The ANC National Health Plan

To the Editor: Thank you for your thoughtful editorial outlining the ANC’s National Health Plan. However, there is one serious flaw in that document that needs to be highlighted and makes the whole plan too dubious to be useful in uplifting the health of our rich and diverse country.

The plan is much too centralised in its conception. It envisages a strong National Health Department that will determine policy for the whole country, monitor its implementation and fund its development. It aims to standardise and control health services of all types from the centre, leaving the periphery merely to carry out orders. It creates a whole new structure that bristles with hundreds of committees that are firmly connected by solid organogramic lines to the Minister of Health.

This is an astonishing model when one considers that there are to be nine provinces in the new South Africa, each of which will have responsibility for its own health services. Each province can set its own constitution, so it is difficult to imagine why central control is so all-pervasive in the ANC’s Health Plan. Surely it makes sense — if only in democratic and participative terms — to devolve decision-making to the lowest possible level? And is that not the main ingredient needed to create a service that is sensitive and responsive to the health needs of communities?

It is also very puzzling to note that the role of local authorities is omitted from this grand scheme. Surely the public health departments were a natural starting point for building the new health services? The district health authorities will be unnecessary once the new local authorities are in place — locally elected, accountable directly to the community, designed for inter-sectoral co-operation, long dedicated to prevention (perverted by apartheid’s priorities to date).

The new municipalities are the best base for building this new health service. They are also the best guarantee that the hospitals will not come to dominate a purely health structure.

Lastly, a centralised service is far more prone than locally controlled structures to bureaucracy and insensitivity. We have a wonderfully diverse country and will only transform the existing inequalities and inadequacies by giving each municipality as much power as the Cabinet.

The local Director of Public Health should have at least as much standing as the Minister of Health in deciding local priorities. This is the situation in Cuba and other countries, and is the kind of model we should follow.

Lastly, sir, do not count the ANC’s chickens before they hatch. They are not yet the government, and our profession need not yet watch ‘the implementation of the ANC’s National Health Plan’. Surely it makes sense — if only in the future of health care — of paying at the point of service, we too often see patients who present late or are reluctant to return for follow-up because of the costs involved. Experience around the world has shown increases in morbidity and mortality as a result of the introduction of fees.

In a country that still has vast unmet basic health needs the idea of inappropriate patient demand for health care is untenable. Why should the few be allowed to continue pilfering their plates high while the majority are forced to peer through the window? Rationing of resources should be based upon health care need rather than the ability to pay.

Having previously worked in the British National Health Service, which provides care free at the point of service, we at no time felt the service we provided was cheap. It is the quality of the health providers that determines the level of patient and provider satisfaction.

Surely it is time we turn with the tide of South African history and start advocating the right of all South Africans to high-quality and easily accessible health care?

M. CHOPRA
D. MCCOY
G. R. DAVIES
Hlabisa Hospital
Hlabisa; Natal/ KwaZulu


To the Editor: While welcoming the general support given to the ANC’s National Health Plan in your editorial, we disagree with your concluding remarks. Free health care at the point of delivery has a fundamental role to play in redressing the gross inequalities in our health system.

A fee-paying system will continue to perpetuate the gross inequalities in our society by further denying many people important health care.

We need to pull down the barriers to cost-effective preventive and curative health care. Here in Hlabisa, a fairly typical rural Zululand hospital, the number of new cases of tuberculosis and HIV infection is doubling every year. Yet, despite only charging a nominal fee of R3 for basic outpatient consultation, we too often see patients who present late or are reluctant to return for follow-up because of the costs involved. Experience around the world has shown increases in morbidity and mortality as a result of the introduction of fees.

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Unselected referrals from peripheral provincial hospitals

To the Editor: This is the sad story of Mrs A, who at the age of 47 dared to seek medical help. She presented with a common chronic problem at one of the Transvaal provincial hospitals. The attending doctor was of the opinion that she could be helped with a simple everyday surgical procedure. He transferred her, however, to the nearest academic institution. Here, 100 km away from her 6 children, Mrs A heard for the first time that she had to be admitted. Since neither this issue nor her feelings about an operation had been discussed initially, she set off back home, which was always perceived as superior to the free injection at the clinic. In the rural setting, a thing of value simply cannot be free. — Editor

Obstacles to submitting occupational disease claims

To the Editor: The recent letter by Rees et al.1 setting out guidelines for the medical practitioner’s report in occupational asthma claims under the Workmen’s Compensation Act (WCA), is to be welcomed. In our view, published guides of this nature are overdue and this practice should be extended to all the more common conditions on the schedule of compensable diseases.

However, from our experience with occupational lung disease, we can identify at least two administrative obstacles that serve to discourage all but the most committed practitioners from pursuing claims for occupational disease under the WCA.

The first obstacle is the inappropriate nature of the forms that require completion. The most important of these, the First Medical Report and the Final/Progress Medical Report, have been designed for accidents, and require arbitrary adaptation to the purpose of occupational disease claims. Those supplementary forms designed for occupational lung disease claims (Medical Report and Industrial History) are outmoded and confusing.

The second barrier is the inordinate time taken by the office of the Workmen’s Compensation Commissioner to resolve occupational disease claims. This delay may stem partly from failure of the medical practitioner to submit all of the required documentation and radiographs, or from difficulty in obtaining an Employer’s Report. However, there is little doubt that claims languish in the Commissioner’s office, in some cases for well over a year.2

Private practitioners are understandably reluctant to carry accounts for the management of such cases, while employees face the risk of having to pay a sizeable lump sum for medical expenses incurred in good faith in pursuing the claim should it be repudiated. Employers may also be reluctant to make the monthly payment (at present discretionary) to the employee for time off work in the uncertain expectation of reimbursement for temporary disablement expenses.

