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patients with obvious manifestations of carditis usually seek treatment in hospitals with indoor facilities and support of admission. Every patient with suspected ARF should undergo echocardiography for evaluation of carditis, with those who UHPDLQQHJDWLYHLQWKHLUVWHYDOXDWLRQ Echocardiography@ LV PRUH VSHFLILFWKDQ DXVFXOWDWLRQ DQG LWH[FOXGHVGLDJQRVLV of clinical carditis.[2,22] Recently, echocardiography (both conventional and portable) is being used increasingly, as a result, more and more cases of subclinical carditis are being diagnosed.[23] Joint manifestation of ARF was present in about seventy percent of patients among whom majority had polyarthralgia and migratory polyarthritis was present in only 5.4% patients. Arthritis of ARF is most classically a painful large joint migratory polyarthritis; it improves dramatically ZLWK DQWLLQÀPPDWRU\ WKHUDS\ DQG D KLVWRU\ RI VHOI medication prior to presentation can mask its recognition. 0LJUDWRU\SRO\DUWKULWLV LV RIWHQ WKH ¿UVW VPSWRPDWLF VLJQ of ARF. Though diagnosis of arthritis in ARF is challenging EHFDXVH RI LWV QRQVSHFL¿F SUHVHQWDWLRQ DQG GHODHG RQVHW [6] NCCRF&HD, being a specialized center received a fair number of referred patients and due to its location in capital city, most of the patients came here after being treated or self-medicated with NSAIDs. Therefore, majority of them presented with arthralgia rather than arthritis and number of patients seeking treatment with arthritis or arthralgia was lower than normally should have been found if they came without medication.

In this study two children had isolated chorea; both of them were female and had delayed presentation (70 and 90 days). Sydenham chorea is characterized by abrupt and involuntary movements of trunk and/or extremities.[24] Chorea is often associated with emotional labiality and obsessive-compulsive GLVRUGHU DQG FDQ EH XVHG DORQH WR FRQ¿UP $)>@ KH incidence of Erythema marginatum was very low and was seen only in one patient in this study. It is a rare manifestation of ARF and is seen in less than 10% of cases.[26] Low level of detection (0.4-3%) was reported in several studies.[13,17,20] Erythema marginatum is transient and may not be present at the time of examining the patient by physicians. Besides, this skin manifestation is more often missed due to darker skin complexion in Bangladeshi patients. Another major criterion, subcutaneous nodules was not present in any patient in our study. Erythema marginatum and subcutaneous nodules are rare manifestations of ARF. These were even absent in a few studies in this geographical region. [10,27,28] Some authors argued about reconsideration of these symptoms in major Jones criteria mentioning that they had no importance in the diagnosis of new cases. [27,29]

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Our study was a single-center study. The sample size was not rich and our study period was short. After evaluating those patients, we did not follow them up for a long term and have not known about other possible interference that may happen in the long term with these patients.

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Acute rheumatic fever was common in females and among 8 to 15years of age patients. Fever was the commonest presenting complaint of patients followed by joint pain. Carditis was the most common major manifestation, two-thirds of which was subclinical. Therefore, echocardiography should be used to diagnose subclinical carditis in every suspected ARF patient. So, we recommend that further study with a prospective and longitudinal study design including a larger sample size needs to be done on rheumatic fever for early diagnosis and to reduce morbidity.

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