Wrath caused by Rath

A recent letter to the *Star* claimed that differing views about AIDS were being stifled. In support of this the writer, from the Treatment Information Group (TIG), cited that the *SAMJ* had announced as much in an editorial, and that two articles submitted for publication that were critical of the scientific views had been rejected. In response the *Journal* filled in the information selectively omitted, including the fact that authors were advised of the reasons for rejection, *inter alia* for containing falsehoods. Searching the website of the TIG revealed that it had formed a strategic alliance with the Dr Rath Foundation. Apart from the bizarre therapeutic claims, the TIG stated that their members had been in telephone contact with the Minister of Health, who had read all their documents. If this is true it is a privilege rarely accorded to the health professions and explains some of the astounding statements by the Minister, especially concerning the toxicity of antiretroviral medication.

Were it not so serious for the people of South Africa, the report by Chris Bateman (p. 372) on some of the effects of the Rath Foundation shenanigans would be material for a far-fetched stage farce.

Childhood eczema consensus

In a recent editorial Dan Ncayiyana critically reviewed the value of published clinical guidelines (*SAMJ* December 2004). From time to time the *SAMJ* has readily published such material and in the guise of a 'consensus document' we publish another, by the South African Childhood Atopic Eczema Working Group, as a Part 2 to this issue. Despite the fact that the development of good guidelines does not ensure their use in practice, the following benefits are apparent: (*i*) in a country with a small number of experts in various specialties, a consensus document of this nature is likely to reflect a genuine 'country view' of the topic; (*ii*) since the experts are influential teachers, the information will be conveyed to large numbers of undergraduate and postgraduate students; (*iii*) the reviews of the topic provide practitioners with valuable update material; and (*iv*) funders have an authoritative source to rely on.

The prevalence of atopic eczema (AE) has risen over the past few decades, though there is a paucity of data on its prevalence in South Africa. A recent study found that it is very rare in Xhosa children in rural settlements, and a clear urban/rural gradient exists for the occurrence of AE in black children. In children and young adults with an atopic constitution, the underlying inflammation is dominated by an immunoglobulin E (IgE) antibody-associated reaction. The diagnosis of AE cannot be reached without an IgE antibody determination or skin test. Children with AE have a greater risk of developing asthma than children with non-atopic eczema. They also have food allergies and IgE-induced urticaria. Provoking factors for eczema exacerbations include microbial colonisation, barrier disruption, environmental exposure, contact, inhalant and ingestant allergens, sweating, pollutants, sensory irritants (wool), chemical irritants, and maternal ingestants (in breast-milk).

Exclusive breast-feeding of high-risk infants for at least 4 months prevents the development of AE. There is no good evidence that substitution of breast-milk with soya formula will prevent allergic diseases, although soya milk may be used as an alternative in infants who have confirmed cow's milk allergy. Because of the high prevalence of food allergy in infants and young children with atopic dermatitis, testing for food allergy is an essential part in management of the infant.

The **management of atopic dermatitis** should comprise general measures including avoidance of trigger factors, adjuvant measures and anti-inflammatory therapy.

Topical steroids have been the cornerstone of **AE therapy** for the last 40 years. Systemic antihistamines have been found to benefit some patients, but the effectiveness is often short-lived. Topical antihistamine applications may be of use for very short periods but should not be used chronically. New therapies such as the topical calciteurin inhibitor pimecrolimus represent major advances in the management of AE.

Childhood SLE

Systemic lupus erythematosus (SLE) is a multisystem, autoimmune disorder characterised by the formation of antibodies to cellular components. Faller *et al.* (p. 424) investigated the demographics and presenting features of childhood SLE.

Worldwide, 15 - 17% of SLE patients present before 16 years of age, with a peak incidence at 10 - 14 years. It is rare in children below 4 years old and there is a female preponderance in adolescence and adulthood. Warning signs of childhood SLE include unexplained rash, photosensitivity, Raynaud's phenomenon, oral ulcers, arthritis/arthralgia, serositis, ongoing constitutional symptoms and lymphadenopathy/hepatosplenomegaly. SLE is also likely if there is multiorgan involvement.

Their findings suggest that patients in their population are being missed early on, and therefore present late, and that childhood SLE is an insidious disease initially. There has been an increased recognition of the disease in young black South Africans since 1986.

Playstation thumb

We have published student papers in the past – now read our first 'pre-student paper' (p. 412).

JPvN