnan, S. *et al.* Prevalence of rheumatic heart disease: has it declined in India? *Natl. Med. J. India* **22**, 72–74 (2009).

Acknowledgements

M.W.C. was supported by grants HL35280 and HL56267 from the National Heart, Lung and Blood Institute, the American Heart Association and the Oklahoma Center for the Advancement of Science, all in the USA.

Author contributions

Introduction (J.R.C.); Epidemiology (J.R.C.); Mechanisms/pathophysiology (J.R.C., L.G. and M.W.C.); Diagnosis, screening and prevention (A.B., A.S., C.S. and J.R.C.); Management (J.R.C. and N.W.); Quality of life (J.R.C., L.Z. and R.W.); Outlook (B.M.M., G.K. and J.R.C.); overview of Primer (J.R.C.).

Competing interests statement

G.K., L.Z., A.S., J.R.C., A.B., N.W., L.G., C.S., R.W. and B.M.M. have no conflict of interest. M.W.C. has financial interest in and is Chief Scientific Officer of Moleculera Labs, a company offering diagnostic testing for neurological disorders.