Key Takeaways – SME Chat on Rheumatic Heart Disease (RHD) with The Menzies School of Health Research

This SME Chat discusses the new ARF-RHD Guideline, referral criteria and triggers, emerging tools and treatments, and systemic and practical challenges for GPs in rural and remote areas.

According to a recent media release in June 2025, Menzies School of Health Research (Menzies) and the Heart Foundation of Australia have released an updated clinical practice guideline that includes key changes to enhance the diagnosis of RHD and prevent its progression, aligned with international standards.

Despite being preventable, ARF and RHD affect over 11,000 Australians, with nearly 80% of cases among First Nations peoples and over one-third under 25. Addressing this inequity is vital to Closing the Gap and achieving Australia's goal to eliminate RHD by 2031.

Supporting WQ HealthPathways:

- Rheumatic Heart Disease (RHD)
- Cardiology Requests

SME

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Questions

What's new in the guidelines?

- 2025 National RHD Guidelines updated to adopt the 2023 World Heart Federation (WHF) diagnostic and staging criteria for RHD.
    - Old terms (borderline/definite) replaced by Stage A–D classification.

  - Aligns with staging used in other cardiac diseases and reflects risk of progression.
- **Priority system** (P1–P4) still in use; translation tables will be provided soon to align stages with priority/follow-up/prophylaxis duration.
- **Cultural safety framework** integrated into the Guideline since 2020; emphasises importance of cultural context in ARF-RHD management.
- **Admission guidance**: A small subset of stable patients (for example: no fever, no cardiac involvement, not young children or pregnant – not a complete list) may not need immediate hospitalisation but must be referred for echo within weeks.
- **Secondary antibiotic prophylaxis**:
  - Guidance added for reviewing ongoing appropriateness (age, risk, palliative care).
  - Checklist included for clinicians (continue injections, consider oral penicillin, or cease).
- **New management notes**: Adjustments for corticosteroids in Sydenham's chorea; general "clean-up" of recommendations.
- **Tools for clinicians**: Key information summary documents and updated app with ARF diagnostic calculator.

Why have classifications changed?

- Driven by **World Heart Federation** (not Australia alone).
- Aim: **standardise diagnosis and staging** internationally for research and clinical practice.
- Stages (A–D) better align with other cardiovascular disease frameworks.
- Based on **risk of progression**:
  - Stage A/B = lower risk.
  - Stage C/D = higher risk, with D = complications.
- Challenges remain in translating new staging with existing **priority levels** used for clinical follow-up.

What are key referral triggers for RHD?

- **Referral encouraged on suspicion** of ARF or RHD (not just confirmed cases).
- **Red flags**:
  - Fever and joint pain in **high-risk individuals** (Aboriginal/Torres Strait Islander people in remote areas, Pacific Islander, Māori, people from high-burden countries, or past history of RHD).

  - Recurrent presentations by concerned family members should be taken seriously.

- **Notification**: Essential to trigger public health unit involvement (investigations, follow-up, register entry).

What situations may not need immediate referral/hospital admission?

- **Stable acute rheumatic fever presentations**
- **Established RHD patients on prophylaxis**
  - Routine follow-up (bicillin injections, register updates, adherence checks) doesn't always need a new referral if:
    - The patient is stable,
    - There is no change in symptoms, and
    - There are no complications (e.g., worsening murmur, heart failure signs).
- **Mild valvular disease (Stage A/B)**
  - Many patients in Stage A (at risk, no valvular disease) and Stage B (subclinical/early disease) are lower risk.
  - They often need monitoring, prophylaxis decisions, and register entry rather than immediate cardiology or tertiary referral, unless symptoms develop.
- **Ceasing prophylaxis**
  - The guidelines now allow clinicians to review if ongoing penicillin is still appropriate (age, risk group, palliative stage).
  - Not every case requires specialist sign-off; decisions can be made in consultation with the register and based on guideline criteria.

But — always notify!

Even if referral is not needed (for example, a stable, low-risk case), notification is still required so the public health team and register can coordinate follow-up, echo scheduling, and prophylaxis tracking.

- Do not necessarily need referral:
  - Stable, known RHD patients on prophylaxis with no new symptoms.
  - Stage A/B cases without progression.
  - Cases where bicillin cessation is being considered. Note: when ceasing bicillin an echocardiogram and review by a RHD expert (cardiologist, physician, paediatricitan, IDP) is neeed. The register displays a cease date but the decision to cease must be done by a professional.

Any emerging tools or treatments?

- **ARF-RHD App**: Guidelines + diagnostic calculator, supports suspicion, diagnosis, and notification.
- **Clinical Education programmes**: Eight modules (2020) including “Recognising Rheumatic Fever” for doctors.
- **Subcutaneous penicillin (SCIP trial)**:
    - Alternative to IM injections, lasts up to 3 months.
    - Still in research, requires higher volumes of penicillin, supply issues ongoing.
- **NEARER scan**: Handheld echo screening for RHD in children and pregnant women; images reviewed off-site by experts.
- **Expanded guideline accessibility**: “What’s changed” section and online Key Information document for quick reference.

What systemic or practical challenges should GPs be aware of?

- **High burden in rural/remote** Aboriginal and Torres Strait Islander communities.
- **Barriers**:
    - Inconsistent IT systems; difficulty accessing live RHD register data via Viewer (slow processes, patchy coverage, lack of integration with My Health Record – can take a visiting doctor with no access up to 4 weeks for the registration process).
    - Fragmented care across states/regions; five separate registers in Australia.
    - No updated, live access to RHD register in QLD causes frustrations and lack of necessary information for treatment of patients.
    - Workforce turnover and locum reliance in remote areas disrupts continuity.
    - Practical challenges in delivering regular painful penicillin injections, especially in large cohorts.
- **Systemic frustrations**:
    - Notifications require clunky processes (PDF/email).
    - Missed opportunistic care due to lack of integrated systems and patient reluctance.
    - Inconsistent bicillin injection adherence (approx. 80% in rural/remote, lower in metro areas).
- **Bigger picture**:
    - RHD is a **socioeconomic disease** driven by poverty, household crowding, and poor housing; medical care alone won’t eliminate it.

- Australia still focuses heavily on **secondary prevention** instead of elimination through primordial prevention.

More Information

ARF and RHD Guideline - RHD Menzies
Queensland RHD register | Queensland Health