

Characteristics, complications, and gaps in evidence-based interventions in rheumatic heart disease: the Global Rheumatic Heart Disease Registry (the REMEDY study)

Liesl Zühlke^{1,2}, Mark E. Engel¹, Ganesan Karthikeyan³, Sumathy Rangarajan⁴, Pam Mackie⁴, Blanche Cupido¹, Katya Mauff⁵, Shofiquel Islam⁴, Alexia Joachim¹, Releen Daniels¹, Veronica Francis¹, Stephen Ogen⁶, Bernard Gitura⁷, Charles Mondo⁸, Emmy Okello⁹, Peter Lwabi⁹, Mohammed M. Al-Kebisi¹⁰, Christopher Hugo-Hamman^{2,11}, Sahar S. Sheta¹², Abraham Haileamlak¹³, Wandimu Daniel¹³, Dejuma Y. Goshu¹⁴, Senbeta G. Abdissa¹⁴, Araya G. Desta¹⁴, Bekele A. Shasho¹⁴, Dufera M. Begna¹⁴, Ahmed ElSayed¹⁵, Ahmed S. Ibrahim¹⁵, John Musuku¹⁶, Fidelia Bode-Thomas¹⁷, Basil N. Okeahialam¹⁷, Olukemi Ige¹⁷, Christopher Sutton¹⁸, Rajeev Misra¹⁹, Azza Abul Fadl²⁰, Neil Kennedy²¹, Albertino Damasceno²², Mahmoud Sani²³, Okechukwu S. Ogah^{24,25,26}, Taiwo Olunuga²⁶, Huda H.M. Elhassan²⁷, Ana Olga Mocumbi²⁸, Abiodun M. Adeoye²⁴, Phindile Mntla²⁹, Dike Oji³⁰, Joseph Mucumbitsi³¹, Koon Teo⁴, Salim Yusuf⁴, and Bongani M. Mayosi^{1*}

¹The Cardiac Clinic, Department of Medicine, Groote Schuur Hospital and University of Cape Town, J Floor Old Groote Schuur Hospital, Groote Schuur Drive, Observatory 7925, Cape Town, South Africa; ²Division of Paediatric Cardiology, Department of Paediatrics and Child Health, Red Cross War Memorial Children's Hospital and University of Cape Town, Cape Town, South Africa; ³Department of Cardiology, All India Institute of Medical Sciences, New Delhi, India; ⁴Population Health Research Institute, Hamilton Health Sciences and McMaster University, Hamilton, ON, Canada; ⁵Department of Statistical Sciences, University of Cape Town, Cape Town, South Africa; ⁶Department of Surgery, School of Medicine, College of Health Sciences, University of Nairobi, Nairobi, Kenya; ⁷Cardiology Unit, Department of Medicine, Kenyatta National Teaching and Referral Hospital, Nairobi, Kenya; ⁸Cardiology Unit, Department of Medicine, Mulago Hospital, Kampala, Uganda; ⁹Uganda Heart Institute, Kampala, Uganda; ¹⁰Faculty of Medicine and Surgery, University of Sana'a, Al-Thawrah Cardiac Center, Sana'a, Yemen; ¹¹Paediatric Cardiology Service, Windhoek Central Hospital, Windhoek, Namibia; ¹²Department of Paediatrics, Division of Paediatric Cardiology, Faculty of Medicine, Cairo University Children's Hospital, Cairo, Egypt; ¹³Department of Paediatrics and Child Health, Jimma University Hospital, Jimma, Ethiopia; ¹⁴Department of Internal Medicine, Faculty of Medicine, Addis Ababa, Ethiopia; ¹⁵Department of Cardiothoracic Surgery, Al Shaab Teaching Hospital, Faculty of Medicine, Alzaem Alazhari University, Khartoum, Sudan; ¹⁶Department of Paediatrics and Child Health, University Teaching Hospital, University of Zambia, Lusaka, Zambia; ¹⁷Department of Paediatrics, Jos University Teaching Hospital, Jos, Nigeria; ¹⁸Department of Paediatrics and Child Health, University of Limpopo, Polokwane, South Africa; ¹⁹Department of Internal Medicine, University of Limpopo, Polokwane, South Africa; ²⁰Faculty of Medicine, Benha University, Cairo, Egypt; ²¹Department of Paediatrics and Child Health, College of Medicine, University of Malawi, Blantyre, Malawi; ²²Department of Cardiology, Eduardo Mondlane University, Maputo, Mozambique; ²³Department of Medicine, Bayero University and Aminu Kano Teaching Hospital, Kano, Nigeria; ²⁴Division of Cardiology, Department of Medicine, University College Hospital, Ibadan, Nigeria; ²⁵Nigeria Ministry of Health, Umuahia, Abia State, Nigeria; ²⁶Department of Medicine, Federal Medical Centre, Abeokuta, Nigeria; ²⁷Ahmed Gasim Teaching Hospital, Khartoum, Sudan; ²⁸Instituto Nacional de Saúde and Eduardo Mondlane University, Maputo, Mozambique; ²⁹Department of Cardiology, Dr. George Mukhari Hospital and University of Limpopo (MEDUNSA Campus), Tshwane, South Africa; ³⁰Cardiology Unit, Department of Medicine, University of Abuja Teaching Hospital, Abuja, Nigeria; and ³¹Paediatric Cardiology Unit, Department of Paediatrics, King Faisal Hospital, Kigali, Rwanda

Received 17 August 2014; revised 19 October 2014; accepted 23 October 2014; online publish-ahead-of-print 26 November 2014

See page 1070 for the editorial comment on this article (doi:10.1093/eurheartj/ehu507)

Aims

Rheumatic heart disease (RHD) accounts for over a million premature deaths annually; however, there is little contemporary information on presentation, complications, and treatment.

Methods and results

This prospective registry enrolled 3343 patients (median age 28 years, 66.2% female) presenting with RHD at 25 hospitals in 12 African countries, India, and Yemen between January 2010 and November 2012. The majority (63.9%) had moderate-to-severe multivalvular disease complicated by congestive heart failure (33.4%), pulmonary hypertension (28.8%), atrial fibrillation (AF) (21.8%), stroke (7.1%), infective endocarditis (4%), and major bleeding (2.7%).

* Corresponding author: Tel: +27 21 406 6200, Fax: +27 21 448 6815, Email: bongani.mayosi@uct.ac.za

Published on behalf of the European Society of Cardiology. All rights reserved. © The Author 2014. For permissions please email: journals.permissions@oup.com.

