



Opioid management

South Africa faces increasing drug dependency problems. Much has recently been made of the serious 'tik' abuse problem among children in the Western Cape. The *SAMJ* has also carried a plea for the abolition from clinical use of pethidine in favour of morphine as the former is more likely to have harmful effects including addiction, especially among medical practitioners. Lize Weich and colleagues provide a timely review of the medical management of opioid dependence in South Africa.¹

Heroin is the main illicit opioid of abuse, with an increasing trend in South Africa. Between 11% and 20% of all patients who presented for substance rehabilitation in the second half of 2006 stated that heroin was their primary or secondary drug of choice. The use of heroin in combination with other drugs has also become popular. Heroin is mostly smoked in South Africa.

Opioid dependence is a chronic relapsing disease that develops from repeated self-administration of opioids, including heroin, over-the-counter and prescription opioids. Genetic and environmental factors contribute to its development.

The aim of treatment for opioid dependence is total abstinence from all opioids, but the short-term success rate is low. Trends in treating opioid dependence have moved from focusing only on total opioid abstinence towards including strategies aimed at harm reduction (keeping patients alive until they eventually go into remission).

In substitute opioid prescribing, reviews have confirmed that maintenance treatment with methadone and buprenorphine has proven effectiveness provided that adequate dosages are prescribed and appropriate supervision is given.

Nuchal translucency in first-trimester screening

The use of first-trimester screening to detect chromosomal and structural abnormalities is well established. Health care costs have risen above inflation over the last decade, with only marginal increments in the health budget, and as a result many first-trimester screening centres in Gauteng have been forced to omit biochemical screening.

Naidoo and colleagues from the fetal medicine unit at Chris Hani Baragwanath Hospital evaluated the use of a first-trimester screening programme without biochemical screening, in a predominantly black population.²

Their programme to detect structural and chromosomal abnormalities was shown to be cost effective with an efficacy equivalent to international standards. This is a positive finding for South Africa, where budget limitations influence the quality of medical services provided. The benefit of a reduced procedure rate in the setting of a high incidence of HIV seropositivity lends additional benefit to the implementation of a first-trimester screening programme.

HIV positive results: coping strategies

Experts and other interested parties have pleaded for the 'normalisation' of HIV/AIDS, which would include testing for it as for any other disease. Built into the existing programme of voluntary testing is supposedly a system of counselling. But with the lack of capacity at most public health facilities, what will happen if testing is increased and more people receive notice of being HIV-positive?

Tim Myint and Bob Mash investigated the coping strategies and social support after receiving HIV-positive results at a South African district hospital.³ The initial reaction to extreme bad news includes physiological, cognitive and emotional responses.

The ability to cope with change is related to the nature of the change, availability of social support and personal factors. Social support can offer practical help, provide information, or help contain or deal with strong emotions. Poorer adjustment is associated with persistent denial, venting of emotions, and behaviour disengagement that avoids dealing with change. How a health care worker breaks the bad news is an additional, important factor in a patient's ability to cope with it.

There was a significant association between social support from families and religion as a coping strategy.

Corticosteroids in *Pneumocystis jiroveci* pneumonia in infants

Randomised trials recommend adjunctive corticosteroid therapy for *P. jiroveci* pneumonia (PCP) in adults. Terblanche and colleagues investigated the use of adjunctive corticosteroid treatment of clinical PCP in infants in a randomised controlled trial.⁴

A study found PCP in 16 - 51% of HIV-positive African children who died from respiratory illness, being the most common cause of death in HIV-infected infants less than 6 months of age.

Patients with a clinical diagnosis of PCP were randomised to receive either prednisone or placebo. They concluded that in HIV-exposed infants with clinical PCP, adjunctive corticosteroid therapy does not appear to add benefit regarding time to recovery or oxygen independency, but early administration may improve survival. A large multicentred trial is needed to confirm these findings.

JPvN

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4. Terblanche A, Green R, Rheeder P, Wittenberg DF. Adjunctive corticosteroid treatment of clinical *Pneumocystis jiroveci* pneumonia in infants less than 18 months of age - a randomised controlled trial. *S Afr Med J* 2008; 98: 287-290.