EDITORIAL / VAN DIE REDAKSIE

Vitamin A — time for action

In the last decade, it has become apparent that vitamin A, apart from its function in vision, is also essential for child health and survival.[1] Available evidence indicates that marginal vitamin A status is associated with an increase in the incidence and severity of infections, poor growth, iron deficiency anaemia and excessive childhood mortality. Improvement of vitamin A status in children results is the enhancement of growth and iron status, a decrease in infectious morbidity and, most strikingly, a 30% reduction in overall childhood mortality rates, according to community-based studies.[2] Marginal vitamin A status is now recognised as a major public health problem in many parts of the developing world and it is estimated that tens of millions of children are affected. In addition, clinical vitamin A deficiency is still one of the leading causes of childhood blindness in many developing countries, with over 0,5 million children going blind annually because of it. Even though the true extent of the problem is not known in South Africa, limited data[3] indicate that marginal vitamin A status may be a major concern in this country (G. Hussey, A. Coutsoudis, D. Labadarios — unpublished data).

In 1983 a longitudinal study from Indonesia[4] reported that children with marginal vitamin A status had a significantly greater risk of dying compared with children not deficient. These findings are consistent with experimental studies which indicate that vitamin A-depleted animals die prematurely, usually from overwhelming sepsis. Subsequent to this study, eleven community-based prophylactic vitamin A supplementation trials were done worldwide.[2,5] In most of these studies, children were given vitamin A capsules (100 000 - 200 000 IU every 4 - 6 months). Analysis of all of these studies indicate a significant 30% decrease in the mortality rate of the supplemented children. The reason for this decline in mortality is probably related to a decrease in the incidence and severity of infections in the children given vitamin A.

The association between vitamin A and infection has been known for over 100 years. Clinicians observed that common childhood infections frequently precipitated xerophthalmia and that children who presented with the latter frequently developed severe and often fatal infections. In 1928, Green and Mellanby[6] proposed that vitamin A be regarded as an anti-infective agent. Scrimshaw *et al.*,[7] in their review in 1964, evaluated the work of about 50 researchers, and stated that no nutritional deficiency is more synergistic with infectious diseases than that of vitamin A. One of the first recognised features of hypovitaminosis A, increased susceptibility to infection, has had strong confirmation. Recent studies have reported that children with marginal vitamin A status have a significantly greater risk of developing respiratory infections, diarrhoeal disease and severe measles when compared with children of adequate status. Children given vitamin A supplements every 4 - 6 months in community-based studies have been noted to have a lower prevalence of diarrhoea and pneumonia.[5] In preterm infants, supplementation has also been associated with fewer respiratory tract infections.

Measles is one of the leading causes of childhood mortality; according to the World Health Organisation it accounts for about 1,2 million deaths annually. Children at risk of severe measles include those who are malnourished, the very young and those who are vitamin A-deficient. Children who are vitamin A-deficient (even those with marginal status) develop more severe disease and have a higher case-fatality rate.[8] Measles is also a well-recognised precipitating factor for the development of xerophthalmia. Ooman *et al.*[9] in a global review of xerophthalmia stated that 'there appears to be a universal relationship between infectious diseases and xerophthalmia. This relates especially to measles . . .' Controlled clinical trials in children hospitalised with measles have shown that vitamin A supplementation reduced the mortality rate significantly, in some cases by more than 50%.[10] In addition, the severity of complications such as pneumonia and diarrhoea were also decreased. The WHO[11] has recommended vitamin A supplements for children with severe measles. The dose recommended is 200 000 IU orally daily for 2 days (in children under 1 year of age, half the dose is given).

The precise mechanisms by which vitamin A exerts its newly described effects are not fully understood. Certainly, vitamin A is important in maintaining the integrity of epithelial surfaces.[12] Vitamin A deficiency results in decreased cellular turnover, stratification of epithelial cells and ultimately squamous metaplasia, keratinisation and desquamation. The net effect of these changes is loss of the first-line host defence barriers, predisposing the host to infections. In addition, the body's major defence mechanisms, both cellular and humoral immune function, are adversely affected.[13,14] Children who are vitamin A-deficient may also not respond adequately to immunisations.