One-quarter of adults and 5.3% of children had decreased left ventricular (LV) systolic function; 23% of adults and 14.1% of children had dilated LVs. Fifty-five percent ($n = 1761$) of patients were on secondary antibiotic prophylaxis. Oral anti-coagulants were prescribed in 69.5% ($n = 946$) of patients with mechanical valves ($n = 501$), AF ($n = 397$), and high-risk mitral stenosis in sinus rhythm ($n = 48$). However, only 28.3% ($n = 269$) had a therapeutic international normalized ratio. Among 1825 women of childbearing age (12–51 years), only 3.6% ($n = 65$) were on contraception. The utilization of valvuloplasty and valve surgery was higher in upper-middle compared with lower-income countries.

Conclusion

Rheumatic heart disease patients were young, predominantly female, and had high prevalence of major cardiovascular complications. There is suboptimal utilization of secondary antibiotic prophylaxis, oral anti-coagulation, and contraception, and variations in the use of percutaneous and surgical interventions by country income level.

Keywords

Rheumatic heart disease • Atrial fibrillation • Congestive heart failure • Stroke • Infective endocarditis • Valvuloplasty • Valve surgery

Introduction

Rheumatic heart disease (RHD) is one of the leading non-communicable diseases in low- and middle-income countries and accounts for up to 1.4 million deaths per year.^{1,2} Patients with RHD also suffer from complications related to atrial fibrillation (AF), infective endocarditis, and during pregnancy.^{3–5} Despite the magnitude of the problem, there are few systematically collected contemporary data on disease characteristics, treatments, complications, and long-term outcomes in patients with RHD.⁶ The proposal of the World Health Organization to reduce mortality from RHD and other NCDs by 25% by the year 2025 requires an understanding of the contemporary characteristics and the use of proven interventions in patients living in endemic countries.⁷

Much of the morbidity and mortality due to RHD can be prevented by existing therapies.^{8,9} There is good evidence to suggest that secondary prophylaxis with long-acting penicillin reduces the recurrence of episodes of acute rheumatic fever.¹⁰ Oral anti-coagulants (OACs) in patients with rheumatic AF can reduce thromboembolic complications, and percutaneous or surgical interventions can improve symptoms and prevent congestive heart failure (CHF).^{11,12} However, several older reports from developing countries have documented inadequate adherence to secondary prophylaxis and poor control of OAC therapy,^{13–15} and it is not known whether this has changed in recent times. In addition, rates of the use of percutaneous and surgical interventions in developing countries may be limited by the shortage of health facilities and trained staff.¹⁶

The Global Rheumatic Heart Disease Registry (the REMEDY study) was designed to assemble a contemporary cohort of RHD patients from developing countries to document patient characteristics and treatment patterns with particular reference to valvular involvement, the prevalence of adverse cardiac events and the use of key treatments.¹⁷

Methods

Study design

The Global Rheumatic Heart Disease Registry is a multi-centre, international hospital-based prospective registry of patients with RHD which is conducted in two phases: a pilot phase which will be followed

by a full study. The baseline characteristics of patients enrolled in the pilot phase are reported here. Enrolled patients underwent assessment and treatment according to standard practices followed at each participating site. Patients were enrolled from 25 sites in 12 African countries, Yemen, and India. Countries were grouped into three income categories (2011 World Bank definitions): low-income countries (Ethiopia, Kenya, Malawi, Rwanda, Uganda, and Zambia), lower-middle-income countries (Egypt, India, Mozambique, Nigeria, Sudan, and Yemen), and upper-middle-income countries (Namibia and South Africa).¹⁸ This study was approved by local ethics committees and written informed consent was obtained from the subjects (adults ≥ 18 years) or their guardians (children < 18 years).

The rationale, design, and objectives of the REMEDY study have been described previously.¹⁷

We enrolled patients regardless of age with a primary diagnosis of symptomatic RHD from outpatient clinics, emergency departments, or inpatient facilities, based on clinical and echocardiographic criteria.¹⁹ Patients with asymptomatic disease diagnosed through community screening were not included. The AHA/ACC guidelines were used for assessment of severity of valve lesions, left ventricular (LV) systolic dysfunction (i.e. left ventricular ejection fraction, LVEF $< 54\%$ in children and adults), and LV dilatation (i.e. LV end diastolic dimension < 50 mm in children and < 55 mm in adults).¹¹ Adherence to penicillin prophylaxis was calculated based on percentage of prescriptions received over the 12 months preceding enrolment. Patients were excluded from the study if the primary diagnosis of valvular disease was not RHD.

Data collection

Demographic data, clinical findings, and details of electrocardiographic and echocardiographic findings were recorded on case report forms at research sites and transmitted to the University of Cape Town Department of Medicine Project Coordinating Office. These were relayed to the Population Health Research Institute at Hamilton Health Sciences and McMaster University, Hamilton, Ontario, Canada for further data checks and data storage.

Statistical considerations

Continuous variables were expressed as means with standard deviations or as medians with interquartile ranges as appropriate, and categorical variables as frequencies and percentages. Comparisons between categorical variables were assessed for statistical significance using the χ^2 test, and the unpaired t-test was used to determine group differences for continuous variables. Linear regression was utilized to explore relationships between variables. Test results were adjusted by age and by

specifying study centres as clusters. Statistical analyses were performed using STATA 11 (StataCorp, College Station, TX, USA).

Results

Clinical characteristics

A total of 3343 participants with RHD were enrolled between January 2010 and November 2012 (Supplementary material online, Table S1). Patients with RHD were young (median age 28 years), mainly female (66.2%), and largely unemployed (75.3%) (Table 1 and Figure 1). There were greater proportions of women in childbearing age in low-income (86.5%) and lower-middle-income countries (90.3%) compared with upper-middle-income countries (66.9%) ($P < 0.01$).

Atrial fibrillation was documented in 586/2688 (21.8%) of patients with electrocardiograms performed at enrolment to the study (Table 2). There were substantial variations in clinical features and the use of percutaneous and surgical interventions between the different country income groups (Table 2). Stroke, peripheral embolism, and the composite outcome of cardiovascular complications (i.e. stroke, systemic embolism, bleeding, or infective endocarditis) were reported more frequently in patients living in upper-middle-income countries (14.5, 2.2, and 22.2%, respectively) compared with those from lower-middle-income (3.8, 0.2, and 10.1%, respectively) and low-income countries (5.2, 0.3, and 8.7%, respectively) ($P < 0.02$). The proportion of children with decreased LVEF was lower in upper-middle-income countries than in lower-middle- and low-income countries ($P < 0.01$). The use of valve replacement/repair and valvuloplasty positively correlated with rising country income level ($P \leq 0.03$) (Table 2 and Figure 2).

