upon which the premium of the plan was based, but a mechanism to permit consideration of other costlier drugs, which become cost-effective because they specifically address a more serious clinical situation.

Applications for non-formulary drugs for patients with mild or newly diagnosed conditions not included in this definition will not be accepted, consistent with good and cost-effective clinical practice.

E Gottlich

Principal Clinical Specialist
Discovery Health

1. Rayner B. Prescribed minimum benefits or minimum prescribed benefits? *S Afr Med J* 2004; **94:** 623-624.

Brian Rayner replies: I would like to thank Dr Gottlich, Principal Clinical Specialist, Discovery Health for replying to my article in the *Journal*. It is a very sad state of affairs that I had to place my viewpoint in the *Journal* to get his attention. Over the past year I have made several motivations to Discovery Health and I have never received a reply. This complete lack of recognition of my (and other doctors') professional standing is certainly cause for umbrage.

It seems that Dr Gottlich has also missed several key points in my article. Firstly, as I clearly stated, I am in favour of the use of affordable and cost-effective medication for hypertension. I also have no issue with the use of formularies by medical funders provided that these are based on recognised clinical standards, preferably the Southern African Guidelines for Hypertention.[1] I see many patients who are members of Discovery Health, and I can usually manage their hypertention effectively with the use of their formulary. Yet as a prominent specialist in this field I am referred complicated hypertensive patients, who just cannot be managed within the confines of a very basic formulary or algorithm.

Secondly, Dr Gottlich is incorrect in stating that patients on prescribed *minimum* benefits (PMBs) are only entitled to receive benefits within the Council for Medical Schemes algorithm, or Discovery Health formulary. Apart from the fact that the PMBs constitute the standard care to be afforded to members on the lowest options, and should not be construed as to become the maximum, the regulations to the Medical Schemes Act of 1998 (Act No. 131 of 1998) clearly state that '. . . provision must be made for appropriate exceptions where the protocol has been ineffective or causes or would cause harm to the beneficiary *without penalty to the beneficiary*. Furthermore if managed health care entails use of a formulary or restricted list of drugs such formulary or restricted list must be developed on the basis of evidence-based medicine taking into account considerations of cost-effectiveness and affordability, but must make provision for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause harm to the beneficiary *without penalty to the beneficiary.*'

Thirdly, despite protestations, Discovery Health's compliance with the hypertension algorithm is selective. It does not allow the use of angiotensin receptor blockers in patients with type 2 diabetes and microalbuminuria.

Fourthly, regarding the specific patient who prompted my communication, it is simply a distortion of the truth to state that Discovery Health changed their mind on review. This occurred because I lodged a formal complaint with the Council for Medical Schemes. Sadly, most patients are unaware of their rights in this regard. This leaves medical practitioners with no option but to face time-consuming administrative hurdles, including difficulty in accessing clinical peers in such cases as the one I described.

1. FJ Milne and VJ Pinkney-Atkinson for the Southern African Hypertension Society Hypertension Guideline Working Groups 2000 and 2003. Hypertension guideline 2003 update. *S Afr Med J* 2004; **94:** Part 2, 209-226.

A tale of two industries

To the Editor: On 30 September, Merck voluntarily stopped selling its arthritis drug rofecoxib (Vioxx) because new data found that it doubled patients' risk of heart attack and stroke.

Vioxx was a bestseller, with global annual sales of R16 billion. Merck could have continued marketing the drug with appropriate health warnings, but it decided that it was in the best interests of its patients to withdraw the medication.

Cigarettes, too, double the risk of heart attacks and stroke. In addition, smokers are 10 times more likely to die of emphysema or lung cancer. In fact, smoking is linked to 50 diseases, from blindness to foot amputations.

So what have cigarette manufacturers done to protect their customers? Did they warn of the dangers and prepare to phase out cigarette sales? Well, no. Actually they did exactly the opposite. They hid the facts and tried to sell more cigarettes.

