

Answer : Mediquiz

1. A : T; B : T; C : F; D : F; E : F

In the 2015 modification of the Jones criteria, there is a difference between low risk and high risk groups as far as the parameters are concerned. **Low risk population is defined as: A low risk population is one in which cases of acute RF occur in = 2/100 000 school-age children or rheumatic heart disease is diagnosed in = 1/1000 patients at any age during one year** (IzabelaSzczygielska et al, 2018). The old criteria are all kept, but there are a few changes. For example, while fever or raised ESR was just mentioned in the old version, now the level of body temperature, or ESR or CRP values to be included as criteria are precisely defined. Also, in the high risk group, polyarthralgia is now included as a major criterion while monoarthralgia is a minor criterion. However, in the low risk group, polyarthralgia is a minor criterion. It is now clearly mentioned that for all risk groups, clinical or subclinical carditis is a major criterion. Subclinical carditis is defined as a lesion which has no clinical findings but echocardiography with Doppler shows valvular lesions. Mitral or aortic valve lesions are considered specific for rheumatic fever.

2. C

This is the temperature level for minor criterion in Jones criteria (2015).

3. D

The WHF has developed a screening program involving only echocardiography for rheumatic fever with cardiac involvement.

4. A

According to International clinical criteria for Behcet disease, recurrent oral ulcers (at least three times per year) is an essential criteria for diagnosis.

5. C

This young male has arthritis with purulent effusion, fever and rash. So, gonococcal arthritis should be a strong possibility. In such cases, i.v. penicillin or ceftriaxone are the drugs of choice. Vancomycin does not act against gram negative organisms.

6. B

Post-viral arthritis is quite common in cases of Chikungunya infection. This can sometimes resolve spontaneously although frequently it evolves into inflammatory arthritis akin to rheumatoid arthritis. Thus, DMARDs may be used in such cases. Also, some clinicians prefer a short course of steroids.

Letter to the Editor

[The Editor is not responsible for the views expressed by the correspondents]

SIR, — Non-valvular atrial fibrillation (NVAF) remains an important indication for the usage of anticoagulation therapy in the prevention of stroke. Given the better efficacy and safety, the use of novel oral anticoagulants (NOAC) is preferred over vitamin K antagonists (VKAs). This study observed the trends of usage of NOACs among the physicians in terms of the preferred NOAC and the probable reason for their preferences.

This study highlighted the preferred use of dabigatran compared to other NOACs among physicians. Nearly two-thirds of the patients were receiving dabigatran followed by apixaban and rivaroxaban with almost equal frequency. According to the study, the major reason for the preferential use of dabigatran over other NOACs was the efficacy and safety of the drug. Various landmark studies have compared the efficacy and safety profile of NOACs with VKAs, though no trials have studied the head to head comparisons between various available NOACs. Literature shows that compared to VKAs, dabigatran and apixaban are superior while rivaroxaban is non-inferior in terms of stroke prevention in patients with NVAF. In terms of safety profile, dabigatran and rivaroxaban have a higher risk of gastrointestinal (GI) bleed while apixaban has similar GI bleeding risk compared to VKA. The risk of haemorrhagic stroke is significantly less for all NOACs when compared with VKAs.

Apart from the safety and efficacy profile, other parameters which could add on to the physician preference include the drug availability, cost, availability of its antidote, and dosing schedule. In this study, these parameters attributed less to their preferences.

The usage of the inappropriately lower dose of a NOAC will defeat the purpose of its superiority over VKA. In this study, it was found that about half of the patients on dabigatran received the inappropriately lower dose. The dosage of the NOACs should be guided by creatinine clearance (CrCl) and other clinical parameters like age, bleeding risk profile, and body weight.

NOACs have a good efficacy and safety margin in preventing stroke and thromboembolic events in patients with NVAF. The patient subset should be appropriately chosen to extend the maximum benefit to the patients. We need to consider bleeding risk profile, renal functions, age, and body weight while choosing the appropriate NOAC and its dosage.

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