Pattern and severity of native valve disease

Figure 3 demonstrates the pattern of valve disease by age group in patients without percutaneous or surgical intervention. Children in the first decade of life presented predominantly with pure mitral regurgitation, with mixed mitral and mixed aortic valve disease emerging as a dominant mitral valve lesion from the second decade of life. The frequency of pure mitral stenosis, isolated aortic valve disease (i.e. aortic stenosis or aortic regurgitation) and mixed aortic valve disease without mitral disease was low in early life, and increased with age.

The majority of cases of mitral stenosis (1119/1535, 72.9%), mitral regurgitation (1479/2464, 60.4%), pulmonary stenosis (19/32, 59.4%), tricuspid stenosis (58/107, 54.2%), and aortic stenosis (187/302, 61.9%) had moderate-to-severe disease, whereas the majority of cases of aortic regurgitation (922/1671, 55.2%) were mild. Patients with native valve disease had a dilated left ventricle (LV) in 23% ($n = 581$) of adults and 16.4% ($n = 413$) of children, and a decreased ejection fraction in 18.3% ($n = 460$) of adults and 5.6% ($n = 140$) of children. There was a gradient as patients increased in age for dilated LV ($P < 0.0001$) and falling LVEF ($P < 0.0001$), which suggest disease progression.

The use of secondary prophylaxis

Overall, secondary penicillin prophylaxis was prescribed in 54.8% (1761/3213) of patients. Intramuscular penicillin was the commonest

mode of administration, used by 1926 (89.5%) of patients with data ($n = 2153$); the remainder (227, 10.5%) were either on oral penicillin or erythromycin. The use of secondary prophylaxis differed by country income group (Figure 4). Whereas oral and parenteral antibiotics were used in almost equal proportions in upper-middle-income countries, nearly all participants in low- and lower-middle-income countries received intramuscular penicillin. Overall, adherence to intramuscular penicillin and oral antibiotic prophylaxis was similar (i.e. 78.6 ± 32.3 and $78.0 \pm 32.9\%$, respectively). However, adherence was higher in children compared with adults, for both intramuscular penicillin (81.8 ± 30.8 vs. $76.9 \pm 33.1\%$, $P < 0.001$) and oral antibiotics (83.1 ± 24.9 vs. $75.0 \pm 36.6\%$; $P < 0.001$), respectively. Post-surgery patients were less likely to be on secondary prophylaxis compared with those awaiting surgery (31.1 compared with 61.5%, $P < 0.001$). Patients on a 2-weekly intramuscular regime showed lower levels of adherence (68.4%) than those on either a 3-weekly (76.0%) or 4-weekly regimen (82.8%) ($P < 0.05$).

The use of oral anti-coagulants and other medications

There were 1362 (40.7%) patients with indications for OACs in RHD (Table 3).¹¹ Oral anti-coagulants were prescribed in 69.5% (946) of such patients; the use of OACs was high in patients with mechanical heart valves (91.6%) and AF (68.6%), but low in those with mitral stenosis in sinus rhythm with either dilated left atrium or left atrial thrombus (20.3%). Of the patients on OACs for the recognized indications, 12.2% (115) had had no international normalized ratio (INR) monitoring, whereas 34.1% (323) had only one to three INR tests in the 6 months preceding enrolment. The INR at enrolment was sub-therapeutic in 32.7% (309), therapeutic in 28.3% (268), and above the therapeutic range in 17.7% (167) (no INR testing on the remainder of 21.4% (202)). Sixty percent of participants were unaware of the therapeutic range of INR values.

There was a high use of additional medication: 67.8% (2239/3296) of patients were on diuretics, 39.3% (1296/3296) on β -blockers, 34.7% (1144/3298) on digoxin, and 1.6% (52/3279) on other anti-arrhythmic drugs. Of those tested for human immune deficiency virus (HIV) infection (1180, 35.3%), 56 (4.7%) were HIV positive; the remainder (2163, 64.7%) were either unaware of their HIV status or declined to provide the information. In 1825, women of childbearing age (12–51 years), only 3.6% (65) were on contraceptive medication. A total of 73 women (3.6%) were pregnant at the time of enrolment, the youngest 14 years, and the oldest 51 years of age. In total, 15 (20.6%) pregnant women were on warfarin.

Discussion

This study has five main findings. First, the patients with RHD from low- and middle-income countries were young (median age 28 years), largely female (66.2%), and had a high unemployment rate (75.3%). Second, the majority had moderate-to-severe valvular heart disease that was associated with pulmonary hypertension and up to a quarter of patients had LV dysfunction. Third, there was an inadequate use of secondary antibiotic prophylaxis in developing countries, with lack of preventive treatment in nearly half of

Table 1 Demographic characteristics of 3343 children and adults with rheumatic heart disease

	Low-income countries	Lower-middle-income countries	Upper-middle-income countries	P	Total
Participants, n (%)	1110 (33.2)	1370 (41.0)	863 (25.8)		3343
Age, median (IQR) ^a	24 (15–34)	28 (18–38)	39 (22–52)	0.4	28 (18–40)
Women, n (%) ^b	728 (65.8)	867 (63)	616 (71.3)	0.33	2211 (66.2)
Women in childbearing age, n (%) ^c	630 (86.5)	783 (90.3)	412 (66.9)	<0.01	1825 (82.5)
Children, n (%) ^d	405 (36.6)	349 (25.5)	167 (19.4)	0.54	921 (27.6)
Adults with no formal schooling, n (%) ^e	66 (9.5)	354 (34.9)	38 (5.5)	<0.01	458 (19.1)
Completed primary level schooling	246 (35.2)	278 (27.4)	204 (29.6)	0.48	728 (30.3)
Completed secondary level schooling	373 (53.4)	372 (36.7)	436 (63.3)	0.03	1181 (49.2)
Completed tertiary level education	13 (1.98)	10 (1.0)	11 (1.6)	0.5	34 (1.4)
Unemployed adults, n (%) ^{f,g}	529 (75.4)	766 (75.1)	520 (75.5)	0.98	1815 (75.3)

^aData are available for 3339 participants.

^bData are available for 3340 participants.

