



Dr James Barry revealed

Dr James Barry is one of the most famous figures in the early history of South African medicine. Apart from his considerable medical contributions, the dramatic revelation upon his death that he was a female has generated considerable interest and controversy. Through extensive original research Michael du Preez has been able to clearly document, for the first time, the early years of the young girl who was to become the legendary Dr Barry.¹

James Barry emerged, seemingly from complete obscurity, as a medical student at Edinburgh late in 1809, graduating MD in 1812. Du Preez describes his early life and career concluding with his appointment as Hospital Assistant. In December 1815, at Plymouth, Barry was promoted to the rank of Assistant Staff Surgeon and in August the following year posted to the Cape of Good Hope. The remainder of the more than four decades of his exceptional service is a matter of army record.

Du Preez was able to trace the early family history of Margaret Ann Bulkley, who became Dr James Barry, back to John Barry (d. 1781), the patriarch of the Barry family. Through family misfortune Margaret and her mother Mary Ann found themselves destitute. The start of what became a remarkable conspiracy commenced when Mrs Bulkley appealed to her artist brother, James Barry, in London for assistance. James Barry had many influential friends who assisted in Margaret's early education. These included Dr Edward Fryer, an academically inclined physician, and General Francisco Miranda, a Venezuelan revolutionary. Du Preez has been able to verify the reasons for and the execution of the audacious plot to enable Margaret to study medicine at Edinburgh University (only men were allowed to study medicine at that time) by a treasure trove of letters and other documents.

Tuberculous pericarditis

In a groundbreaking research model for Africa, Mayosi and colleagues² enrolled patients with presumed tuberculous pericarditis from 15 referral hospitals in Cameroon, Nigeria and South Africa. In his accompanying editorial, Helmuth Reuter³ notes that the strength of the study is that it reflects what clinicians experience in the field and what they perceive to be tuberculosis-related deaths. This experience may differ substantially from statistics captured by national tuberculosis control programmes.

Mayosi and colleagues found that a presumptive diagnosis of tuberculous pericarditis is associated with a high mortality in sub-Saharan Africa.

The management of HIV coinfection is important. Management of pericardial effusion includes pericardiocentesis. Recommended antituberculosis treatment for pericardial TB is the same as for pulmonary TB.

Femur fractures in infants

South Africa's quadruple disease burden has been highlighted by reports from the Medical Research Council. These are diseases related to poverty (infectious diseases, etc); HIV/AIDS, which ties up with the former but is big enough to stand on its own; lifestyle diseases, e.g. obesity, coronary disease; and trauma.

A reminder of our violent society is provided by a short series of femur fractures in infants by Van As and Garach.⁴ There is general agreement in the literature that the majority of fractures in infants are due to child abuse. Consequently a higher degree of suspicion of abuse should exist when femur fractures are seen in children who are not yet walking. While the head is the most common target for abuse, with over half the external wounds found on the surface of the head, fractures are the second most common presentation in non-accidental injuries.

Preventable childhood diseases: Risk of an outbreak

As a medical officer on the mines at Welkom I experienced a major smallpox epidemic, and while relieving in Zambia I found that smallpox was endemic in that region. Smallpox has since been wiped from the globe by successful vaccination programmes. The WHO aims to similarly eradicate polio by 2009. The latter is an example of agreement on international priorities and the collaboration of many differing partners: countries; NGOs, notably Rotary International; and donors such as the Gates Foundation.

A major public health benefit has been vaccination. Its important benefits have been so dramatic that we have tended to become complacent. The study by Corrigan, Coetzee and Cameron⁵ is therefore an important wakeup call. The required level of immunity in populations to prevent epidemics of infectious diseases has been estimated at about 95% and 85% for measles and polio, respectively. They found that the coverage in the Western Cape is too low to consider not running periodic mass campaigns for measles and polio and will need to be improved before rubella vaccine is introduced as part of the Expanded Programme on Immunization schedule.

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1. Du Preez HM. Dr James Barry: The early years revealed. *S Afr Med J* 2008; 98: 52-58.
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3. Reuter H. Tuberculous pericarditis and HIV infection in Africa. *S Afr Med J* 2008; 98: 29-30.
4. Van As AB, Garach SR. Femur fractures in infants. *S Afr Med J* 2008; 98: 23-24.
5. Corrigan J, Coetzee D, Cameron N. Is the Western Cape at risk of an outbreak of preventable childhood disease? Lessons learned from an evaluation of routine immunisation coverage. *S Afr Med J* 2008; 98: 41-45.