The appointment of regional medical panels envisaged in the new Compensation for Occupational Injuries and Diseases Act3 may speed up the medical certification of such cases by decentralising part of the process. However, there is no sign that the delays at central level are being addressed.

We therefore suggest the following: (i) simple forms specific to the process of submitting an occupational disease claim should be provided without delay; and (ii) a sub-department dedicated to the handling of occupational disease claims should be created within the Commissioner’s Office.

Safety of medical gas cylinders with finger control valves

To the Editor: Owing to the polycarbonate finger knob-operated valve on gas cylinders being prone to embrittlement on contact with certain solvents, as mentioned in a recent edition of the SAMJ, ¹ Afrox embarked upon a programme of recall of such valves on 18 October 1993. We had already set out addressing the issues that required our attention.

The aim of introducing a finger knob-operated valve on certain medical pin index valves was to provide a ready and easy means of opening and closing a medical cylinder valve. We were aware that there had been occasions when lifesupporting oxygen could not be administered for want of a spindle key to open the cylinder valve. The finger knob was designed to overcome these problems. Included in this design change was the feature that if the knob was broken, it could be removed and a small adjustable spanner could be used to operate the valve. This was the design of the finger knob-control valve shown in the December 1993 edition.

It was considered that this feature could be improved, so Afrox redesigned the finger knob and spindle to meet the following criteria:

1. The finger knob is now made from Zytel ST801, a high-impact stress-resistant material, and is black in colour for maximum ultraviolet protection. The South African Bureau of Standards (SABS) has endorsed our use of this material now and for the immediate future.

2. The spindle end has been redesigned so that when the knob is removed, by whatever means, it will accommodate the spindle key originally designed for use with the pin index valves. Its dimensions will be in accordance with SABS 758 as amended. When this physical change is introduced early in 1994, we will take the opportunity of introducing an even better finger knob material, Du Pont Delrin Grade 107, which will be dark red in colour. The SABS has approved the use of this material, which contains an ultraviolet stabiliser and is well received in other industries.

As a cautionary note, we would warn medical personnel not to apply solvents or cleaning agents to cylinder valves. Substances that contain hydrocarbons, such as ether and acetone, react extremely violently in the presence of oxygen. Dirty equipment should be returned to the nearest Afrox branch, appropriately marked for cleaning.

D. C. BAWDEN
Operations Standards Manager
Afrox Limited
23 Webber Street
Selby
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Criticisms of the SAMDC

To the Editor: It was intriguing to read Professor Taitz’s critique of the SAMDC ² and the letters from Drs Sonnenfeld ³ and Du Toit, ⁴ together with others that have appeared in the Journal. Twenty years ago they would not have been published. I speak from experience and must congratulate you on the democratic change in policy. I hope that constructive criticism of the MASA itself will also be published, especially since Branch meetings are no longer held (certainly not in the larger centres) where such matters could be raised.

I would like to take advantage of the new dispensation and give examples of my own experiences in this regard.

Twenty-five years ago I reported a colleague’s disgraceful conduct to the SAMDC. Other colleagues and my patients (a GP) said I must do so. I supplied the name of a witness. Eventually they notified me they had noted the case but were not proceeding further (the accused had submitted letters from overseas experts which apparently exonerated his action). My repeated requests to see these letters and the letters requesting the experts’ opinion (did the Council see the latter?) were refused. I pointed out that after seeing those letters I might realise I owed my colleague a profound apology, but on the other hand he might have misinformed the experts (and Council). I was informed by the President of the Johannesburg Bar Council that I should see the letters for justice to be done.) I also asked whether the Council had obtained a report from the witness. The Council replied that they do things their own way, and as far as the witness was concerned — ‘We are not policemen!’ So again facts were never tested and proved.

Appeal against SAMDC decisions — a tribute is due

To the Editor: The MASA has hailed and welcomed the news that there will now be an avenue open for appeal against decisions of the SAMDC.

Much publicity has rightly been given to the role played by the Association in having brought about this change of heart on the part of the SAMDC, which has long resisted these requests.

I do feel that in taking all the credit the editor of Medigram was remiss in not paying tribute to the tireless efforts and sterling work done in this regard by one of the MASA stalwarts, Dr E. D. Sonnenfeld. He more than any other member of the Association has for the past 20 years carried on a personal crusade in order to convince the authorities concerned that there should be a right of appeal against SAMDC decisions. He felt that an appeal was ‘stronger’ in its implications than review.

On an annual basis he proposed motions to this effect at each Federal Council meeting and these were always accepted nem con. For 7 years he raised this issue at Federal Council but it never seemed to get any further.

Des Sonnenfeld then made it his personal mission to carry this through. Over the years he has privately been to see each successive Minister of Health since Dr L. A. P. A. Munnik. He even went as far as obtaining legal opinions at his own expense because he was convinced of the moral right, not to say the legal right, of being allowed to appeal.

That the right of appeal has now been achieved is a tribute to his tenacity and his firm belief that what he was doing was right and just.

Knowing the above background and having on occasion been party to it, I feel that not enough credit has been given to Dr Sonnenfeld for the dogged manner in which he has for nearly 20 years striven to achieve for the profession what he felt was their right.

NORMAN LEVY
501 Medical Square
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ASA stalwarts, Dr E. D. Sonnenfeld. He more
In September 1992 a black man took his infant to a 24-hour emergency clinic at a private hospital one night. He presented his medical scheme card and was charged R50 to be admitted. He was told the child was teething and was given a bottle of medicine. Next he received an account from the clinic doctor for R80 under item 14.0118. He thought it was an error and disregarded it. The hospital submitted an account directly to the scheme for R43 — benefit rates for a special facility, plus R18,13 for the bottle of medicine. In February 1993 he received the doctor's account again with interest added. On 7 June I wrote to the Council on his behalf, with his permission, pointing out that hospital and doctor were both at fault according to the Council's regulations (see SAMDC Bulletin No. 11).

