Letters

Improving primary care for Aboriginal and Torres Strait Islander people with rheumatic heart disease

We thank readers who have raised queries following our article 'Improving primary care for Aboriginal and Torres Strait Islander people with rheumatic heart disease: What can I do?' (*AJGP* December 2022),[1] particularly with regard to the potential role of steroids for immunomodulation of acute rheumatic fever (ARF).

The current Australian guidelines do provide for prednisone use in acute carditis.[2] However, these recommendations reflect only expert opinion that steroids might reduce the duration and severity of carditis. Systematic reviews of steroid use in ARF have failed to demonstrate objective benefit, and widespread use is further tempered by the risks of immunosuppression among people living with ARF.[2,3]

There is a clear need for better treatments for ARF, which could reduce the risk of subsequent rheumatic heart disease. This quest is complicated by the immune pathogenesis of ARF, which is a diffuse set of immune pathologies that differ from one person with ARF to the next, rather than a single targetable defect (as is the case in some autoimmune conditions).[4] Hydroxychloroquine might be an effective agent to modify the inflammatory components (as it is immunomodulatory rather than immunosuppressive), but careful exploration through clinical trials is required to understand the potential risks of QT prolongation complicating carditis.[5] Studies exploring the role of hydroxychloroquine are underway and future work is planned to explore the role of steroids in rheumatic chorea. Multi-site international trials are likely to be required to enrol sufficient participants to provide gold standard new evidence.[6] Ongoing attention to cultural safety in primary care and prevention of *Streptococcus pyogenes* (Strep A) infections remains an ongoing need as progress towards ARF therapeutics continues.

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