ACUTE RHEUMATIC FEVER (ARF)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM

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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Confidentiality of information will be assured.

CASE DEFINITION FOR ACUTE RHEUMATIC FEVER

Report any child up to and including 18 years of age that meets the most recent modifications of the Jones Criteria for diagnosis of an initial attack of rheumatic fever as follows:

Major manifestations	**Minor manifestations**
Carditis	Clinical
Polyarthritis	Arthralgia
Chorea	Fever
Erythema marginatum	Laboratory findings
Subcutaneous nodules	Increased acute phase reactants:
	Increased erythrocyte sedimentation rate
	Increased C-reactive protein
	Prolonged P-R interval

All cases, except Sydenham's chorea, will require documentation of antecedent group A streptococcal infection, either by positive throat culture, rapid antigen test, or an elevated or rising antibody titre. Antistreptolysin O titre measurement is the preferred test to distinguish recent streptococcal infection from chronic pharyngeal carriage.

If there is evidence of recent streptococcal infection, the presence of two major manifestations or one major and two minor manifestations will be considered diagnostic.

SECTION 1 – DEMOGRAPHIC INFORMATION

Patient

1.1 Date of birth: ____ /_____ /_______ (DD MM YYYY)   Born in Canada? Yes ___ No ___ Unknown ___

1.2 Sex: Male ___ Female ___

1.3 Date of diagnosis: ____ /_____ /_______ (DD MM YYYY)

1.4 If deceased, age at time of death: _____________

Family

1.5 Did the child's family immigrate to Canada? Yes ___ No ___ Unknown ___
If yes, specify country: ______________________________ Urban ____ Rural ____
Year of immigration: ________

1.6 In Canada, is family living in – urban area: Yes ___ No ___ Unknown ___
rural area: Yes ___ No ___ Unknown ___

1.7 What is the total number of people living in household? ______
Of these, number under 18 years of age: ______

1.8 Does the child attend daycare? Yes ___ No ___ Unknown ___

SECTION 2 – DIAGNOSIS

2.1 Carditis

2.1.1 Mitral valve disease: Yes ___ No ___ Unknown ___

If yes, specify – clinical findings: ____________________

Stenosis: mild ____ moderate ____ severe ____

Regurgitation: mild ____ moderate ____ severe ____

2.1.2 Aortic valve disease: Yes ___ No ___ Unknown ___

If yes, specify – clinical findings: ____________________

Stenosis: mild ____ moderate ____ severe ____

Insufficiency: mild ____ moderate ____ severe ____

2.1.3 Right-sided valve disease: Yes ___ No ___ Unknown ___

If yes, describe symptoms and signs: ____________________

2.1.4 Pericarditis: Yes ___ No ___ Unknown ___

If yes, describe symptoms and signs: ____________________

2.1.5 Congestive heart failure: Yes ___ No ___ Unknown ___

If yes, describe symptoms and signs: ____________________

2.2 Polyarthritis

2.2.1 Indicate affected joints

Arthralgia	Arthritis	Migratory arthritis
R L	R L	Yes ___ No ___ Unknown ___

2.3 Chorea

2.3.1 Emotional lability: Yes ___ No ___ Unknown ___

2.3.2 Personality change: Yes ___ No ___ Unknown ___

2.3.3 Purposeless movement: Yes ___ No ___ Unknown ___

If yes, specify affected limbs ____________________

2.3.4 Motor weakness: Yes ___ No ___ Unknown ___

2.3.5 Antineuronal antibodies present: Yes ___ No ___ Not done ___

2.4 Erythema marginatum: Yes ___ No ___ Unknown ___

2.5 Subcutaneous nodules: Yes ___ No ___ Unknown ___

2.6 Fever: Yes ___ No ___ Unknown ___

2.7 Elevated acute phase reactants

2.7.1 Erythrocyte sedimentation rate (ESR): Yes ___ No ___ Unknown ___ Results __________mm/hr

2.7.2 C-reactive protein (CRP): Yes ___ No ___ Unknown ___ Results _________μg/L

SECTION 2 – DIAGNOSIS (cont'd)

2.8 Evidence of streptococcal infection

2.8.1 Positive throat swab: Yes ___ No ___ If yes, specify date: ____ /_____ /_______ (DD MM YYYY)

2.8.2 M strain tested: Yes ___ No ___ If yes, specify results: ____________________

2.8.3 Positive-rapid antigen test: Yes ___ No ___

2.8.4 Streptococcal antibody titre (preferred): Yes ___ No ___ If yes, specify results: ______________

SECTION 3 – TREATMENT

3.1 Bed rest recommended: Yes ___ No ___ If yes, specify duration: ________________________________

3.2 Medication

3.2.1 Antibiotics

- Penicillin: Yes ___ No ___
  If yes, specify – Date: ____ /_____ /_______ (DD MM YYYY) Dose: _____________ Duration: ______________
- Other antibiotics: Yes ___ No ___
  If yes, specify – Name of drug: ____
  Date: ____ /_____ /_______ (DD MM YYYY) Dose: _______________ Duration: ________________

3.2.2 Anti-inflammatory: Yes ___ No ___
If yes, specify – Name of drug: ____
Date: ____ /_____ /_______ (DD MM YYYY) Dose: ________________ Duration: ________________

3.2.3 Anti-congestive heart failure: Yes ___ No ___
If yes, specify – Name of drug: ____
Date: ____ /_____ /_______ (DD MM YYYY) Dose: ________________ Duration: ________________

3.2.4 Anti-chorea, including neuroleptic: Yes ___ No ___
If yes, specify – Name of drug: ____
Date: ____ /_____ /_______ (DD MM YYYY) Dose: ________________ Duration: ________________

SECTION 4 – OUTCOME

4.1 Penicillin prophylaxis: Yes ___ No ___ If yes, specify – Drug: ______________________________________
Dose: ____________________ Mode of delivery: Oral ____ IM ____

4.2 Recurrence to date: Yes ___ No ___ If yes, describe – Side effects: ___________________________________
Involvement: ____

4.2.1 Cardiac

- Residual valve disease: Yes ___ No ___ Unknown ___
- Requirement for ongoing medical therapy: Yes ___ No ___
  If yes, specify – Name of drug: ____
  Dose: ____________________ Mode of delivery: Oral ____ IM ____
- Surgical intervention: Yes ___ No ___ Unknown ___
  If yes, specify name of valve: ____
  - ➢ Valve repair: Yes ___ No ___
  - ➢ Valve replacement: Yes ___ No ___
    Bioprosthetic: Yes ___ No ___ Mechanical: Yes ___ No ___

SECTION 4 – OUTCOME (cont'd)

4.2.2 Joint

- Requirement for ongoing therapy: Yes ___ No ___
  If yes, describe: ______________________________

4.2.3 Neurologic

- Requirement for ongoing medical therapy: Yes ___ No ___
  If yes, describe: ______________________________

4.3 Strep eradication rechecked: Yes ___ No ___

If yes, specify: Method ______________________ Results ______________________

Date: ____ /_____ /_______
DD MM YYYY

SECTION 5 – REPORTING PHYSICIAN

First name__________________ Surname______________________________

Address____

City____________________ Province________________ Postal code__________

Telephone number____________________ Fax number____________________

E-mail____________________________ Date completed__________________

Thank you for completing this form.

(ARF 2004-04)