Imagine my surprise when I received a letter from the MASA, dated 10 August, in reply to my letter to the Council! The MASA, it seemed, was also at a loss and sent me copies of the Council rulings on 24-hour emergency service and of a MASA-proposed change in the wording of General Rule B, which deals with after-hours consultation.

My reply to the MASA (copy to the SAMDC) contains the following paragraphs: 'I am well aware that normally the SAMDC has no jurisdiction over private hospitals, but private hospitals have to have the permission of the Council to establish a 24-hour emergency unit. If the hospital does not comply with the Council's regulations then surely Council's permission could be withdrawn and certainly the doctor(s) could be notified to terminate their services.'

In March 1975, I wrote a letter to the SAMJ which was refused publication. Among other matters, I again raised the question of a colleague who had been found guilty of overcharging by the Council in 1971 and suspended from practice for 4 months. I had written to the local MASA Branch Council about the case in 1971 but they said they could not comment on SAMDC decisions, and I raised the matter again at an OSSA meeting, with the same response. The case (October 1969) was a complicated injury to the face, eye and orbit requiring multiple procedures. Post-operative care dragged on for 5 months. Council applied a 30% reduction in the medical schemes tariff, a take-over of the medical aid tariff that had been developed by MASA for an income ceiling class of patients. The standard tariff that did apply for this case was the first ever requested by the SAMDC in 1963 to help them assess complaints of overcharging. This tariff was approved by Federal Council in October 1965 and became applicable on 1 July 1966. There were amendments in 1967 and February 1969. Most important, there were no general rules included, e.g. reductions for second, third and subsequent procedures. Had such reductions not been applied the overcharge would not have been so heinous. So again the 'facts' were not tested and proved by the Council.

The Editor referred my letter to Head Office and I was told my facts were wrong. I rechecked them and said publish and point out the errors, but . . . !

EDWARD EPSTEIN
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Houtston
Johannesburg


Vaccine storage, transportation and handling

To the Editor: From June to October 1992, 2 years after guidelines for vaccine storage, transportation and handling (based on World Health Organisation recommendations) were circulated to all local authorities in the western Cape, compliance with the recommendations was evaluated in a random sample of clinics in the Cape metropolitan area. The sample included 29% of all identified fixed clinics, 23% of all mobile clinics and 17% of all satellite clinics.

Several weak spots in storage were identified. No refrigerator's power supply had a warning to safeguard against accidental disconnection. Only 55% of clinics recorded the temperature of their refrigerator daily, and in 14% thermometers were absent. There was a threat of repeated opening of fridges with resulting temperature fluctuations due to stored food in 45% of cases and the absence of extra water bottles in 73%. Vaccines were improperly stored in the cooler lower half of refrigerators in 45% of the sample and in the warmer door racks in 23%. Used polio vaccine was improperly stored in unmarked containers in 64%, impeding rapid consumption.

In contrast, the transportation and handling of vaccines could not be faulted. Even though any single one of the identified factors might not necessarily compromise the cold chain, a combination can cumulatively reduce the efficacy of vaccines.

J. G. BENADÉ
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Tygerberg, CP


Emergency medicine in South Africa

To the Editor: Please allow me to state a totally different perspective on emergency medicine in South Africa to the view expressed by Dr Nieuwoudt.

This perspective is supported by my past membership of the Examinations and Credentials Committee of the College of Medicine of South Africa, experience of the course of lectures in Primary Emergency Care offered by Professor Coen van der Merwe at the University of Pretoria, and experience in writing the Diploma in Primary Emergency Care. I have also been an invited lecturer in the course leading to the Dip. P.E.C. and subsequently an examiner.

The scope and objectives of the Dip. P.E.C. as stated, is considered to be fair, reasonable, factually correct and reflecting the views of the College of Medicine in this particular field of medicine.

Examiners are invited to compile balanced papers, of which there are two. The panel of examiners is considered to be well balanced, including an academic plus three individuals in clinical practice, one a trauma surgeon and two general practitioners interested in emergency care. The examination is conducted in a most dignified manner and the College instructions are strictly observed.

It is emphatically denied that "an "anything goes" attitude prevails". The field of emergency medicine is vast and includes aspects of most, if not all, disciplines in medicine.

It is certainly true that a very high level of knowledge, expertise, insight and experience is expected of the candidates. The book by Professor Coen van der Merwe, The Management of Emergencies, prepares and assists them particularly well. Candidates who are well acquainted with the contents of this book rarely find the examination particularly difficult. The book is truly remarkable as regards the extent to which it covers the subject of emergency medicine, and the busy general practitioner is urged to rely on the information it offers and to use it in managing emergency situations. Errors are encountered in virtually every book and every publication, but do not detract from this book's very high quality. A review of the book by Professor R. J. van Rooyen, of the Department of Internal Medicine, University of Pretoria, published in Genesistunde (August 1991), states that (translated): 'Professor Coen van der
LETTERS / BRIEWE

Merwe ... succeeded in achieving the impossible ... I predict that this very useful contribution will for many years stand as the norm. The book is also referred to as 'an encyclopaedic work'.

Other books on emergency care are available at any medical library, as are journals on emergency care, which are well worth reading.

I have not personally attended the Primary Emergency Care course at the University of the Witwatersrand, but judging by reports from people who have it appears to be of exceptional value, and this is supported by the fact that it appears to be extremely well attended.