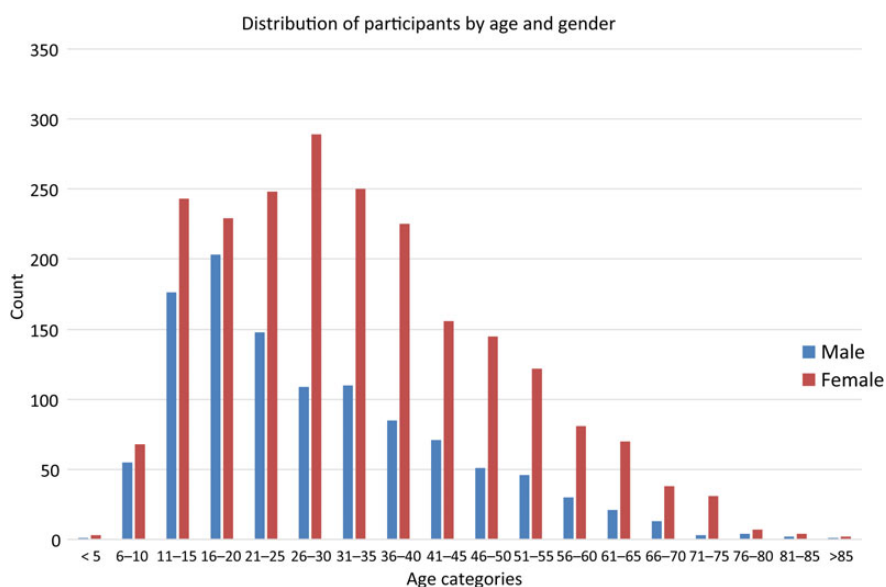
^cDefined as between the ages of 12 and 51.

^dChildren are defined as younger than 19 years of age.

^eData are available for 3317 participants.

^fData are available for 2411 participants.

^gAdults are 19 years or older.

**Figure 1** Age and gender distribution of 3339 children and adults with rheumatic heart disease.

patients. Fourth, whilst the overall use of OACs in patients with appropriate indications was relatively high (69.5%), it was low in patients with mitral stenosis in sinus rhythm at high risk for cardiac embolism. The quality of anti-coagulation control at study enrolment was poor, with only a quarter of patients having INRs in the therapeutic range. Finally, there were variations between low-, lower-middle- and upper-middle-income countries in the ascertainment and prevalence of cardiovascular complications, and the use of percutaneous and surgical interventions for RHD.

Rheumatic heart disease is a chronic disease of the young that accounts for the greatest cardiovascular related loss of disability-adjusted life years in children.²⁰ Whilst female predominance is well recognized,⁹ the prominence of women in the reproductive age has major implications for the reproductive health of patients living in developing countries.²¹ Rheumatic heart disease increases the risk of pregnancy and is one of the major non-obstetric causes of maternal death in Africa.^{3,22} The extremely low rate of the use of contraception in this cohort is alarming, and reflects the poor

Table 2 Clinical characteristics of 3343 children and adults with rheumatic heart disease

	Low-income countries (N 1110) N (%)	Lower-middle-income countries (N 1370) N (%)	Upper-middle-income countries (N 863) N (%)	P
New York Heart Association Functional Class III & IV	306 (27.6)	384 (29.1)	119 (13.9)	0.24
Medical history				
Acute rheumatic fever	247 (22.3)	593 (44.3)	500 (59.0)	0.06
Congestive heart failure	476 (43.0)	285 (21.0)	349 (40.6)	0.06
Pulmonary hypertension	329 (29.9)	465 (34.2)	163 (19)	0.5
Stroke	58 (5.2)	52 (3.8)	125 (14.5)	<0.01
Infective endocarditis	25 (2.3)	59 (4.36)	49 (5.7)	0.1
Major Bleeding	21 (1.9)	38 (2.8)	30 (3.5)	0.61
Peripheral embolism	3 (0.3)	3 (0.2)	19 (2.2)	<0.001
Cardiovascular complications ^a	96 (8.7)	137 (10.1)	191 (22.2)	0.02
Atrial fibrillation	163 (17.9)	241 (22.0)	182 (22.7)	0.49
Echocardiography				
Decreased LVEF in adults	223 (20.6)	262 (19.8)	176 (22.2)	0.58
Decreased LVEF in children	67 (6.2)	83 (6.3)	18 (2.3)	<0.01
Dilated LVEDD in adults	260 (23.9)	302 (22.7)	180 (22.3)	0.81
Dilated LVEDD in children	191 (17.6)	177 (13.3)	86 (10.7)	0.3
Left atrial thrombus	19 (1.8)	18 (1.4)	7 (0.8)	0.6
Surgery				
Valve replacement or repair	81 (11.3)	199 (27.8)	435 (60.8)	<0.01
Mechanical valve only	55 (93.2)	136 (86.6)	349 (93.8)	0.31
Bio-prosthetic valve only	4 (6.8)	18 (11.5)	19 (5.1)	
Mechanical and biological prostheses	0 (0)	3 (1.9)	4 (1.1)	
Percutaneous valvuloplasty	12 (1.1)	54 (4.0)	69 (8.0)	0.03

LVEF, left ventricular ejection fraction; LVEDD, left ventricular end diastolic dimension.

^aCardiovascular complications include any of the following events: stroke, infective endocarditis, major bleeding, or peripheral embolism.

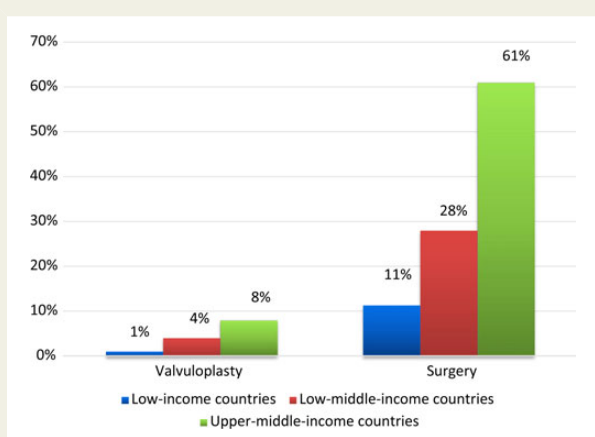


Figure 2 Utilization of valve surgery and valvuloplasty in children and adults from low-income, lower-middle-income, and upper-middle-income countries.

provision of family planning and pre-pregnancy advice for women with heart disease in many regions of the world.^{21,23} We found that 20.6% of women who were pregnant were on warfarin despite the

known teratogenicity of the agent. This calls for safer alternatives in these women.

