



PMTCT programme — partial assessments can build the picture

To the Editor: Delva and Temmerman¹ state that ideally a prevention of mother-to-child transmission (PMTCT) programme's success should be measured by its effectiveness in the community, that our study of the Coronation Women and Children's Hospital (CWCH) PMTCT programme 'partially fails to envelop the entire reality' of the programme and that it is difficult to extrapolate results from a research to a routine service setting. We agree.

Our study was undertaken at a time when virtually no information was available regarding the efficacy of the newly instituted national PMTCT programmes or the 18 government pilot PMTCT sites. Political controversy shrouded PMTCT programmes and doubt was cast on the efficacy of nevirapine (NVP), the ability of South African women to exclusively formula-feed (EFF) and the need to diagnose the HIV status of vertically exposed infants.

We did not intend the findings of our hospital-based study to be extrapolated to the community nor did we suggest that the study population was representative of all women participating in the CWCH PMTCT programme. 'The study enrolled 297 (24%) of the total 1 234 HIV-positive women registered with the PMTCT service, therefore despite any bias introduced by the inclusion criteria and study design the sample represents a significant proportion of patient outcomes in the routine service.'² We simply used the opportunity provided by a research study to document certain parameters of the routine PMTCT programme at CWCH.

Since study enrolment occurred at 2 - 6 weeks of age, voluntary counselling and testing (VCT) was not an aspect we could measure accurately; however it seems likely that the HIV prevalence in women attending CWCH is lower than the Gauteng average and that VCT uptake is both better than estimated by Delva and Temmerman and improving over time.^{1,3} Our study dispels local scepticism that women are unable to EFF successfully but does not conclude that this very low breast-feeding rate applies to all HIV-infected women in the community.

We used a 'snapshot' comprising a quarter of all participants in the routine CWCH PMTCT programme to demonstrate excellent uptake and efficacy of NVP and the ability of women to EFF with good infant outcomes. This was among the first demonstrations in South Africa that a routine PMTCT service could achieve exceptional results which are not diminished even if it is assumed that the study participants represent only the best outcomes in the CWCH PMTCT programme. As advocated by Delva and Temmerman, additional research to inform and optimise PMTCT programmes and policy to increase effectiveness in the

community to the highest levels possible is vital. In the absence of the ideal assessment of the CWCH PMTCT programme, available data must be used to monitor the programme provided that the limitations of such a partial assessment are borne in mind.^{2,3}

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Sedation of children undergoing MRI — a risky business!

To the Editor: It was with great interest that we read the recent article by Kitsa *et al.*¹ concerning the sedation of children undergoing magnetic resonance imaging (MRI). Oral sedation has often been used for children undergoing MRI or even computed tomographic (CT) scanning, being prescribed by a referring paediatrician or other clinician or prescribed and administered by radiologists themselves. Monitoring in the scanner is often suboptimal, consisting of pulse oximetry checked by a nurse or radiographer. Sedation may either not work, or have the opposite effect of stimulating a child at sub-optimal doses, whereas oversedation is extremely dangerous. Furthermore, very few (if indeed any) diagnostic radiologists in South Africa are competent enough to perform paediatric resuscitation if complications should occur. Sedation, as opposed to general anaesthesia, is a useful tool but only in the hands of someone trained in its application and management of complications thereof. In most local settings this role is primarily fulfilled by a specialist anaesthetist, many of whom argue that general anaesthesia is a safer, far more controlled way of rendering a child still enough for an MRI scan. This approach may seem somewhat too aggressive for many clinicians (and parents), but although there are risks inherent with anaesthesia in children, there are also risks inherent in missing a diagnosis because of an inadequate scan and risks

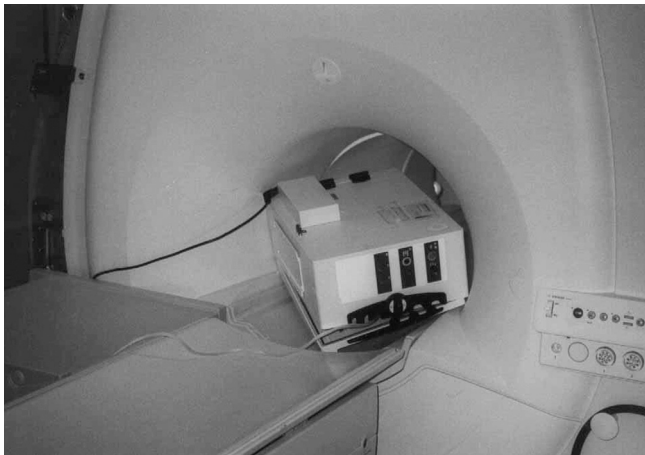


Fig. 1. The costly mistake of placing a monitoring device within reach of the magnetic field of an MRI scanner.

associated with sedation and inadequate monitoring. The anaesthetist, who should be competent and confident managing paediatric cases, must therefore have the final say as to the method best employed for each individual case. Radiologists should not be 'bullied' into accepting this responsibility simply because it could save time and further expense, and any who do should then adhere strictly to the local Guidelines for Sedation-Analgesia in Children.²

Finally, great care should be taken with anaesthetic and monitoring equipment in the MRI scanner room, not only because of potential effects of the magnetic environment on the functioning of equipment but also the potential for mechanical injury from missile effects (Fig. 1). Although specialised MR-compatible anaesthetic and monitoring equipment is available it is very expensive, and if not available then every effort should be made to adapt existing equipment for use in the MR environment without endangering the patient, staff members or the MR unit itself. Such equipment should also permit a complete spectrum of physiological monitoring, not simply pulse oximetry, which is a far less reliable monitoring method in younger children than in adults. We are therefore in full agreement with the conclusion reached by Kitsa *et al.* and wish to further emphasise this issue.