Vitamin A status can be assessed by clinical criteria (the WHO's classification of xerophthalmia), tests for retinal function or conjunctival integrity, assessment of dietary intake and biochemical values such as the serum retinol concentration.[15] All of these methods have technical and practical limitations and are not universally applicable for field use. The WHO has recommended that if the serum retinol concentration (μg /dl) is used to assess vitamin A status, then the following criteria should be used:[16] < 10, deficient; 10 - 19, low; 20 - 50, normal; > 50, high. If more than 5% of the population have levels below 10 μg/dl, then vitamin A deficiency is a major public health problem. The immediate causes of vitamin A deficiency are socio-economic, including food insecurity and poverty, and a consequently decreased intake of vitamin A-rich foods; recurrent acute and chronic infections may also adversely affect vitamin A status by limiting dietary intake, decreasing absorption and increasing requirements of the vitamin.

The realisation that marginal vitamin A status is a major problem in many countries has led a number of international agencies, including the WHO and UNICEF, to call for the worldwide elimination of vitamin A deficiency by the year 2000. Intervention strategies to combat vitamin A deficiency include regular vitamin A supplementation in the form of capsules through a comprehensive or disease-targeted programme (capsules are usually given every 4-6 months at doses varying from 50 000 IU to 200 000 IU), food fortification (the addition of vitamin A to regularly consumed foodstuffs such as sugar, salt, cereals, milk and tea) as well as dietary diversification and nutrition education with regard to the consumption of vitamin A-rich foods.

In the absence of accurate national and regional data on the vitamin A status of children in South Africa, it is debatable[17] whether a comprehensive capsule distribution programme or food fortification policy should be recommended or not.[18] The formulation of a vitamin A policy for South Africa is currently being addressed by a national group, the South African Vitamin A Study Group, which includes representatives from different regions, universities and the Department of Health. The group is about to embark on a national survey of vitamin A status in children, and plans to make recommen-

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dations to the Department of Health on the adoption of appropriate means for the improvement of vitamin A status.

In the meantime and until such policy is formulated, dietary diversification and consumption of vitamin A-rich foods should be encouraged in all individuals and communities; education on vitamin A should also be part of any nutrition education programme. Should supplementation be deemed necessary on clinical grounds, e.g. in children with measles, malnutrition, chronic diarrhoea and pneumonia, a dose of 200 000 IU for children older than 1 year or 100 000 IU for children less than 1 year of age should be given. In children under the age of 6 months, vitamin A supplements should be used with extreme caution and no more than a single 50 000 IU dose should be given within a 6-month period. It should be appreciated, and not forgotten, that high doses of vitamin A may have adverse effects and that supplementation should not be given without a doctor's prescription.[19] Excessive use of vitamin A can lead to acute toxicity — irritability or drowsiness, headache, vomiting, inco-ordination, muscular weakness, bulging of fontanelles (neonates), blurring of vision (diplopia) and peeling of skin.[19,20] As such, should a large dose of vitamin A be given, it should be recorded in the patient's notes and on the clinic's immunisation card. This will prevent excessive dosing and its possible adverse consequences. The daily intake of vitamin A in the form of multivitamin preparations (1 500 - 5 000 IU) is generally known to have an acceptable safety margin.

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Controversial aspects of intravenous corticosteroids in acute severe asthma

The aims of treatment in acute severe asthma are to decrease the incidence of relapses, morbidity and mortality as well as to promote recovery.[1] It was pointed out in a recent review on fatal asthma that the institution of appropriate therapy and careful monitoring of response could have a major impact on morbidity and mortality from asthma.[2] The important question is to decide what constitutes 'appropriate therapy'. This article reappraises the role of parenteral corticosteroids in acute asthma in the light of the controversies that have been noted in the recent literature on the subject.

Corticosteroids have been used to treat bronchial asthma since the 1950s. In the very early work on acute asthma by the British Medical Research Council,[3] steroids were used in a controlled trial and found to be effective, but the number of patients in this study was small. In fact, patients with gradually deteriorating asthma rather than acute severe asthma were used and patients were also treated with sedatives. In addition, the steroid dosages were physiological rather than pharmacological and included oral steroids.

At least seven trials in the past 17 years showed a benefit from intravenous steroids in acute severe asthma.[4-10] In five of the studies patient numbers were small although statistically significant increases in forced expiratory volume in the first second (FEV_1) in the steroid-treated group were reported. In one of the larger studies, Littenberg and Gluck[8] studied 97 acutely ill patients with bronchial asthma in a double-blind,

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placebo-controlled, randomised trial of intravenous methylprednisolone (125 mg) given on presentation in the emergency room. Nineteen per cent of patients treated with methylprednisolone required hospital admission compared with 47% of patients in the control group ($P < 0,003$). In this study the differences in FEV_1 and FVC between the steroid-treated and the placebo group were not statistically significant.