The statement that a candidate has the right to demand value for his money in the examination situation cannot be accepted. A candidate passes or fails, and this depends on his ability to satisfy the examiners. Much depends on his own effort. I do admit that emergency medicine is a vast field and covering it sufficiently well to satisfy the examiners appointed by the College is a difficult project. The requirements/syllabus for the examination are available, and should the scope and objectives be unclear the candidate may correspond with the Honorary Registrar of the College to clarify uncertainties. The oral and practical parts of the examination give the candidate ample opportunity to demonstrate his abilities, particularly in the field of emergency medical procedures.

It is true that no particular financial gain emanates from this qualification, but the professional satisfaction and the personal knowledge that one probably has some expertise in the management of emergency situations more than compensates for the financial expenditure incurred.

Finally, the College Council states in its scope and objectives that this qualification is particularly applicable to doctors practising in emergency and casualty departments, rural areas, the South African Medical Services, mines and industries, and any other situation where primary emergency care forms an important part of practice.

It is trusted that this will clarify many of the problems candidates have with this examination.

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Civic Centre
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To the Editor: Dr Nieuwoudt's erudite letter and Professor Mieny's comment in the same issue of the SAMJ bear elaboration.

The Dip. P.E.C. scope and objectives are defined as per the letter. As one of the initiators and advisers to the Examinations and Credentials Committee of the College of Medicine of South Africa on the setting up of the diploma in 1983, I am aware that the primary objectives are to encourage postgraduate training and raise the standard of practice in emergency medical care in South Africa.

Of concern to me was why so few South African doctors were attempting this examination and why so few doctors in emergency departments had the diploma. Comparatively, an average of 30 doctors a year obtain the Diploma in Immediate Medical Care of the Royal College of Surgeons of Edinburgh, the majority of them being general practitioners and junior doctors in accident and emergency units. (The UK has far more such units, led by career-orientated consultants, senior registrars, registrars and junior doctors, in a far less violent society than South Africa.)

I commiserate with Dr Nieuwoudt and agree with his comments relating to the Dip. P.E.C. I decided to sit for this diploma myself, having been in accident and emergency work for a total of 14 years, including posts in the Johannesburg group of hospitals and as a consultant in accident and emergency medicine in the UK; having initiated and edited the Trauma Journal in South Africa; having written a handbook on accident and emergency medicine; and having lectured, both nationally and internationally, on various topics in accident and emergency medicine and trauma. At considerable cost, time-wise and financially, I did two courses, one in Cape Town and one in Johannesburg, prepared myself by reading the books alluded to in the article, and failed the exam twice!

Professor Mieny's trite comments are purely semantic. I suspect that the 73% pass rate in the October 1993 examination (in comparison with less than 50% in previous years) is due to my personal communications and letters to both Professor Mieny and Professor Lemmer.

In 1983 I personally sent Professor Mieny guidelines to the establishment of such a diploma, extrapolated from courses and postgraduate education on emergency medicine from Canada, the UK, America and Australia. Core contents for undergraduate and postgraduate education in emergency medicine from these countries was also sent to him.

A WINNER IN RESPIRATORY
FROM START....

RECURRENT TONSILLITIS.....OTITIS MEDIA.....PNEUMONIA....
Thus, in 10 years, little or no apparent advance in undergraduate or postgraduate education or in career structures in emergency medicine in South Africa is evident. Outside a few teaching hospitals, staffing in accident and emergency units remains low as regards both quality and quantity. The mushrooming industry of emergency rooms and trauma units attached to private hospitals, staffed by doctors with little skill in emergency medicine, under no senior medical supervision and being ‘fed in’ by questionable ambulance services, is of great concern. Audits and peer reviews need to be implemented as a matter of urgency.

Resistance to change within the College of Medicine seems fundamental, and the fact that trauma surgery, critical care and accident and emergency medicine have not been established as specialties is indeed an indictment.

In a dramatically changing South African society, aggravated by intense political violence, high death rates and severe injuries as a result of motor vehicle accidents, bullet wounds, stabbings and other forms of interpersonal violence, and the high incidence of heart disease, the need for skilled emergency doctors has never been greater. Establishment of emergency medicine as a specialty should be a top priority.

MICHAEL MORRIS
Wentworth
Durban


Extra-amniotic prostaglandin F₂ₐ in the termination of pregnancy

To the Editor: There is no doubt that the introduction of prostaglandins was a milestone in the management of termination of pregnancy, and that gynaecologists are able to avoid the major complications associated with surgical methods.¹² I have used extra-amniotic prostaglandin F₂ₐ (PGF₂ₐ) to terminate pregnancies for almost 6 years. The ages of the patients treated ranged from 16 to 42 years, and the length of gestation from 13 to 36 weeks. The chief indications for the use of this method were missed abortion and intrauterine death.

The technique I employ is as follows. The patient is placed in the lithotomy position, and a Foley catheter is introduced through the cervix into the extra-amniotic space. The size of the catheter used depends on the dilatation of the cervix. The balloon of the catheter is inflated and pulled down against the internal os to prevent leakage of the prostaglandin solution. PGF₂ₐ solution (5 mg) is diluted in 40 ml of 0,9% sodium chloride and injected slowly with a syringe through the catheter. The balloon is then clamped. The patient is then asked to remain supine for about 1 hour. The uterus is evacuated after abortion has occurred if the placenta appears incomplete.
If induction fails, I repeat the procedure the following day, this time using 10 mg PGE₂ in 40 ml 0.9% saline solution with oxytocin augmentation if contractions are not adequate.