The pattern of rheumatic valve involvement that is characterized by pure mitral regurgitation in the first two decades of life is similar to what has been observed previously.^{24–27} This study additionally found that the patients had moderate-to-severe rheumatic valve disease that was associated with pulmonary hypertension and LV dysfunction in substantial proportions of cases. The enrolment of severe cases probably reflects the referral patterns to the participating sites which served as tertiary centres in their countries. These patients are at high risk of developing CHF and infective endocarditis and will require surgical intervention. In the Heart of Soweto study of 344 new cases of RHD seen at a tertiary centre, 22% required valve replacement/repair within a year, and 26% developed infective endocarditis within 30 months.²⁴

While the effectiveness of control programmes of RHD through secondary prevention in the form of regular long-acting intramuscular benzathine penicillin injections is proven,²⁸ implementation is difficult and extremely variable both within and between countries.²⁹ Low uptake has been highlighted in numerous countries.^{13,14,30,31} The WHO recommends the life-long use of antibiotic prophylaxis to prevent rheumatic fever in patients with moderate-to-severe RHD,

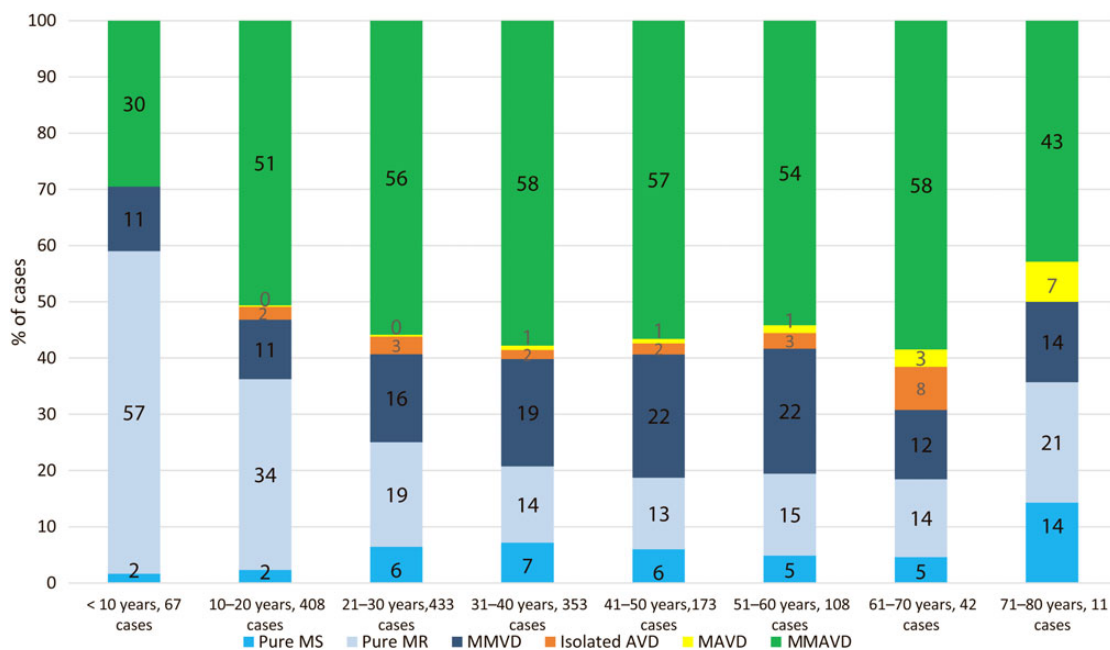


Figure 3 The pattern of native rheumatic valve disease in 2475 children and adults with no percutaneous or surgical interventions. AVD, aortic valve disease; MAVD, mixed aortic valve disease; MMAVD, mixed aortic and mitral valve disease; MMVD, mixed mitral valve disease; MR, mitral regurgitation; MS, mitral stenosis.

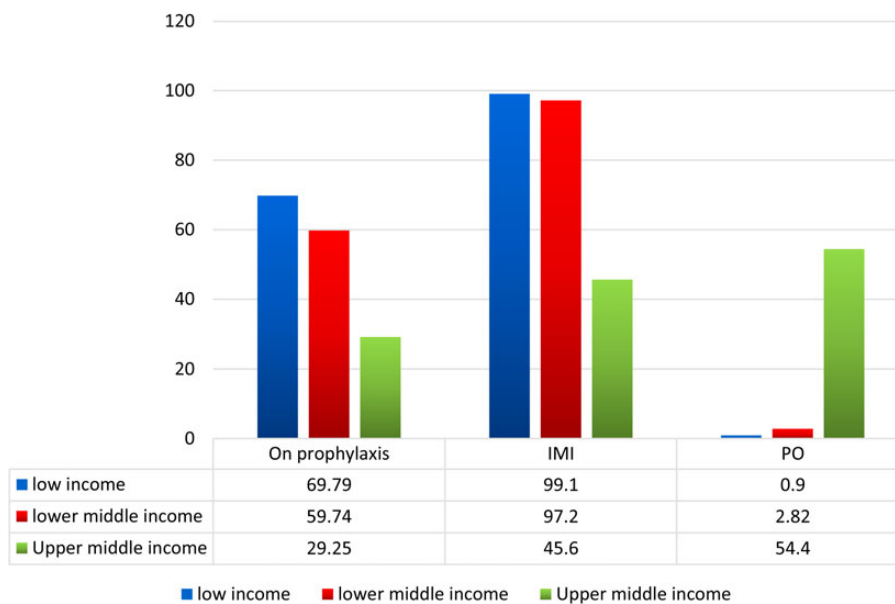


Figure 4 Adherence to secondary prophylaxis with penicillin in low-income, low-middle-income, and upper-middle-income countries.

such as those enrolled in this study.³² However, nearly half of participants in this study were not on antibiotic prophylaxis at the time of enrolment. Thus, there is a need to identify barriers and enhance the delivery of secondary prophylaxis for RHD within the framework of care for chronic diseases in low- and middle-income countries.³³

Oral anti-coagulants are recommended in RHD patients with mechanical heart valves, valvular heart disease associated with AF, or patients in sinus rhythm with mitral stenosis associated with a high-risk factor such as previous stroke, left atrial thrombus, or dilated left atrium.¹¹ In the present study, OACs were prescribed in 70% of

Table 3 Use of anti-thrombotic medication and quality of anti-coagulation in patients with an indication for oral anti-coagulant therapy

Indication	Anti-thrombotic medication	N (%)	Details	N (%) ^a
Mechanical valves	Warfarin	501 (91.6)	No INR tests done in 6 months prior to enrolment	28 (5.6)
			1–3 INR tests done 6 months prior to enrolment	155 (30.9)
			Enrolment INR tests <2.5	198 (39.5)
			Enrolment INR tests in 2.5–3.5 range	168 (33.5)
	Enrolment INR tests > 3.5	72 (14.4)		
	None	41 (7.5)		
	Aspirin	5 (0.9)		
	Total	547		
Atrial fibrillation	Warfarin	397 (67.8)	No INR tests done in 6 months prior to enrolment	58 (14.6)
			1–3 INR tests done 6 months prior to enrolment	147 (37.0)
			Enrolment INR tests <2.0	94 (23.7)
			Enrolment INR tests in 2.0–3.0 range	88 (22.2)
	Enrolment INR > 3.0	85 (21.4)		
	None	126 (21.5)		
	Aspirin	55 (9.5)		
Other (heparin)	8 (1.5)			
Total	586			
Mitral stenosis in sinus rhythm and left atrial diameter ≥ 55 or left atrial thrombus	Warfarin	48 (20.3)	No INR tests done in 6 months prior to enrolment	29 (60.4)
			1–3 INR tests done 6 months prior to enrolment	21 (43.8)
			Enrolment INR tests <2.0	17 (35.4)
			Enrolment INR tests in 2.0–3.0 range	12 (25.0)
	Enrolment INR >3.0	10 (20.8)		
	None	169 (71.6)		
Aspirin	19 (8.0)			
Total	236			