The US Justice Department has charged the companies with behaving like an organised crime syndicate. In a current court case, US cigarette makers are accused of conspiracy to defraud consumers by denying the dangers of smoking and passive smoking; of sponsoring junk science by funding sympathetic scientists to carry out research to cloud the issue; of manipulating nicotine levels to keep smokers hooked; of intentionally marketing to youth; of promoting low-tar cigarettes as less harmful knowing that this is not true; and of destroying and concealing documents to hide their illegal activities.

The truth is that the cigarette companies have lost touch with reality and what is responsible behaviour. British American Tobacco, for instance, blathers that government proposals for new picture-based health warnings to better inform the public of

the dangers of tobacco could cost it 'hundreds of millions of rands.'

Once again it puts its own profits above its customers' welfare. In sharp contrast to Merck, this irresponsible industry wants to laugh all the way to the bank, while its customers and their families limp to hospitals and early graves.

Yussuf Saloojee

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Houghton
2041

Pruritus ani

To the Editor: I read the short piece in a recent *SAMJ*[1] reporting on a small clinical trial of capsaicin in the treatment of pruritus ani. I have never understood the logic of using a counter-irritant to treat skin lesions. I would expect such topical treatment to aggravate the lesions.

The report correctly points out that pruritus ani is perpetuated by, *inter alia*, irritant chemicals in faeces. Therefore I tell my patients that they must not use toilet paper, which serves to rub the faeces into the inflamed peri-anal skin. They must programme themselves to defecate in the comfort of their own home, and to use only soap and water thereafter. The vicious scratch-itch cycle can be broken using 1% hydrocortisone oitment 12-hourly.

This simple management was told to me when a student by that mainstay of good patient care — an experienced rural general practitioner. I can assure your readers that it works, at minimal cost. Very similar management has recently been promoted in South Africa.[2]

S A Craven

9 Remington Road
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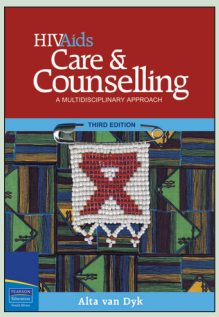
7800

1. A novel and effective treatment for pruritus ani (In Brief). *S Afr Med J* 2004; **94:** 912.
2. Saxe N, Jessop S, Todd G. *Handbook of Dermatology for Primary Care.* Cape Town: Oxford University Press, 1997: 162-163.



This book is for people whose lives are touched by HIV and Aids: those who are HIV-positive themselves, and those who are affected by people who have HIV or Aids.

This third edition has been updated to reflect the most recent advances in research on the HI virus, and to address more fully:
- the use of anti-retroviral therapy
- tuberculosis
- sexually transmitted infections
- home-based care
- support for the caregiver
- care of orphans and other vulnerable children.

It provides knowledge, skills and support for every aspect of living with HIV/Aids, and will be invaluable to counsellors, nurses, home-based caregivers, social workers, teachers, doctors, therapists, spiritual workers, volunteers, as well as to people living with HIV and their loved ones.

Issues addressed include:
- the fundamental facts about HIV/Aids
- principles and strategies for enabling behaviour change
- HIV/Aids and life skills training for schoolchildren
- basic counselling principles and skills
- pre- and post-HIV-test counselling
- counselling in various contexts, including crisis counselling, couple counselling, and counselling children
- spiritual and bereavement counselling
- nursing care principles for hospitals, clinics and in the home
- the legal and ethical aspects of HIV/Aids and policy development.

Special attention is paid to women and children's issues and rights, self-awareness and attitudes, cross-cultural counselling, and traditional African beliefs and customs. Practical advice is offered on how to care for people in health care settings with limited resources, facilities and finances, such as those found in many clinics and homes in Africa.

About the author:
Professor Alta van Dyk is a psychologist, professional nurse, and HIV/Aids counsellor and educator. She is a lecturer at the University of South Africa, where she teaches psychology and courses in HIV/Aids care and counselling.

'Thank you for addressing and dealing with every issue that manifests with caring for the HIV/Aids infected person. HIV/Aids Care & Counselling is a MUST for every care giver, professional or lay.' Gail Johnson - *Nkosi Johnson's mother*

HIV/Aids care and counselling: a multidisciplinary approach
Third edition

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