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PROGRESS IN CONTROL OF ACUTE RHEUMATISM AND CHRONIC RHEUMATIC CARDITIS IN FIJI

by

Dr. Desmond W. Beckett, M.D., D.P.H.,
Deputy Director of Medical Services, Fiji.

(Edited by A. Guinea, SPC Medical Officer)

One of the reasons why diseases of the circulatory system have remained at the top of the top ten causes of death in Fiji is the frequency with which rheumatic fever or acute rheumatism used to occur. Now, however, the pattern is changing and the epidemiology of the disease is considered to be of sufficient importance, generally, in the Pacific Islands, to justify a short article on the Fijian experience.

It had always been known from hospital statistics that acute rheumatism was prevalent in Fiji and, furthermore, that it was more frequently seen among Indians. In 1958, for example, there were 162 admissions to hospitals classified as rheumatic fever of whom 134 (82.7 per cent) were Indians. When, in 1964, the condition was made statutorily notifiable, the pattern became more apparent. In 1966 notifications of acute rheumatism numbered 288 and 87.7 per cent of these were Indians. Why the disease should be so much more common in Indian children than Fijian ones has not been determined and there is room for further epidemiological research in this field.

From these figures it was obvious that there was developing among the children of Fiji a large reservoir of cardiac cripples. This was supported by the figures of admissions of patients suffering from chronic rheumatic heart disease which, in 1966, numbered 190. Since this pool of morbidity, chronic illness, financial and physical crippling and early death was eminently preventable, the Department decided in 1966 to tackle the problem with energy. Admittedly it is probably impossible to prevent the initial attack of acute rheumatism but the degree of cardiac damage increases greatly with each successive attack and the programme developed by the Department was designed particularly to prevent these recurrent attacks of the disease.

With effect from 1st January, 1967, it became compulsory for all medical officer diagnosing acute rheumatism to refer the patient to a Consultant Physician for assessment. Not until the diagnosis has been confirmed by the Consultant is the case notifed as actute rheumatism. The patient is then put on a register and the central Medical Statistics Section is informed. When the patient is discharged from hospital, the Medical Statistics Section informs the nearest Subdivisional Medical Officer and this officer then becomes responsible for ensuring that the patient receives monthly injections of benzathine penicillin or whatever other prophylactic treatment the Consultant may have prescribed. He is also required to see that the patient receives regular visits from the District Nurse and returns to the Consultant's clinic on the required date.

As a result of the introduction of this policy the number of cases notified in 1967 dropped dramatically to 95. It was pointed out in the annual report of that year that this was presumably due to the weeding out of many false notifications but that hospital statistics indicated that the Consultants were omitting to notify all cases coming to their attention. This fact was drawn to their notice and, in 1968, the number of cases notified rose to 146. Of these, 129 (88.4 per cent) were Indian and 101 (69.2 per cent) were female.

In 1969 the number of cases of acute rheumatism that were notified dropped again to 87 of which 70 (80.46 per cent) were Indian and 51 (58.62 per cent) were female. Admissions to hospitals, however, amounted to 166 (132 or 79.52 per cent of whom were Indian) revealing that the problem of under notification is again occurring. Even if some of these cases were re-admissions it is unlikely that all the excess can be accounted for in this way. The number of admissions in 1968 was 160 which gave a rate per thousand of 0.29 and the equivalent rate for 1969 is 0.31. The general pattern with regard to acute rheumatism would appear therefore not to have changed in the last few years although the incidence is considerably less than it used to be a decade ago.

There is, nevertheless, mounting evidence that the control programme to which reference has been made is having an effect in reducing cardiac damage due to rheumatic fever. Prior to 1966 the number of admissions to hospital of patients suffering from chronic rheumatic heart disease was in the neighbourhood of 200 each year. Since the current programme was introduced in 1966, the following pattern has been produced.

CASES OF CHRONIC RHEUMATIC HEART DISEASE ADMITTED TO HOSPITAL.

Year	Fijian	Indian	Others	Total
1965	35	159	10	204
1966	41	142	7	190
1967	29	134	8	171
1968	19	80	8	107
1969	16	60	8	84

It will be noted that the incidence of rheumatic heart disease is steadily dropping and that the improvement is mainly among the Indians who are more likely to ensure that their children have their monthly prophylactic injections. It would seem that the control programme to prevent the crippling sequelae of rheumatic fever is producing rsults in spite of the fact that the improving standard of living in Fiji has not yet begun to exercise the effect on the incidence of first attacks that it has done elsewhere.

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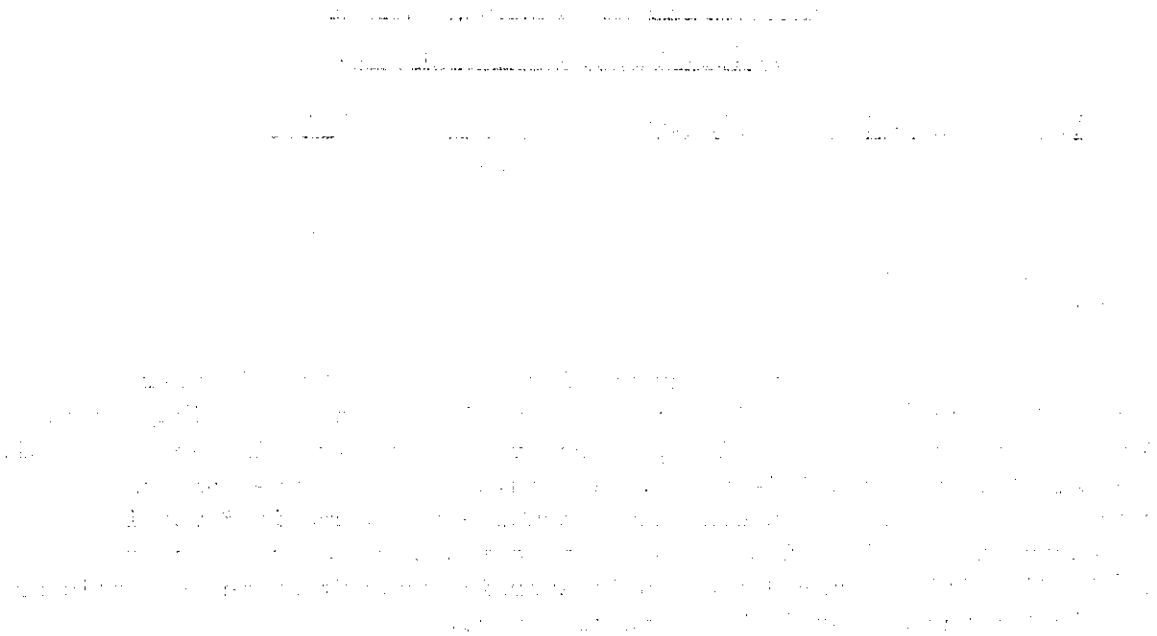

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