^aThe denominator is the number of patients on warfarin for each indication; INR, international normalized ratio; target range for mechanical prosthetic valves, 2.5–3.5; target range for rheumatic atrial fibrillation or mitral stenosis in sinus rhythm with high-risk features, 2.0–3.0.

patients with these indications, which is higher than the 58% use of OACs found in a world-wide registry of non-rheumatic AF.¹⁵ International normalized ratio control was however poor, with only ~1 in 4 patients on OACs having therapeutic INR levels at the time of enrolment. Alternative strategies for improving anticoagulation in lower- and middle-income countries need to be considered, including the use of point-of-care INR testing and trials of new forms of oral anti-coagulants in RHD patients with native valves.^{34–36} This study provides a basis for trials comparing different strategies for anti-coagulation in RHD patients who have been excluded in virtually all randomized controlled trials of stroke prevention.¹⁵

We observed variations in the ascertainment of cardiovascular complications, echocardiographic LV dysfunction and the use of percutaneous and surgical intervention by country income status. The increasing prevalence of cardiovascular sequelae with rising country income status was independent of age, suggesting more effective detection of such sequelae. The use of percutaneous and surgical interventions was extremely low in low-income countries compared with upper-middle-income countries, despite the greater prevalence of patients with RHD and LV dysfunction who require these interventions in low-income countries. These disparities in the ascertainment of cardiovascular complications and the use of effective invasive interventions probably reflect differences in access to healthcare between countries.

Limitations: We report a hospital-based registry and cannot address the burden of disease in the community. Owing to the need for availability of cardiology expertise and echocardiography facilities for the diagnosis of RHD in the study, we have enrolled cases of moderate-to-severe symptomatic RHD typically seen at referral centres. But several of our participating sites (e.g. Namibia and Zambia) were the sole (or one of few) referral centres in their respective countries, thereby providing a representative snapshot of symptomatic disease in these countries. Furthermore, past events were self- or physician reported, and were not independently verified. Similarly, adherence to secondary prophylaxis was not verified using pill counts or registers, as these were largely unavailable in the countries involved. However, INR measurements were verified from laboratory records. Finally, an additional limitation of the REMEDY baseline study is that we report observations of a cross-sectional study. The interpretation of the findings of a cross-sectional study are inherently limited. This particularly applies to comparisons across country income status as those are prone to ecological fallacy.

Conclusions

There are gaps in the implementation of medical and surgical interventions of proven effectiveness for RHD in low- and middle-income countries.^{7,19} These include the suboptimal use of penicillin for

secondary prophylaxis, inadequate monitoring and control of oral anti-coagulant therapy, the dearth of reproductive services for women with RHD, and disparities in the use of percutaneous and surgical interventions between different countries.

Supplementary material

Supplementary material is available at *European Heart Journal* online.

Acknowledgements

New Delhi, India: Jitender Sharma, Gaurav Purohit; Nairobi, Kenya: Christine Yuko Jowi; Windhoek, Namibia: Henning du Toit, Masomi Kaaya, Liina Sikwaya, Andreas Wilberg, Abeokuta, Nigeria: Tanimowo Sunkanmi; Jos, Nigeria: Ganiyu Amusa, Ludu Audu, Charity Durojaiye-Amodu, Ngozi Elekwa, Ogechi Maduka, Oludolapo Marcaulay, Shamsudeen Mohammed, Halim Odiachi, Christopher Yilgwan; Cape Town, South Africa: Dylan Barth, Patrick Commerford, Felicia Gili, John Lawrenson, Nonkululeko Koyana, Carolise Lemmer, Wendy Matthiassen, Alet Meiring, Peggy Mgwai, Lwazi Mhlanti, Alice Ngcolomba, Simpiwe Nkepu, Mpiko Ntsekhe, Janine Saaman, Unita September, Kathie Walker, Marnie van de Wall; Polokwane, South Africa: Priscilla Adolf, Jabulani Mbokazi, Susan Perkins; Maputo, Mozambique: Neusa Jessen; Khartoum, Sudan: Tagwa Eltahir, Huda Hamid.

Funding

The REMEDY study is funded by grants from the Canadian Network and Centre for Trials Internationally (CANNectIN), South African Medical Research Council, Lily and Ernst Hausmann Trust, the Else Kroner Frasenius Foundation, the University of Cape Town, the National Research Foundation of South Africa, and the World Heart Federation. The Jos site is funded by the Jos University Teaching Hospital, the Heart Aid Trust Inc., and FaithAlive Foundation. The Sudan sites had partial funding from Sheikan Insurance Company. Drs Blanche Cupido and Liesl Zühlke were funded in part by the Discovery Foundation. Dr Zühlke was also funded by a US National Institutes of Health Fogarty International Clinical Research Fellowship, Thrasher Research Fund Early Career Award, Wellcome Trust Clinical Infectious Disease Research Initiative (CIDRI) Research Officer Award, and the Hamilton Naki Clinical Scholarship.

Conflict of interest: A.E. has received a grant from Sheikan Insurance Company to assist with data collection for this work.

