in the postoperative period and bringing the profession of specialist surgeon into disrepute is provocative and laughable. I'm surprised that this hearing favoured the 'expertise' presented by a retired surgical academic, who by his own admission had done very little laparoscopic surgery, over that of a professor and a specialist intensivist currently at the top of their careers. Surely experienced medical personnel should be appointed to hear public grievances? Those of us who are members of the Medical Protection Society (MPS) are concerned that in a case like this the legal representatives failed dismally. This case should have won hands down.

There is a perception among the lay public and litigation lawyers that as most of us have some form of medical protection there's no harm in 'having a go'! MPS reports suggest that medicolegal claims in South Africa have escalated way above rates in the rest of the world. It is my impression that we in clinical medicine are seen as an easily milked cash cow. We are under continual pressure from medical aids, hospital groups and the media – and now our very own HPCSA.

I sincerely hope that the colleague in question has the stamina to exercise his rights and appeal against the findings of the HPCSA, and that his surgical association reacts strongly to this disgraceful decision.

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Well done, SAMA's Industrial Relations Unit!

To the Editor: It is reassuring to know that the South African Medical Association, through its Industrial Relations Unit, has the capacity to assist doctors, especially hospital doctors, should any have reason to believe that they have been subjected to unfair labour practices.

My own experience is that about 3 years after retirement I was phoned by the hospital concerned and told that I had received a salary increase some 2 or 3 years before retirement for which I had not been paid. I was told that if I supplied my bank details I would be paid. Having heard nothing for a year I made further enquiries, only to be told that the provincial health department concern had no money.

I had no recourse other than through the SAMA Industrial Labour Unit, which was entirely successful in obtaining my back pay.

I don't hesitate to recommend to all doctors that they should become SAMA members, for this and many other reasons!

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Selective serotonin reuptake inhibitors in children and adolescents

To the Editor: The introduction of the selective serotonin reuptake inhibitors (SSRIs) was widely viewed as an important advance in clinical psychopharmacology, not only because of their broad-spectrum efficacy but also because of their tolerability and safety advantages, particularly compared with the older tricyclic antidepressants (TCAs) and monoamine oxide inhibitors (MAOIs). Subsequently there has been considerable controversy about this class of agents, partly because of concerns about the extent to which they have been injudiciously prescribed for 'cosmetic' problems rather than for genuine psychopathology,[1] and partly because of concerns regarding their adverse effects. Most recently, attention has been paid to the appropriate use of SSRIs in children and adolescents.

The 'Drug Alert' published by the National Adverse Drug Event Monitoring Centre in the September 2005 SAMJ[2] is singularly unhelpful in this regard. The report takes a far more conservative stance than that taken by regulators in the USA, the UK and the EU; it may be misleading by implication and omission; and (if followed to the letter) it may cause child and adolescent psychiatric patients significant harm.

The 'Drug Alert' warns practitioners on four points. First, 'None of the SSRIs are currently approved in South Africa for any indication in children and adolescents.' It should be pointed out, however, that fluoxetine is registered with the US Food and Drug Administration (FDA) for child and adolescent depression and several of the SSRIs (fluvoxamine, sertraline, and fluoxetine) are also FDA-registered for child and adolescent obsessive-compulsive disorder (OCD).[3] Practitioners should also be aware that decisions about whether to submit pharmaceutical agents to the Medicines Control Council for registration of particular indications may often be made on the basis of cost rather than scientific or clinical considerations.

Second, 'SSRIs have been associated with an increase in the risk of suicidal thinking and behaviour (suicidality) in children and adolescents with MDD [major depressive disorder] and other psychiatric disorders.' However, as the drug alert also states, 'no suicides occurred' in the 24 trials involving over 4 400 patients. In addition, a systematic review[4] published recently found no significant difference in the risk of suicide in patients taking SSRIs compared with those taking TCAs. As several commentators have pointed out, patients with overt suicidal ideation are excluded from clinical trials and the heterogeneous nature of the trial designs employed (use of different definitions and assessments of self-harm in different study populations) further contributes to the difficulty of interpreting the data. The trials quoted were not designed to address the question of whether SSRIs increase suicidal ideation, and cannot in fact do so.[5]

Third, products 'containing citalopram, escitalopram, fluvoxamine, paroxetine, sertraline and venlafaxine are contraindicated in children under 18 years of age'. While many regulatory authorities have cautioned practitioners about possible adverse events of these agents, so far none have taken so inflexible an approach as to say that they are all 'contraindicated' in children and adolescents. The European Medicines Agency in the same press release referred to by the MCC concedes that: 'It is recognised that a doctor may sometimes take a decision based on the individual clinical needs of a child or an adolescent to use these products for the treatment of depression or anxiety. The CHMP [Committee for Medicinal Products for Human Use] is recommending that in these cases patients be monitored carefully for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment.'[6]

