Treat the patient, not the result

To the Editor: Several episodes of nursing and laboratory staff at a specialist tuberculosis (TB) hospital presenting with flu-like symptoms, who on further investigation were found to have acid-fast bacilli in their sputum yet normal chest radiographs, have occurred. In many instances, in the absence of other evidence of TB, these staff were not initiated on anti-TB treatment. Serial sputum investigations remained negative and the symptoms disappeared. Similarly, in the same institution there have been several reports of patients referred with a microbiological diagnosis of multi- or extensively drug-resistant tuberculosis. Owing to the protracted period of time needed to grow these organisms, the individuals concerned are commenced on first-line TB treatment. By the time the susceptibility results are received (usually several months later) and the patients referred to the specialist TB hospital for further management, both clinical and radiological improvement in response to first-line TB treatment has taken place, which suggests that there might have been some contact with TB (drug-susceptible or resistant), and the bacillus could have infected and behaved as a commensal for a short period and not caused disease in the 'carrier'. This scenario is more relevant today, with the prevalence of MDR and XDR TB. If a chest radiograph is reported as clear by an experienced reader, and the individual is asymptomatic, then the sputum test should be repeated, including culture and susceptibility testing, before embarking on therapy with potentially toxic second-line TB drugs. Health workers should be cognisant of these confounders and remember to treat the patient – and not laboratory reports or radiographs.

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(ARV-) Free State? The moratorium's threat to patients' adherence and the development of drug-resistant HIV

To the Editor: Despite early fears that people living with HIV (PLWHs) in Africa would not be able to adhere to antiretrovirals (ARVs),[1,2] research has shown that the proportion of PLWHs reporting ≥95% adherence in sub-Saharan Africa is higher than that in North America.[3] However, maintaining adherence is complex, and several factors affect patient ability to access and adhere to ARVs: patient characteristics and context, ARV regimen, clinical situation and the patient/health staff relationship.[4]

In October 2008, the new Minister of Health announced that 550 000 PLWHs – the highest number in the world – were on ARVs in South Africa.[5] This achievement was recently tarnished by increasing alarm over Free State province's public sector ARV programme. The Free State has the third-highest HIV prevalence (of 31%) in the country.[6] Since December 2008, the province's Department of Health stopped initiating new patients on ARVs[7] because of out-of-stock drugs and lack of funds. An estimated 30 PLWHs are dying every day in the province while this hiatus continues.[8] The moratorium will increase morbidity and mortality, but the loss of trust in the health system and the potential impact of the ARV crisis on existing patient adherence also need to be considered.

Campero *et al*. reported that patients already on ARVs share their medication with neighbours, relatives or friends who experience delays in receiving ARVs.[9] This practice could lead to the development of drug resistance in people sharing medication if they consequently have differential exposure to ARVs,[10-13] and raises serious public health concerns about drug failure, subsequent and more expensive drug regimens, and the spread of drug-resistant strains of HIV.

Patients' perceptions of staff attitudes and waiting times were reported to be key factors for patients' ARV adherence.[14] Conceivably, PLWHs will seek care in other provinces, and would consequently be required to return monthly to outlying clinics to pick up their ARVs. Transport costs and the time needed to reach clinics are risk factors to adherence and retention in care.[15,16] Patients currently on treatment – in the Free State and elsewhere – are understandably anxious about the health system's ability to guarantee lifelong access to ARVs.

An estimated 300 000 people might not have died of AIDS if the South African government had responded to the AIDS crisis quickly and in a coherent manner.[17] How the government proceeds to contain and repair the damage being done in the Free State will be a litmus test for the long-term success of South Africa's ARV programme.

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