

Evaluation of the Cases with Silent Carditis

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Introduction: The first rheumatic fever attack may cause no clinical signs, but as a result of recurrent attacks may develop rheumatic heart disease. The aim of this study is to establish important of the silent carditis.

Methods: Between October 2005 and June 2010, 226 patients admitted to our section were included. The mean age was $11,78 \pm 2,9$, average follow-up period was $30,2 \pm 10,98$ months. Valvar structure was detected by two dimensional and Doppler echocardiography. WHO echocardiographic criteria for making the diagnosis of silent carditis was accepted as the basis. Patients with rheumatic fever arthritis and chorea were defined as group 1 (78 patient); patient with chest pain, palpitation, syncope, murmur, athralgia and fulfilling the criteria of WHO were defined as group 2 (148 patient). All the patients were given the benzathine penicilin prophylaxy.

Results: All patients with Sydenham's chorea and 75% of patient with rheumatic fever arthritis showed signs of silent carditis in our study. 78 patients fulfilling the revised Jones criteria for rheumatic fever, 67 of the patients have had arthritis and 11 had chorea as major Jones criteria. Mitral insufficiency was mild in 89.4%, moderate in 10.6%, aortic insufficiency was mild %88.8, moderate in %11,2 of group 1 ; mitral insufficiency was mild in 89.2%, moderate in 10.8%, aortic insufficiency was mild in %88, moderate in %12 of group 2. Mitral valve in 80.9%, aort valve in 3.8%, both valve in 15,3 % of the group 1, mitral valve in 81,7%, aort valve in 3.7%, both valve in 14,6 % of the group 2 was affected. Regression in mitral and aortic regurgitation were 62,6 % -50 % and 64,2 % - 52 % in group1 and 2 respectively. Mitral and aortic regurgitation length and velocity was sigificantly decreased in both group during follow up($p < 0,001$). No patient had progression of valvulary lesions. There was no difference between two groups in terms of improvement of valvulary lesions.

Conclusion: Subclinical lesions aren't evanescent and could be detected by Doppler echocardiography. We suggest that echocardiographic findings should be accepted as a major criterion for the diagnosis of rheumatic fever.