In over 200 terminations using this technique I have observed minor complications (nausea, vomiting, skin rash and transient dyspnoea) in only 7 women. I have never observed any serious complications despite using the technique to terminate pregnancy in women with intra-uterine deaths after 2 previous caesarean sections!

As long as better drugs are not available locally, extra-amniotic infusion of PGE₂ seems to be the best and safest method of termination of pregnancy complicated by intra-uterine death in the third, as well as the second, trimester.

A. KROLIKOFSKI
Eshowe Hospital
Eshowe
Natal


This letter was referred for review and comment to a consultant in the Department of Obstetrics and Gynaecology at the University of Cape Town, who expressed concern about the ‘very high dose’ of PGE₂ cited in Dr Krolikowski’s letter. The practice at UCT is to use a dose of 0.5-1 mg/h, and not a stat dose. The concern here is the possibility of inadvertent intravascular injection, which at this dose ‘could indeed be lethal’, according to the consultant. Finally, concern was expressed about possible uterine rupture. On the other hand, Dr Krolikowski has used this method on more than 200 patients over a period of 6 years, with no serious adverse effects. The SAMJ would be glad to receive an account of the experience of others in this country and/or abroad. — Editor

A sincere thank-you
To the Editor: On Saturday 11 December, crossing the road at the entrance to the Cape Town Waterfront, I softly banged the top of my head on the bottom part of a metal sign. I felt something hot — and, to my astonishment, it was blood! It poured out like water from a tap. I became very hysterical.

Luckily, in the first car that stopped was a doctor (Dr Kwinana, 17 Buller Street, Cambridge, East London). He got out of his car with his fiancée and put lots of toilet paper onto my head, then took me to Somerset Hospital. These were the only people who came to my aid.

The young doctor at Somerset Hospital and his staff of three also did me a wonderful service. Thanks to the MASA for its high-quality medical personnel!

A. GAFFAR BEGG
29 Coleridge Road
Salt River
Cape Town

Prevention of measles
To the Editor: The results of the 1990 national measles campaign and the possible reasons for the subsequent measles epidemic have recently been discussed.²

During the 12-month period 1 July 1991 - 30 June 1992, 80 patients with measles (6 per month) were admitted to a rural hospital in northern Zululand. Three children died (case-fatality rate 3.75%). The age distribution is shown in Fig. 1. Fifteen children (19%) had proven immunisation, 42 (52%) had definitely not been immunised, and the remaining 23 (29%) had no record of immunisation.

Measles immunisation coverage for 1991 was estimated at 68%, using an estimated target population calculated from available birth data.³ These findings suggested the need to improve immunisation coverage and to strengthen existing services, and this was attempted through the identification of a senior nurse with responsibility for immunisation services, the holding of update workshops and the provision of extra mobile clinic services.

In the second half of 1992 and early 1993 the measles epidemic continued and, as a follow-up evaluation, between 6 April and 6 September 1993, 62 consecutive measles admissions (12.5 per month) were studied. The age range was similar to the previous study. Three children died (case-fatality rate 4.8%). Ten (16%) had proven immunisation, 30 (48%) had definitely not been immunised, and the remaining 22 (36%) had no record of immunisation (there was no significant difference between the two study periods, r² for linear trend). Measles immunisation coverage for 1992, using the same method of calculation as above, was estimated at 78%.

In 1992 only 30% of measles vaccine issued from the hospital could be accounted for from statistical returns for immunisations. Only 40% of issued measles vaccine for all Kwazulu institutions could be accounted for in 1991 (M. Short — personal communication). Although our policy is to immunise any child who requires it, at any time, regardless of waste, these figures suggest fundamental operational weaknesses (not least administrative).

Our results confirm that the measles epidemic also occurred in this health ward, despite some success in increasing vaccination coverage. We believe that although ‘vaccination days’ or ‘weeks’ may play a role, the most appropriate and sustainable approach to achieving consistently high levels of immunisation coverage is through the strengthening and extension of existing primary health care services.¹ Our experience suggests that this may be a long and difficult process. The issue of ‘missed opportunities’ for immunisation is of fundamental importance.

We acknowledge the assistance of David Eaton, a medical student from the UK, who carried out the first study as an elective project.

D. WILKINSON
J. KENDSELL
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Prevalence and management of childhood diarrhoea
To the Editor: Acute diarrhoea is one of the world’s leading causes of childhood morbidity and mortality.¹ Its greatest impact is felt in underdeveloped countries, where diarrhoeal diseases (DDs) are also major contributors to childhood malnutrition.²

Although South Africa is a middle-income country, its political policies have resulted in socio-economically deprived communities with poor access to the basic commodities of life (water supplies, sanitation, health care). Not surprisingly, DDs contribute significantly to childhood mortality.³

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Despite previous appeals for pro-active policies on oral rehydration therapy (ORT) with pre-packaged or home-prepared water, sugar and salt solutions, in South Africa these have been no campaigns either for control of DDs or for the promotion of oral rehydration therapy, leaving mothers without an essential child-caring skill. Studies done in Venda,1 Gelukspaan,2,3 Gazankulu,4,5 Soweto,6 farming areas in the Transvaal,7 Johannesburg8 and Khayelitsha9 have confirmed that mothers lack the knowledge or ability to use the solutions correctly.

Studies conducted in Alexandra Township10 have shown inadequate maternal knowledge of ORT.11 In this article we report findings from a descriptive cross-sectional cluster sample survey (based on interviews of 451 mothers of children aged between 6 months and 2 years) which aimed to assess: (i) how many children had had diarrhoea during the 2 weeks preceding the survey and what treatment they had received; and (ii) maternal awareness of ORT and knowledge on how and why to use it.