It must be remembered that TCAs are not effective in child and adolescent depression, while SSRIs have been shown to be effective (on their own and in combination with cognitive behavioural therapy) for child and adolescent depression, and as a sole intervention in some childhood anxiety disorders, especially OCD.[7-10] Fluoxetine, the only SSRI not on the MCC's 'contraindicated' list, is not always tolerated by younger patients, especially those who have severe anxiety, and is also not available in any form except 20 mg capsules in most of the state sector, making appropriate dosing difficult. The effect of implementing the MCC recommendations as published would be to deprive child and adolescent patients with these disorders of available, effective and potentially life-saving alternative medications.

Depression is a common, disabling, and potentially fatal disorder that is substantially and unequivocally associated with suicide and deliberate self-harm in children and adolescents. A large recent Swedish forensic study[11] showed that only 13% and 4% respectively of children and adolescents who actually committed suicide had received any antidepressant medication at all; youth suicide is far more likely to occur due to untreated depression than the adverse effects of any antidepressant. It should also be noted that since the advent of the SSRIs in 1988, suicide rates have decreased significantly in many countries.[12,13]

Fourth, 'Discontinuation of SSRIs, especially abrupt discontinuation, commonly leads to significant withdrawal symptoms.' While it is true that discontinuation symptoms can be seen with some SSRIs after abrupt discontinuation, this warning runs the risk of conflating SSRIs, which are not associated with dependence, with medication classes such as the benzodiazepines, where dependence is an acknowledged risk.

In view of the above points we urge practitioners to note that these warnings from the MCC do not seem to reflect a balanced view of current scientific thinking, and may have significant adverse consequences for patients if implemented

inflexibly. We would argue that the SSRIs do have an important role to play in psychiatric practice, including that of child and adolescent psychiatry, and that clinicians should, as always, balance the benefits and risks for any particular patient and keep the interests of the patient paramount. Obtaining an expert opinion from a child and adolescent psychiatrist would be useful in situations where a practitioner is unsure. We hope that the MCC will urgently reconsider the wording of this directive, in the interests of the many young patients who may otherwise be deprived of necessary and effective treatments.

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Rocephin – the thin end of the wedge

To the Editor: I am sure I speak for many colleagues who have been cajoled, squeezed, begged and pressurised by medical aids, hospital administrators, pharmacists and representatives to stick to formularies to the point at which, backs against the wall, we say, 'No more!' The 'thin edge of the wedge' for me is the Rocephin issue.

I have grown up with Rocephin. For me, rightly or wrongly, Rocephin is the drug that diminishes my anxiety, oh so slightly, over the safety of my patients; that may prevent meningitis secondary to sinus surgery; and that may stop a child's otorrhoea when other drugs have failed and prevent him or her from developing mastoiditis.

But despite evidence that many generics are inferior,[1] the pressure is on me not to use Rocephin, but to prescribe a generic, for the vast saving of about R5 per dose.

When will this pressure stop? If I surrender on the Rocephin issue, what comes next? Are the medical aid administrators, the hospital managers and the pharmaceutical buyers willing to share the medical risk that I face on a daily basis? Will they stand in the dock with me one day, and admit to using medications that are not proven to be equal in efficacy?

We hear so much about 'sharing risk' nowadays. The best way those pressurising me to use 'their' not 'my' choice of drugs can share risk, is by sharing my risk. What about, as a suggestion, paying all or part of my medical indemnity insurance?

I'm not looking for handouts. I'm not looking for perverse incentives. I don't even know, or care, whether the 'local' generic ceftriaxone is equivalent to Rocephin. For a saving of only R5 a dose? I learn from one generic manufacturer that their local factory manufacturing quality is excellent, and then I hear that the drug I am interested in is allegedly manufactured in Turkey, shipped to Germany, and then to South Africa where it is distributed.

For me there is a line I dare not cross, on the other side of which my autonomy stands for nothing. Where I still have a choice, I must fight to maintain it, lest that thin edge of the wedge be pushed in further and further, until it becomes a thick edge, and then a wall. 'Rocephin' for me is that issue, and I will not budge. It is time we as a collective organisation of medical professionals stand up and say to those who would manipulate us 'This far and no further'.

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Problematic childhood atopic eczema consensus document?

To the Editor: The childhood atopic eczema consensus document published as part 2 of the June issue of the *SAMJ*[1] is problematic and necessitates the following comments.

A discussion of the controversy over the definition of atopic eczema is necessary, particularly in view of the recommendations that pertain to allergy testing. Without this the rest of the article is open to misinterpretation. When dermatologists speak of atopic eczema they mean a clinical diagnosis. As