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Unjustified comments

To the Editor: I want to thank Chris Bateman for his recent report on "outfoxed" surgeons'.¹

I think his comment on the case was balanced and fair. This letter is aimed at the spokeswoman for the HPCSA, Anina Steele, who made me angry with her comments on who had or had not 'seen the light' (see end of report where she is quoted in relation to ourselves and Dr Levy).

Ms Steele will have seen the light when she realises the following.

1. That she works for an organisation where the committee tried to railroad us into proceeding with an enquiry while we were bereft of legal representation — they did this with indecent and unseemly haste.
2. That she works for an organisation where justice is unfair and off balance — four of us were charged while four practitioners were not charged. The reason for this inequality is still unknown.
3. That there was a subtle, unconscious, religious bias in relation to the four who were charged and the four not charged.
4. That she works for an organisation in which the committee, according to the Appeal Chairman and Judge, seriously 'misdirected' itself against me — and not one of those in that august body made any comment, noted it, or made any attempt to correct this.
5. That she works for an organisation that fails to tackle the enormous socio-political and psychological problems abounding in medicine in the private and public sector.
6. That she works for an organisation that is very conscious of its image and that postures accordingly in relation to this image when it dispenses its so-called justice.
7. That she works for an organisation that would do better to be more honest in approach to all matters medical and social — perhaps it should not be quite so 'politically correct' at all times.

For her to talk about us 'seeing the light' is like a mole trapped in darkness beneath the ground, thinking and talking about the sun, when that sun is seen only in the mole's imagination.

Her explanation with regard to Dr Levy and a Certificate of Good Standing, whereby it was never proven that he got the money, 'in spite of him having admitted it', can hardly be believed.

The dishonesty of the Council with regard to the radiologists is even more mind boggling. They now propose going back on their word after having reached a firm agreement and a contract with the radiologists with regard to monies paid, sentences to be carried out, strike-offs for a



definite period of time, etc. Both parties accepted the agreement, but they now propose going back on their word and reconsidering the sentence — what dishonesty and hypocrisy.

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Impact of chronic diseases on the health-related quality of life of South Africans

To the Editor: Chronic diseases such as diabetes mellitus (DM) and hypertension account for a substantial amount of South African health care.¹ As there are no cures for DM and hypertension, the primary goals of health care for these patients are to maximise functioning in everyday life and to achieve the highest possible level of well-being, thereby improving their health-related quality of life (QOL).² To determine the impact of chronic diseases on health-related QOL, a study was conducted among 243 South African DM outpatients (100 with hypertension) and 371 controls, with no self-reported chronic diseases/disabilities.

The patients reported more limited physical and role functioning compared with social functioning (Fig. 1). They also had poorer levels of health than wellbeing. These findings were not unexpected as chronic conditions tend to have greater impact on physical activity and perceived health than on social activity and well-being. Patients with DM alone reported relatively high levels of physical, role and social functioning, indicating that one of the goals of health care has been achieved (Fig. 1).²

The proportion of patients scoring in the 'good' health category was very similar to that reported for US and South African DM patients.^{2,4} However, our sample of DM patients had considerably higher scores for health and well-being than was found in Finland,⁵ suggesting that DM has more impact on the general health and well-being of Finnish patients than South African or US patients. Patients with hypertension had significantly poorer functioning, health and well-being than patients with DM alone ($p < 0.05$). It would appear that dual chronic conditions place an added burden on health-related quality of life.

Controls consistently reported good health-related QOL (Fig. 1), indicating the interdependence of functioning, health and well-being. They also had significantly better functioning, health and well-being and lower levels of pain than patients

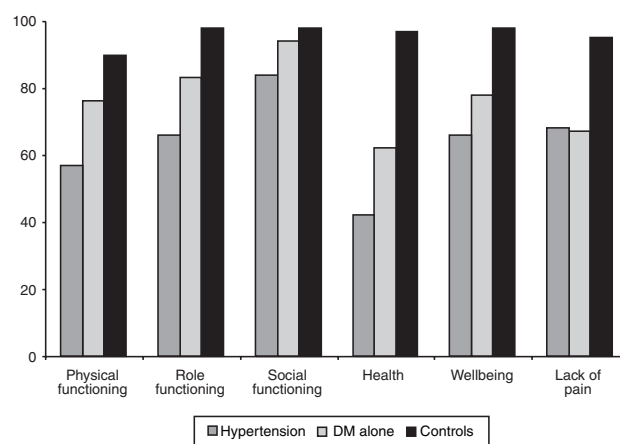


Fig. 1. Proportion of patients and controls reporting good health-related quality of life (patients with DM and hypertension (Hypertension), DM alone and controls).

with DM alone and patients with DM and hypertension ($p < 0.01$). In contrast with previous findings,⁵ controls had better well-being than the patients. This was most certainly because of the extremely poor well-being reported by Finnish DM patients and controls.⁵

Overall findings indicated that chronic disease impacts negatively on functioning, health and well-being; that patients with dual chronic conditions have greater decrements in their health-related QOL than those with a single chronic condition; and that functioning, health and well-being are core elements of health-related QOL.

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