



Antiretroviral treatment in the Northern Cape

To the Editor: We would like to report on our experience with the first 100 paediatric patients started on antiretroviral treatment in the Northern Cape. All of these patients were on treatment for at least 6 months.

Patients were started on treatment between August 2003 and September 2004, with ages ranging between 3 months and 13 years (mean 66 months). They were all World Health Organization (WHO) paediatric stages 2 and 3 (stages 1 - 3).

Eighty-six patients were from Kimberley, 13 were from other towns in the Northern Cape and 1 was from a neighbouring province. Two patients had received nevirapine at birth in an attempt to prevent transmission of the virus from mother to child.

Ninety-six patients had CD4 counts below 15%; in 28 of these cases CD4 counts were below 5%. Only 1 patient with bronchiectasis had a CD4 count above 20%. Eighty-two of our patients had viral loads above 100 000 copies/ml.

Stavudine and lamivudine formed the backbone of treatment in 98 of the patients. The choice of the third drug depended on patient weight, previous exposure to nevirapine, treatment for tuberculosis and viral load. Patients with viral loads greater than 750 000 copies/ml were put on lopinavir/ritonavir.

Forty-eight patients were started on efavirenz, 38 on lopinavir/ritonavir and 14 on nevirapine. Extra ritonavir was added in the case of 1 patient on lopinavir/ritonavir because the patient was also on treatment for tuberculosis.

Outcome after at least 6 months on treatment is shown in Table I. One patient was resistant to treatment and was changed to abacavir, ddI, lamivudine and lopinavir/ritonavir. This patient had previously been exposed to monotherapy and dual therapy in the private sector. He is currently improving on this regimen. We are working on adherence in the other 11 patients with viral loads above 100 000 copies/ml and a final decision on resistance still has to be taken. All 72 patients with loads below 10 000 copies/ml are doing well.

Three patients on nevirapine were changed to efavirenz. One patient on lopinavir/ritonavir was changed to efavirenz, and 1

patient on nevirapine to lopinavir/ritonavir. No changes were made to the nucleoside reverse transcriptase inhibitors.

One of the 9 deaths was probably caused by AZT bone marrow suppression. This patient was placed on AZT because of a severe HIV encephalopathy. Three of the deaths occurred in the first month after treatment was commenced, and 2 deaths 6 months after triple therapy was started. These 2 patients both suffered from cardiomyopathy.

It took us only 6 months to add another 100 patients to our treatment register, and by May 2005 we had started 232 children in the Northern Cape on highly active antiretroviral therapy.

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Better ultrasound service, less misguided litigation

To the Editor: The 2005 *Doctors' Billing Manual* recommends that in pregnancy two ultrasound examinations should be paid for by medical schemes. The first (of two) should be done 'preferably at 10 to 14 weeks gestational age, to include Nuchal Translucency Assessment (NTT) (tariff code 3615) and the second at '20 to 24 weeks, to include detailed anatomical assessment' (tariff code 3617). Only if 'an abnormality is suspected, such as ectopic pregnancy, abortion or a discrepancy in dates vs. size' can tariff code 5106 be used. It should *not* be used to see if the pregnancy is *normal*.

But how can the doctor reasonably be expected to reassure the patient that all is well at the first visit, which usually happens at 6 - 9 weeks, without making use of ultrasound? Obviously some doctors may pretend to 'suspect' something is wrong and may use/abuse this tariff code (i.e. this particular tariff code is therefore open to abuse, or let's call it petty fraud). It is also true that the patient's first visit at 6 - 9 weeks is her most exciting, her most important and intimate visit from a personal point of view. That is the visit where she wants to know if the fetus is in the right position, whether it is a singleton or multiple pregnancy, and if 'everything looks normal'. This is especially true with the infertility patient. To deny her an ultrasound scan at this stage seems unreasonable, and also puts the doctor at increased risk of litigation ('Could you not have diagnosed the molar pregnancy earlier, doc?', for example). I therefore suggest that a routine *early* 'reassurance' scan at the present tariff (5106) be negotiated with the medical aids, in addition to the two scans already allowed.

Table I. Outcome after at least 6 months on treatment

Outcome	Number
< 400 copies/ml	67
400 - 999 copies/ml	2
1 000 - 9 999 copies/ml	3
10 000 - 99 999 copies/ml	9
100 000 - 999 999 copies/ml	3
Lost to follow-up	3
Treatment stopped	3
Patient transferred	1
Patient died	9



Furthermore, the best time for a reliable NTT is at 13 - 14 weeks, not at 10, 11 or 12 weeks as suggested in the tariff book. The NTT is a specialised ultrasound 'procedure' in its own right, and therefore time-consuming, and a high degree of technical skill and exactness is required. It is therefore unfair to squeeze the NTT assessment in as part of a tight-budget, all-in-mixed-bag scan programme, designed to fit the medical aid purse. NTT and the relevant risk assessment programme carries a high medico-legal risk, and if done incorrectly, the consequences in terms of litigation can be very costly, not to mention the consequences for the fetus. If an ordinary 'office gynaecologist' has any doubts about the NTT measurement he should then have free access to the super-experts, without feeling intimidated by medical aid restrictions. I also feel that the super-experts who have spent a lot of extra time and money super-specialising, who carry the eventual responsibility, who invest in superior equipment and who make a living out of fetal assessment, must be remunerated on a separate, higher scale of payment, if they work on referral from other specialists only.

In summary, I feel that the early, first-visit scan is a very important diagnostic procedure, both from the litigation *and*

maternal reassurance points of view, which after all is only human. Tariff code 5106 should therefore be 'allowed' as a routine first-visit procedure, and not only where there are complications. We can't send all patients for super-specialist opinion, so the ordinary office gynaecologist should serve as the screening agent, but cannot be expected to do so for free. Super-specialists in early fetal assessment (including NTT, early genetic screening, and detailed anatomical assessment at 24 weeks) should be freely available for second opinion and should be reimbursed appropriately, on a significantly higher scale. Most patients nowadays have access to the Internet. There is therefore increasing awareness as well as a growing demand for more specialised ultrasound assessment at earlier stages of the pregnancy. Failure to provide such is a common cause of massive lawsuits, unfortunately often misguided. I am pleading for a more realistic fee structure to improve ultrasound services in early pregnancy, which will hopefully eventually impact positively on our sky-high insurance premiums.

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