References

- Carapetis JR, Steer AC, Mulholland EK, Weber M. The global burden of group A streptococcal diseases. *Lancet Infect Dis* 2005;**5**:685–694.
- Paar JA, Berrios NM, Rose JD, Cáceres M, Peña R, Pérez W, Chen-Mok M, Jolles E, Dale JB. Prevalence of rheumatic heart disease in children and young adults in Nicaragua. *Am J Cardiol* 2010;**105**:1809–1814.
- Diao M, Kane A, Ndiaye MB, Mbaye A, Bodian M, Dia MM, Sarr M, Kane A, Monsuez JJ, Ba SA. Pregnancy in women with heart disease in Sub-Saharan Africa. *Arch Cardiovasc Dis*. 2011;**104**:370–374.
- Koegelenberg CF, Doubell AF, Orth H, Reuter H. Infective endocarditis in the western cape province of south Africa: A three-year prospective study. *QJM* 2003;**96**:217–225.
- Benjamin EJ, Wolf PA, D'Agostino RB, Silbershatz H, Kannel WB, Levy D. Impact of atrial fibrillation on the risk of death: the Framingham heart study. *Circulation* 1998;**98**:946–952.
- Carapetis JR. Rheumatic heart disease in Asia. *Circulation* 2008;**118**:2748–2753.
- Remenyi B, Carapetis J, Wyber R, Taubert K, Mayosi BM. Position statement of the world heart federation on the prevention and control of rheumatic heart disease. *Nat Rev Cardiol* 2013;**10**:284–292.
- Carapetis JR, Mayosi BM, Kaplan EL. Controlling rheumatic heart disease in developing countries. *Cardiovasc J S Afr* 2006;**17**:164–165.
- Lawrence JG, Carapetis JR, Griffiths K, Edwards K, Condon JR. Acute rheumatic fever and rheumatic heart disease: incidence and progression in the northern territory of Australia, 1997 to 2010. *Circulation* 2013;**128**:492–501.
- Manyemba J, Mayosi BM. Intramuscular penicillin is more effective than oral penicillin in secondary prevention of rheumatic fever – a systematic review. *S Afr Med J* 2003;**93**:212–218.
- Nishimura RA, Otto CM, Bonow RO, Carabello BA, Erwin JP III, Guyton RA, O'Gara PT, Ruiz CE, Skubas NJ, Sorajja P, Sundt TM III, Thomas JD. 2014 AHA/ACC guideline for the management of patients with valvular heart disease: executive summary: a report of the American college of cardiology/American Heart Association Task Force on practice guidelines. *Circulation* 2014;**129**:2440–2492.
- RHDAustralia (ARF/RHD writing group). *Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease*. Darwin, Australia: RHDAustralia, Menzies School of Health Research; 2012.
- Bassili A, Zaher SR, Zaki A, Abdel-Fattah M, Tognoni G. Profile of secondary prophylaxis among children with rheumatic heart disease in Alexandria, Egypt. *East Mediterr Health J* 2000;**6**:437–446.
- Pelajo CF, Lopez-Benitez JM, Torres JM, de Oliveira SK. Adherence to secondary prophylaxis and disease recurrence in 536 Brazilian children with rheumatic fever. *Pediatr Rheumatol Online J* 2010;**8**:22.
- Oldgren J, Healey JS, Ezekowitz M, Commerford P, Avezum A, Pais P, Zhu J, Jansky P, Sigamani A, Morillo CA, Liu L, Damasceno A, Grinvalds A, Nakamya J, Reilly PA, Keltai K, Van Gelder IC, Yusufali AH, Watanabe E, Wallentin L, Connolly SJ, Yusuf S. Variations in cause and management of atrial fibrillation in a prospective registry of 15 400 emergency department patients in 46 countries: The RE-LY atrial fibrillation registry. *Circulation* 2014;**129**:1568–1576.
- Zühlke L, Mirabel M, Marijon E. Congenital heart disease and rheumatic heart disease in Africa: recent advances and current priorities. *Heart* 2013;**99**:1554–1561.
- Karthikeyan G, Zühlke L, Engel M, Rangarajan S, Yusuf S, Teo K, Mayosi BM. Rationale and design of a global rheumatic heart disease registry: the remedy study. *Am Heart J* 2012;**163**:535–540.
- Webb R, Wilson NJ, Lennon D, Marijon E, Celermajer DS, Jouven X. Rheumatic heart disease detected by echocardiographic screening. *N Engl J Med* 2007;**357**:2088–2089.
- World Health Organization. Rheumatic fever and rheumatic heart disease: report of a who expert consultation, Geneva, 29 October–1 November 2001. *WHO Technical Report Series*. 2004.
- Murray CJL, Vos T, Lozano R, Naghavi M, Flaxman AD, Michaud C, Ezzati M, Shibuya K, Salomon JA, Abdalla S, Aboyans V, Abraham J, Ackerman I, Aggarwal R, Ahn SY, Ali MK, Alvarado M, Anderson HR, Anderson LM, Andrews KG, Atkinson C, Baddour LM, Bahalim AN, Barker-Collo S, Barrero LH, Bartels DH, Basáñez M-G, Baxter A, Bell ML, Benjamin EJ, Bennett D, Bernabé E, Bhalla K, Bhandari B, Bikbov B, Abdulhak AB, Birbeck G, Black JA, Blencowe H, Blore JD, Blyth F, Bolliger I, Bonaventure A, Boufous S, Bourne R, Boussinesq M, Braithwaite T, Brayne C, Bridgett L, Brooker S, Brooks P, Brugha TS, Bryan-Hancock C, Bucello C, Buchbinder R, Buckle G, Budke CM, Burch M, Burney P, Burstein R, Calabria B, Campbell B, Canter CE, Carabin H, Carapetis J, Carmona L, Cella C, Charlson F, Chen H, Cheng AT-A, Chou D, Chugh SS, Coffeng LE, Colan SD, Colquhoun S, Colson KE, Condon J, Connor MD, Cooper LT, Corriere M, Cortinovis M, de Vaccaro KC, Couser W, Cowie BC, Criqui MH, Cross M, Dabhadkar KC, Dahiya M, Dahodwala N, Damsere-Derry J, Danaei G, Davis A, De Leo DD, Degenhardt L, Dellavalle R, Delossantos A, Denenberg J, Derrett S, Des Jarlais DC, Dharmaratne SD, Dherani M, Diaz-Torne C, Dolk H, Dorsey ER, Driscoll T, Duber H, Ebel H, Ebel B, Elbaz A, Ali SE, Erskine H, Erwin PJ, Espindola P, Ewoigbokhan SE, Farzadfar F, Feigin V, Felson DT, Ferrari A, Ferri CP, Fèvre EM, Finucane MM, Flaxman S, Flood L, Foreman K, Forouzanfar MH, Fowkes FGR, Fransen M, Freeman RK, Gabbe BJ, Gabriel SE, Gakidou E, Ganatra HA, Garcia B, Gaspari F, Gillum RF, Gmel G, Gonzalez-Medina D, Gosselin R, Grainger R, Grant B, Groeger J, Guillemin F, Gunnell D, Gupta R, Haagsma J, Hagan H, Halasa YA, Hall W, Haring D, Haro JM, Harrison JE, Havmoeller R, Hay RJ, Higashi H, Hill C, Hoen B, Hoffman H, Hotez PJ, Hoy D, Huang JJ, Ibeanusi SE, Jacobsen KH, James SL, Jarvis D, Jasrasaria R, Jayaraman S, Johns N, Jonas JB, Karthikeyan G, Kassebaum N, Kawakami N, Keren A, Khoo J-P, King CH, Knowlton LM, Kobusingye O, Koranteng A, Krishnamurthi R, Laden F, Laloo R, Laslett LL, Lathlean T, Leasher JL, Lee YY, Leigh J, Levinson D, Lim SS, Limb E, Lin JK, Lipnick M, Lipshultz SE, Liu W, Loane M, Ohno SL, Lyons R, Mabweijano J, MacIntyre MF, Malekzadeh R, Mallinger L, Manivannan S, Marcenes W, March L, Margolis DJ, Marks GB, Marks R, Matsumori A, Matzopoulos R, Mayosi BM, McAnulty JH, McDermott MM, McGill N, McGrath J, Medina-Mora ME, Meltzer M, Mensah GA, Merriman TR, Meyer A-C, Miglioli V, Miller M, Miller TR, Mitchell PB, Mock C, Mocumbi AO, Moffitt TE, Mokdad AA, Monasta L, Montico M, Moradi-Lakeh M, Moran A, Morawska L, Mori R, Murdoch ME, Mwaniki MK, Naidoo K, Nair MN,