The prevalence of diarrhoea (using a 2-week recall period) was 54% (N = 242). Table 1 shows the mothers’ source of care.

### Table 1

<table>
<thead>
<tr>
<th>Source of care for a child’s episode of diarrhoea (N = 214)</th>
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<tbody>
<tr>
<td>Home care only</td>
</tr>
<tr>
<td>Clinic</td>
</tr>
<tr>
<td>General practitioner</td>
</tr>
<tr>
<td>Chemist</td>
</tr>
<tr>
<td>Traditional healer</td>
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DDs are probably still the commonest cause of death of small children12 in Alexandra. A simple solution13 is available, but it is still not promoted efficiently enough by health professionals and still not properly understood by the mothers of small children.14 We need to introduce a national diarrhoeal disease control programme in South Africa as a matter of urgency, and to complement awareness of the mothers of small children who do not yet have a full understanding of maternal awareness of ORT and maternal knowledge of ORT.

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A. BELLINGHAN  
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**Paediatric HIV infection in a rural Zululand hospital**

To the Editor: The Natal/KwaZulu region has the highest seroprevalence of HIV infection in South Africa.1 As part of local efforts to monitor the epidemic we are measuring HIV seroprevalence in various groups.2 Since 15% of all patients who have tested HIV-positive in this hospital over the last 5 years were young children (unpublished data), we are monitoring rates of infection in children admitted to the paediatric ward.

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**Halotaan versus isofluraan**

Aan die Redakteur: In die November 1993-uitgawe van die SAMJ het u 'n bylae gepubliseer getiteld 'Inhalation anaesthetics and liver damage'. Ek het hierdie artikel baie interessant en leeraam gevind. Ek dank u vir die poging om rigting te gee aan die jarelange debat oor die lewertoeknie van die narkosedampe wat algemeen in gebruik is. Tog wil ek vermaak toen blindelingse veroordeling van halotaan en die opheffing van isofluraan tot die status van 'ideale' narkosedampe.

Die 'National Halothane Study' uitgevoer in die VSA het bevind dat 1 in 50 000 pasiënte wat bloedgestoot was aan halotaan, postoperatief 'n mate van levernekrose onder­
vind. Die mortaliteit in hierdie groep pasiënte beloop 50%. Dit is 'n baie ernstige toestand. Hou egrer in gedagte dat die gemiddelde narkotiseur, indien ek na my eie prakryk kyk, ongeveer 2 000 keer per jaar narkose toedien. Dus na 35 jaar in praktyk sal hierdie verhouding van levernekrose gepsitiepte het, waarvan 1 pasiënt gesterf het. Voorwaar nie 'n swak praktyrkrekord nie.

Gedurende hierdie swak ekonomiese tyd wanneer mediese koste behoorlik in dek geruk moet word, moet die koste van halotaan teen isofluraan gekontrasteer word. Indien halotaan teen 1 MAC vir 1 uur toegedien word met 'n vars gasvloei van 5 l/min kos dit die hospitaal R5 6,07. Vir elke uur van narkose toegedien teen die isofluraan kos dit die hospitaal R3,99. Indien isofluraan teen 1 MAC kos dit R52,08. Ek laat dit aan u om te bereken wat die kosteventile sou wees oor 35 jaar van narkosepraktekvoering.

Hierdie publikasie mag verrekenelik gevolge inhou soos mediesepraktek aspekte in praktyk betrek. Lewe het nie 'n swak praktyrkrekord nie.

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LETTERS / BRIEWE

Between 1 September 1992 and 31 July 1993, 1091 children were admitted to the paediatric medical ward. Three hundred and four (17%) were tested for HIV infection after pre-test counselling of the mother or other care-giver; post-test counselling was offered to all. All children with marasmus or kwashiorkor were tested, as were most children with severe, life-threatening pneumonia (assessed clinically). A less well-defined group who had chronic diarrhoea, or whose failure to thrive (FTT) did not respond to conventional therapy, or who had pneumonia and FTT, or whose mothers exhibited signs of HIV infection, were also tested. Overall 55 of 304 (18%) tested HIV-positive; this gives a minimum figure of 55 of 1 091 (5%, 95% confidence interval 3.7 - 6.5) for all admissions. HIV-positive children were aged 1 week to 14 years; 16% were aged 1 year or less as HIV-negative children. Stratified analysis of mortality for age showed HIV-positive children to be almost 3 times as likely to die during their admission as HIV-negative children (39% v. 14%; P = 0.0001). A third of all HIV-positive children presented with an AIDS-defining illness.

Stratified analysis for age confirmed findings from a previous report1 that significantly more marasmic children than children with kwashiorkor were HIV-positive (27% v. 9%; P = 0.0001).

Many symptoms and signs of HIV infection in children are nonspecific and may be seen in other common childhood illnesses. An important characteristic is that they are often persistent or recurrent.2 Weight loss or failure to thrive, chronic diarrhoea or severe pneumonia are all common presentations. Hepatosplenomegaly, lymphadenopathy or oral candidiasis may also be seen. As described here, infected children were more likely to be aged less than 1 year, commonly presented with AIDS-defining illnesses and had very high mortality rates during admission.

These findings are reported to emphasise the need to consider HIV infection in children presenting with severe or recurrent childhood illnesses. As the diagnosis is often the first indication of maternal HIV infection, it also offers the opportunity for counselling, and possible limitation of further spread of infection.

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Carbon fibre replacement of knee ligaments

To the Editor: In 1980 a 20-year-old amateur soccer player first presented to me with laxity of the anterior cruciate and medial ligaments of the right knee. Rotatory instability was also present. The patient had previously undergone a ligament reconstruction. In 1980 there was great enthusiasm for carbon fibre replacement of torn knee and other ligaments. At the time, looking for a better way of treating knee ligament injuries, I shared in this excitement, but subsequent long-term follow-up results did not justify this enthusiasm.