Pierson *et al.*[7] had demonstrated in a placebo-controlled study of 45 paediatric patients that there was response to corticosteroids irrespective of the type used (betamethasone, hydrocortisone, dexamethasone). In addition, this study demonstrated that arterial hypoxaemia improved in the patients treated with steroids.

It appears that the current practice of using high doses of intravenous hydrocortisone (usually 200 mg 4-hourly) was based on the study by Collins *et al.*[4] In this study 23 patients with acute severe asthma were given intravenous hydrocortisone in a dose of 3 mg/kg body weight every 6 hours. The limitations of this study were the absence of a control group and the small number of patients. It was notable that objective evidence of improvement in these patients did not appear until 6 hours after the start of treatment.

A further factor in favour of the use of steroids in acute severe asthma is that intravenous prednisolone was found to restore adrenergic responsiveness.[11] This may be advantageous in patients who show a poor bronchodilator response to β_2-adrenoreceptor stimulants.

Surprisingly, recent studies found no benefit from intravenous corticosteroids in patients with acute severe asthma compared to controls in whom steroids were not used.[12,13] To add further evidence to the possibility that the role of steroids may have been overestimated in acute asthma a few studies have shown that there is no difference in spirometry regardless of the steroid dose used compared to controls.[14,15]

The side-effects of intravenous steroids in acute severe asthma may be aggravated by unnecessarily high doses. One of the disturbing side-effects of steroids in acute asthma is steroid-induced myopathy.[16-21] In a report by Shee[16] 4 out of 9 patients ventilated for acute asthma developed hydrocortisone-associated myopathy. The hallmarks of corticosteroid myopathy in asthma are normal creatine kinase levels[19] and predominantly painless proximal muscle weakness.[16] Type II fibre atrophy is the commonest pathological abnormality demonstrated.[22] Steroid myopathy is not selective for the type of steroid used, but most cases have occurred in patients given high doses of steroids while on mechanical ventilation. It is postulated that neuromuscular blockade, due to the paralytic agents used during mechanical ventilation may contribute in some way to steroid myopathy.[16] Recovery of muscle power can take 6 weeks to 6 months.[16,21]

Worsening of asthma in aspirin-sensitive individuals given hydrocortisone intravenously has also been noted.[23] Possibly other cases have occurred and the increased airflow obstruction may have been attributed to progression of asthma rather than to steroids. There should be an increased awareness of the problem of worsening airflow obstruction in aspirin-sensitive patients given intravenous hydrocortisone.

There are no prospective placebo-controlled trials showing that emergency room treatment of acute asthma with intravenous corticosteroids reduced asthma mortality.[1]

With the above information it is tempting to suggest that in the acute attack of asthma intravenous corticosteroids may not be necessary. In the acute attack bronchodilator therapy is likely to mask any beneficial effects of steroids and this issue needs to be examined in future studies. There is evidence that steroids improve the responsiveness of β_2-agonists in the acute stage.[1,11] If parenteral corticosteroids are beneficial in acute asthma the optimal dose still needs to be determined.

In the light of the controversies surrounding the use of intravenous corticosteroids for acute asthma we would like to recommend that most patients with mild to moderate attacks probably only require a loading dose of 30-60 mg oral prednisolone (or equivalent). In patients with severe exacerbations of asthma the large doses of intravenous corticosteroids currently recommended may be excessive and 100 mg hydrocortisone 6-hourly or equivalent may be adequate. This would result in a reduction of acute steroid side-effects and cost. Patients recovering from an acute asthma attack should be given a short course of oral corticosteroids to prevent relapses.[24] The issue relating to the use of intravenous corticosteroids in acute asthma is still controversial and a placebo-controlled trial with large numbers of patients is required to resolve the dilemma.

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A million tickets to Disneyland — the tragedy of the AIDS children

World AIDS Day seems to have passed relatively unnoticed by the general populace, and this probably applies to the medical community as well, except for those directly involved with AIDS education, treatment and counselling.

The apathy which seems to greet any talk of AIDS and the disaster facing our country is frightening: it may be due to the 'ostrich' syndrome, but we have to get our heads out of the sand and face the truth sooner or later; it may be due to lack of experience with HIV-positive individuals or those with full-blown AIDS; it may be due to ignorance.