- Naldi L, Narayan KMV, Nelson PK, Nelson RG, Nevitt MC, Newton CR, Nolte S, Norman P, Norman R, O'Donnell M, O'Hanlon S, Olives C, Omer SB, Ortblad K, Osborne R, Ozgediz D, Page A, Pahari B, Pandian JD, Rivero AP, Patten SB, Pearce N, Padilla RP, Perez-Ruiz F, Perico N, Pesudovs K, Phillips D, Phillips MR, Pierce K, Pion S, Polanczyk GV, Polinder S, Pope CA, Popova S, Porrini E, Pourmalek F, Prince M, Pullan RL, Ramaiah KD, Ranganathan D, Razavi H, Regan M, Rehm JT, Rein DB, Remuzzi G, Richardson K, Rivara FP, Roberts T, Robinson C, De Leòn FR, Ronfani L, Room R, Rosenfeld LC, Rushton L, Sacco RL, Saha S, Sampson U, Sanchez-Riera L, Sanman E, Schwebel DC, Scott JG, Segui-Gomez M, Shahraz S, Shepard DS, Shin H, Shivakoti R, Singh D, Singh GM, Singh JA, Singleton J, Sleet DA, Sliwa K, Smith E, Smith JL, Stapelberg NJC, Steer A, Steiner T, Stolk WA, Stovner LJ, Sudfeld C, Syed S, Tamburlini G, Tavakkoli M, Taylor HR, Taylor JA, Taylor WJ, Thomas B, Thomson WM, Thurston GD, Tleyjeh IM, Tonelli M, Towbin JA, Truelsen T, Tsilimbaris MK, Ubeda C, Undurraga EA, van der Werf MJ, van Os J, Vavilala MS, Venketasubramanian N, Wang M, Wang W, Watt K, Weatherall DJ, Weinstock MA, Weintraub R, Weisskopf MG, Weissman MM, White RA, Whiteford H, Wiebe N, Wiersma ST, Wilkinson JD, Williams HC, Williams SRM, Witt E, Wolfe F, Woolf AD, Wulf S, Yeh P-H, Zaidi AKM, Zheng Z-J, Zonies D, Lopez AD. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the global burden of disease study 2010. *The Lancet* 2012;**380**: 2197–2223.
21. Mocumbi AO, Sliwa K. Women's cardiovascular health in Africa. *Heart* 2012;**98**: 450–455.
22. Watkins D, Sebitloane M, Engel M, Mayosi B. The burden of antenatal heart disease in South Africa: a systematic review. *BMC Cardiovasc Dis* 2012;**12**:23.
23. Thorne S, MacGregor A, Nelson-Piercy C. Risks of contraception and pregnancy in heart disease. *Heart* 2006;**92**:1520–1525.
24. Sliwa K, Carrington M, Mayosi BM, Zigiariadis E, Mvungi R, Stewart S. Incidence and characteristics of newly diagnosed rheumatic heart disease in urban African adults: insights from the heart of Soweto study. *Eur Heart J* 2010;**31**:719–727.
25. Sani MU, Karaye KM, Borodo MM. Prevalence and pattern of rheumatic heart disease in the Nigerian savannah: an echocardiographic study. *Cardiovasc J Afr* 2007;**18**: 295–299.
26. Tantchou Tchoumi JC, Butera G. Profile of cardiac disease in Cameroon and impact on health care services. *Cardiovasc Diagn Ther* 2013;**3**:236–243.
27. Demirbag R, Sade LE, Aydin M, Bozkurt A, Acarturk E. The Turkish registry of heart valve disease. *Turk Kardiyoloji Dernegi Arsivi: Turk Kardiyoloji Derneginin Yayin Organidir*. 2013;**41**:1–10.
28. Nordet P, Lopez R, Duenas A, Sarmiento L. Prevention and control of rheumatic fever and rheumatic heart disease: the Cuban experience (1986–1996–2002). *Cardiovasc J Afr* 2008;**19**:135–140.
29. Remond MG, Severin KL, Hodder Y, Martin J, Nelson C, Atkinson D, Maguire GP. Variability in disease burden and management of rheumatic fever and rheumatic heart disease in two regions of tropical Australia. *Intern Med J* 2013;**43**:386–393.
30. Lue HC, Chen CL, Wei H. Some problems in long-term prevention of streptococcal infection among children with rheumatic heart disease in Taiwan. *Jpn Heart J* 1976;**17**: 550–559.
31. Walker KG, Human DG, De Moor MM, Sprenger KJ. The problem of compliance in rheumatic fever. *S Afr Med J*. 1987;**72**:781–783.
32. WHO Technical Report Series. *Rheumatic fever and rheumatic heart disease: report of a who expert panel, Geneva 29 October–1 November 2001*. Geneva: WHO, 2004.
33. Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Affairs (Project Hope)*. 2001;**20**:64–78.
34. Ruff CT, Giugliano RP, Braunwald E, Hoffman EB, Deenadayalu N, Ezekowitz MD, Camm AJ, Weitz JI, Lewis BS, Parkhomenko A, Yamashita T, Antman EM. Comparison of the efficacy and safety of new oral anticoagulants with warfarin in patients with atrial fibrillation: a meta-analysis of randomised trials. *The Lancet* 2014;**383**:955–962.
35. Ellis DJ, Usman MH, Milner PG, Canafax DM, Ezekowitz MD. The first evaluation of a novel vitamin k antagonist, tecarfarin (ati-5923), in patients with atrial fibrillation. *Circulation* 2009;**120**:1029–1035.
36. Okuyama Y, Matsuo M, Matsuo H, Sakaguchi Y, Takai H, Horiguchi Y, Ryomoto T, Adachi S, Amano T, Togawa M, Masuda M, Minamiguchi H, Nanto S, Komuro I, Sakata Y. Introduction of point-of-care testing in Japanese outpatient clinics is associated with improvement in time in therapeutic range in anticoagulant-treated patients. *Circ J* 2014;**78**:1342–1348.