The patient under discussion consulted me again on 3 April 1993 with a haemarthrosis of the left knee, the injury having been sustained the previous day during a soccer game. He stated that the right knee was ‘fine’ and that since I had performed carbon fibre replacement of the ligaments in 1980 he had played soccer for 13 years at high amateur level and had experienced no problems.

Examination revealed grade I anterior cruciate laxity of the right knee with the knee in external rotation; otherwise there was a full range of movement. There was no laxity of the medial ligament, which had also been replaced by carbon fibre.

In Durban long-term follow-up after an orthopaedic operation can be difficult because our population tends to be mobile. In this case it was interesting to have this opportunity and to note that an anterior cruciate and medial ligament replacement with carbon fibre can function so well in a young man who places high demands on the reconstructed ligaments by playing top-grade amateur soccer. Obviously ‘one swallow does not make a summer’, but this case shows that good long-term results can be achieved with this procedure.

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An unusual cause of urethral obstruction

To the Editor: An 18-year-old youth was shot in the left buttock and presented to a peripheral hospital with macroscopic haematuria. The findings on cystography and excretory urography were reported as normal; the bullet was thought to be in soft tissue. He was discharged but returned 2 days later with acute urinary retention. Urethral catheterisation was unsuccessful and a suprapubic catheter was inserted. A cysto-urethrogram performed via the suprapubic catheter revealed complete occlusion of the penile urethra by the bullet (Fig. 1). The bullet was removed by pushing it back into the bladder and extricating it with grasping forceps. Cystoscopy revealed an inflammatory region on the left bladder wall but no other abnormalities.

FIG. 1. Cysto-urethrogram revealing complete occlusion of the penile urethra by the bullet.
Spontaneous passage of a bullet during voiding has previously been described. This would have occurred in this case, but the bullet lodged in the distal penile urethra, causing complete occlusion. Removal of the bullet with grasping forceps in the urethra would have caused excessive trauma, and we elected to push the bullet back into the bladder. Irregular objects in the bladder may be removed via suprapubic cystostomy if endoscopic removal is unsuccessful.

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Sexually transmitted diseases in general practice

To the Editor: A lack of comprehensive surveillance data hampers attempts at evaluating the success of sexually transmitted disease (STD) control programmes in developing countries, and in South Africa in particular. The aspect most lacking in STD surveillance systems attempting a comprehensive approach is information on the extent of the STD epidemic in patients treated in private general practice.

During 1 week in March 1993 a descriptive investigation was undertaken with the aim of determining the STD case-load in general practice in Cape Town. The study population consisted of all 699 general practitioners in private practice as listed in the 1992/93 Cape Peninsula telephone directory. A systematic sample of 100 subjects was selected and a pretested questionnaire was administered to respondents by means of telephonic interviews. This method has been used in a previous STD survey. Doctors were asked about the number of STD cases and the total patient load (all conditions) they had seen during the previous month (4 weeks). STD was defined as all cases of male urethritis, genital ulcerative disease, syphilis and any other disease (including vaginitis) the practitioner believed could be transmitted during sexual contact.

Sixty-two practitioners (62%) responded (non-responders consisted of those who refused and those who could not be contacted after 2 telephone calls). A median of 4 (range 0 - 90) existing cases and 3 (range 0 - 70) new cases were seen per practitioner each month. The average total patient load per practitioner (STD and all other diagnoses) was 668 patients over the 4-week period. The total practice patient load was used to calculate an average STD consultation rate of 1.4% (95% confidence interval (CI) 1.3 - 1.5%) for prevalent cases and 1.1% (95% CI 1.0 - 1.1%) for incident cases. These rates allow for a minimum estimate of 4 142 existing and 3 255 new cases of STD receiving treatment in general practice in Cape Town every month. Male urethritis comprised 52% of prevalent cases, genital ulcerative disease 5%, syphilis 5%, and unspecified disease 38%. Of the practitioners 97% reported treating every case of STD they diagnosed. Reasons for referral (mainly to
Left upper molar pain — the tip of the iceberg

To the Editor: A 48-year-old woman presented at the Dental Clinic, Addington Hospital, with a vague but severe pain in the left upper molar (LUM) 25, 26, 27 region. The pain was sometimes spontaneous and continuous, at other times precipitated by cold air. It radiated to the left temporal region.

A clinical history and radiograph revealed the presence of amalgam fillings on 25, 26, 27 and some sensitivity of the cervical margins of the buccal mucosal surfaces of 25, 26, 27. No dental abnormality was evident, although further investigation revealed that the patient suffered from nocturnal bruxism. Teeth 25, 26, 27 were not particularly sensitive to ethyl chloride or percussion. It was, however, considered necessary to remove the restorations on 26 and 27 and to insert non-conductive temporary fillings.

The cervical margins of 25, 26, 27 were also desensitised.

After several visits the patient returned with little improvement. She was a good and co-operative patient, but seemed to be under stress. The dentist was not convinced that 26 and 27 had irreversible pulpsitis that would justify root canal therapy, so the patient was referred to the Addington Hospital Pain Clinic. During a 2-hour assessment there the following psychosocial history was obtained.

The patient was married, to an only child who had been over-indulged by his parents and was a very demanding husband, which the patient found very stressful. They had one daughter, who had developed epilepsy (controlled by medication) after a motor-bike accident. One year previously the patient's husband had been retrenched. He had been unable to find another job so he and the patient had moved to Durban and live with her parents-in-law, from coping with her husband's emotional reactions, and from having to leave her daughter in Pretoria, as she was very concerned about her. Her work was also very demanding and stressful, although she found it interesting.