All these problems will be addressed by an integrated campaign in *SAMJ* and *CME* during the coming year.

We will be including loose inserts in *SAMJ* which will deal with various aspects of counselling and management of HIV-positive patients. The material will be provided by the Western Province AIDS Training Information and Counselling Centre, in conjunction with other organisations. These inserts will be linked with a series of articles in *CME* in alternate months, from the same sources, expanding on the material in the inserts. It is hoped that this campaign will add to the knowledge of the medical practitioners in South Africa, and will help to contain this plague which threatens us all.

It may not be clear what Disneyland has to do with AIDS. Let me explain: in a television special broadcast on M-Net on World AIDS Day, an HIV-positive little boy of 6 was interviewed. He had contracted AIDS from his mother, who did not even realise that she was HIV-positive until her son's test results were received. She was subsequently tested and it turned out that she had been infected by a college boyfriend who had been a drug addict.

The little boy was asked by the interviewer, 'What do you think heaven is like?'

He replied, 'It's like going to Disneyland with a million tickets — and you can ride on anything as much as you want.' He seemed unaware of his impending suffering but one could only pray that his remaining time would not be too excruciating.

The tragedy of the children affected by the HIV — both those who are orphaned and those who are infected — is something that the medical community and the rest of society are going to have to face and cope with for many years to come. This is apart from the already well-known and widely predicted effects on the economy, health services and other community-based organisations.

The active participation of doctors in education, prevention and proper management is essential if the human race is to survive with any semblance of optimism.

Don't deny the facts; don't bury your heads in the sand; and take every opportunity to educate yourselves.

SAMJ and *CME* are there to help. Use them.

F. N. SANDERS

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T: M. Thompson, A. Tooke.
V: J. van den Ende, J. W. van der Spuy, Z. M. van der Spuy, J. P. de V. van Niekerk, C. W. van Wyk, R. van Zyl-Smit, Y. E. R. von Schirnding.
W: D. J. H. Wagenfeld, E. G. Weinberg, D. Werner, N. White, A. Williamson, I. M. Winship, J. Wright.
Y: D. Yach.

A million tickets to Disneyland — the tragedy of the AIDS children

World AIDS Day seems to have passed relatively unnoticed by the general populace, and this probably applies to the medical community as well, except for those directly involved with AIDS education, treatment and counselling.

The apathy which seems to greet any talk of AIDS and the disaster facing our country is frightening: it may be due to the 'ostrich' syndrome, but we have to get our heads out of the sand and face the truth sooner or later; it may be due to lack of experience with HIV-positive individuals or those with full-blown AIDS; it may be due to ignorance.

All these problems will be addressed by an integrated campaign in *SAMJ* and *CME* during the coming year.

We will be including loose inserts in *SAMJ* which will deal with various aspects of counselling and management of HIV-positive patients. The material will be provided by the Western Province AIDS Training Information and Counselling Centre, in conjunction with other organisations. These inserts will be linked with a series of articles in *CME* in alternate months, from the same sources, expanding on the material in the inserts. It is hoped that this campaign will add to the knowledge of the medical practitioners in South Africa, and will help to contain this plague which threatens us all.

It may not be clear what Disneyland has to do with AIDS. Let me explain: in a television special broadcast on M-Net on World AIDS Day, an HIV-positive little boy of 6 was interviewed. He had contracted AIDS from his mother, who did not even realise that she was HIV-positive until her son's test results were received. She was subsequently tested and it turned out that she had been infected by a college boyfriend who had been a drug addict.

The little boy was asked by the interviewer, 'What do you think heaven is like?'

He replied, 'It's like going to Disneyland with a million tickets — and you can ride on anything as much as you want.' He seemed unaware of his impending suffering but one could only pray that his remaining time would not be too excruciating.

The tragedy of the children affected by the HIV — both those who are orphaned and those who are infected — is something that the medical community and the rest of society are going to have to face and cope with for many years to come. This is apart from the already well-known and widely predicted effects on the economy, health services and other community-based organisations.

The active participation of doctors in education, prevention and proper management is essential if the human race is to survive with any semblance of optimism.

Don't deny the facts; don't bury your heads in the sand; and take every opportunity to educate yourselves.

SAMJ and *CME* are there to help. Use them.

F. N. SANDERS