the general practitioner, whereas 14 per cent of group B chose
to do so ($p < 0.05$ by $\chi^2$). With respect to the causes of sore
throat, 74 per cent of group A claimed to know the causes of
sore throat but only 4 per cent said it was due to a causative
organism; the others attributed it to a variety of causes
including weather, food, etc. Likewise, in group B, 48 per
cent of the respondents claimed to be aware of causes, with 30
per cent demonstrating an understanding of the microbiological
basis. The knowledge of the association between sore throats
and rheumatic heart disease was minimal: 14 per cent in group
A and 30 per cent in group B. Among the sources quoted for this
information are medical professionals (doctors and nurses) as
well as the respondent’s own reading. As to the treatment
attitudes of medical practitioners, all 30 answered that they
would treat the sore throats with an appropriate antibiotic and
an accompanying antipyretic.

The results of this small questionnaire survey suggest that
the increased prevalence of rheumatic carditis in our sample
population is not related to undertreatment by medical
professionals but may be due to a basic lack of understanding
amongst the public as to the cause of sore throats and its
relationship to heart disease. Although these are data derived
from a random survey and may not represent the country as a
whole, nevertheless our data support the introduction of an
education programme directed at the public, at least in
Malaysia, regarding the need to seek medical intervention
when suffering from pharyngitis so as to prevent its sequelae.
Furthermore, it also identifies possible routes for the dissemin-
ation of this information, such as via medical professionals, in
public forums and by pamphlets for out-patient groups.

It is possible that there is a variation in the prevalence of
rheumatic fever and rheumatic heart disease between rural and
urban communities and between different socioeconomic groups.
This study does not propose otherwise, but suggests that further
investigations is indicated on the prevalence in rural areas and
smaller towns in Malaysia to identify target groups, and if
necessary to implement education and control programmes.
Such public or community health measures would help reduce
the cost of hospitalization and cardiac surgery, as currently
rheumatic heart disease accounts for the largest group of valve
surgery operations at the General Hospital, Kuala Lumpur.5

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References

1 Taranta A, Markowitz M. *Rheumatic fever: a guide to its
recognition, prevention and cure*. London: MTP Press,
1981.

2 Ekra A, Bertrand E. Rheumatic heart disease in Africa.

3 Nordet P. Rheumatic heart disease in Africa. *World Hlth Forum*
1993; 14: 292–293.

4 Jamal F, Abdullah N, *et al.* Rheumatic heart disease in
referred cases. Experience at a cardiology centre. *Family

5 Awang Y, Haron AM, *et al.* Cardiac surgery in General
Hospital Kuala Lumpur: a review of all open heart
1987; 42(2): 81–85.

Yours faithfully

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Cardiac rehabilitation in Scotland: is
current provision satisfactory?

Sirs,

I was very interested to read the paper on the above subject,
in the December issue.1 I should, however, like to point out
that the title is misleading. It suggests ‘current provision’ –
but current is actually at date of research, which was spring 1994.

I would like to point out that in Forth Valley there are now
Cardiac Rehabilitation Programmes running in both Stirling
Royal Infirmary and Falkirk & District Royal Infirmary,
following an investment by Forth Valley Health during 1994
in cardiology and associated services. As such, the proportion
of our population provided with cardiac rehabilitation has
changed significantly from that described in your paper.

Reference

1 Campbell NC, Grimshaw JM, Rawles JM, Ritchie LD.
Cardiac rehabilitation in Scotland: is current provision

Yours faithfully

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