The patient scored 9 on the Beck Depression Inventory, indicating normal mood fluctuations, although she also had a disturbed sleep pattern, characterised by bruxism, early morning awakening, and a poor body image, despite being attractive and well-groomed. Her fragile emotional state was evident from her tearfulness during the interview as she talked about her problems.

It was concluded that the patient was experiencing considerable physical and emotional tension, of which the bruxism was one expression and possibly also led to the LUM pain complaint. A good rapport was established with her during this first interview, although she was resistant to the suggestion of stress management counselling because of her husband's adverse attitude to such interventions.

Pain Clinic management was to recommend the following: (i) an exercise programme to facilitate release of tension — the patient is now running 5 days a week; (ii) use of a mood elevator — dothepin 25 mg at night to facilitate a better night's sleep, and counteract any masked depression; (iii) hormonal replacement therapy, as recommended by a gynaecologist; (iv) a low-dose anticonvulsant (carbamazepine 100 mg at night); and (c) telephonic contact with the first author to discuss any problems, whenever necessary.

At follow-up after 2 weeks the patient's pain intensity level, measured on a visual analogue scale of 0 - 10 (0 = no pain, 10 = extreme pain), had dropped from 7 to 3. She reported that her husband had at last found work, and she was visibly more cheerful.

A clue to the psychosocial causes of the patient's dental pain was her concern to the examining dentist about how kind he was, indicating that she needed empathetic understanding of her stressful situation. This case illustrates how initial awareness of a psychological overlay to an expressed somatic, non-pathological, chronic pain complaint, followed by a multidisciplinary intervention, can produce rapid results. In this patient's case there is no doubt that her husband's re-employment played a large part in her rapid improvement.

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Research and child mental health policy

To the Editor: Moodley and Pillay examined the demographic and clinical characteristics of the first 100 patients admitted to Natal's first inpatient child mental health centre over the first 2 years of operation. They found that almost a third of the children were diagnosed as having disruptive behaviour disorders, and that parent-child problems were also very prevalent. They argue that such information is valuable for the ongoing development of the
Proper film reading with proper film reading

To the Editor: I have read a paper by Mohanlal et al., reporting an interesting case of Wegener's granulomatosis in an 11-year-old Indian girl. It is well presented with pathological proof. They point out the importance of early diagnosis, because proper treatment is life-saving.

I would like to discuss the radiograph illustrated in Fig. 1. [We reprint Fig. 1 here, since the article referred to by Dr. Hu appeared in 1988.] Besides the two right apical nodular lesions arrowed by the authors, there are other abnormal shadows.

1. In the inner medial portion of the right posterior third intercostal space (ICS), partially overshadowed by the upper mediastinum ('A' superimposed on Fig. 1 by me), is a big patch shadow about 3 - 4 cm in size with a nodular appearance, especially to the lower left, possibly a 2.5 cm nodular shadow with central cavitation.

2. There is another patch shadow, nearly the same size, just below the outer arrow and located in the lower middle portion of the second ICS (B). It also possesses some cavitary possibilities. These are the characteristic radiographic signs in Wegener's granulomatosis. These two patch shadows are all closely connected with the upper lung root shadow (LRS) with linear streaks which give a kind of fan-shaped triangular combination of lung markings.

3. The right LRS appears more elevated than normal. The left LRS is always higher than the right in adults, and even in teenagers (L. B. Hu — measurements of the LRS in 883 normal Chinese; unpublished data). In this patient, the bifurcation of the right pulmonary artery is about 1.5 - 2 cm higher than the origin of the left pulmonary artery.

This is very different from the normal measurement according to my experience and suggests that the lesions in the right upper lung have been present for a rather long time, causing the upper lung to shrink or become less pneumatic than normal.

4. There is a round mass shadow about 3 cm in diameter overshadowed with the right LRS (C). It looks like an aneurysmal dilatation of the right lower pulmonary artery. It also suggests a wide connection between the right LRS and the mediastinum; normally I have found the LRS to be narrowly connected with the mediastinal shadow by the lung pedicle. Therefore the lower right LRS is greatly enlarged. But in judging such hilar shadows one must be careful to ascertain whether it belongs to the LRS itself or is an overlapped lesion anterior or posterior to it; this must be proved by a lateral projection, and that's why a postero-anterior (P-A) film alone is not a complete examination in chest radiography.

5. There may be other abnormal shadows overlapped with other portions of this LRS (D and D'), but this is just a possibility. I can't be sure. They should be checked by lateral views.

6. It seems that the left lung has escaped involvement, but to me, the encroachment of the left lung appears no less than on the right side: (i) the vascular clearness of the left LRS is markedly reduced; (ii) the pulmonary markings are very uneven in the upper lung field; and (iii) the vascular branchings are markedly decreased in the left lower lung field. Vascular damage in the lung may explain why the pulmonary trunk is so enlarged, and there may be thrombotic or embolic phenomena in the lung, on this side, on the right or on both.

7. The right hemidiaphragm is more elevated than the left, and its surface is wavy in appearance. I suspect there is liver enlargement as well as involvement underneath.

8. Lastly, a lateral film may well have given more information than this P-A film alone. And this P-A film is not properly exposed. We usually prefer high KVP exposure in order to visualise the intervertebral spaces behind the heart, and so obtain more details besides the usual blind spots. For lateral films, we prefer that the thoracic vertebral bodies are clearly visible.

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I'm sure that Dr. Hu would appreciate any comments on the points he makes here, and we will publish and/or forward them to him. — Editor