



for dialysis (haemodialysis or peritoneal dialysis) should be to use scarce resources to provide maximum benefit while affording such patients a good quality of life. Race, colour, creed, political affiliation and chronic disease (such as diabetes) should not influence selection and age should not be a criterion either.<sup>1</sup> Moreover, patients suffering from hepatitis B and C or HIV should not be excluded from dialysis therapy especially when receiving concomitant antiretroviral therapy, as their outcomes are similar to those of non-infected patients.<sup>2</sup>

To this end selection should be the responsibility of the treating nephrologist together with the nephrology team (social workers, psychologists, nursing staff) who are best qualified to judge prognosis and benefit from therapy. Patients with a poor overall prognosis, as assessed by the nephrologist and team, should receive optimal conservative therapy.

Response to therapy, patient outcomes and cost-effectiveness of treatment should be monitored, both by the treating dialysis units and by a peer-reviewed national nephrology forum or registry. Such close monitoring will not only improve the patient's lot but will also ensure adequate and economic dialysis in the private and public sectors.

Gone are the days when the state should be allowed to make draconian decisions on patient management, and I believe it is essential that all parties involved in dialysis therapy be consulted before any national criteria for dialysis are adopted.

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1. Feest TG, Rajamahesh J, Byrne C. Trends in adult renal replacement therapy in the UK: 1982-2002. *QJM* 2005; **98**(1): 21-28.
2. Mandayam S, Ahuja TS. Dialyzing a patient with human immunodeficiency virus infection: what a nephrologist needs to know. *Am J Nephrol* 2004; **24**: 511-521.

## **Caesarean section — claims and concerns**

**To the Editor:** The article on caesarean section (CS) in a recent issue of the *Journal*<sup>1</sup> raises many interesting points. Unfortunately your senior news journalist does not reveal his sources so we have no way of verifying the claim that in

privately funded health facilities 65% of women deliver their babies by CS compared with 10 - 20% in public health facilities, or that 65% is 'almost double the percentages in the UK and USA'.

Nevertheless, assuming that these claims are correct and while costs of medical care are always a concern, surely our primary interest must be health outcomes? In this regard it would be interesting to see comment on the respective morbidity and mortality rates for babies born by CS compared with those delivered pelvically. To eliminate compounding variables, that study would presumably best be done in our public institutions. Anecdotally, the virtual absence in our practice of hypoxic ischaemic encephalopathy following elective CS suggests that CS may be of protective benefit to the child.

Of equal concern are the effects on women of ill-advised vaginal delivery. While the focus of these articles is usually on rates of CS and the direct cost of that mode of delivery, I have not seen commentators reflect on the substantial longer-term cost of repairs to the damaged pelvic floor and perineum in women who have delivered their babies vaginally. The psychological and physical morbidity related to urinary stress incontinence, cystoceles, rectoceles, prolapse, anal incontinence, dyspareunia, etc. is substantial. Any sensible economic appraisal of costs of caesarean versus pelvic 'normal delivery' ought to compute the costs of repair of the pelvic floor, vagina and perineum later in women's lives.

I am a paediatrician in private practice with part-time public hospital appointments. I am in favour of the mode of delivery that in each case brings the best health outcome to mother and baby. I believe that patients enjoy certain rights under our constitution, one of which is to make informed decisions about procedures and interventions that may affect their health and the health of their babies. I am also, therefore, pro choice.

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1. Bateman C. Rendering unto Caesar? (*Izindaba*) *S Afr Med J* 2004; **94**: 800-802.