KwaZulu-Natal. Funders will have to assume responsibility for morbidity and mortality of patients with meningococcal septicaemia for whom they choose to deny treatment with DroAA.

DroAA has been used in South Africa to treat patients with severe sepsis who are potentially salvageable but failing to improve or deteriorating despite best supportive care. The proviso that patients be deteriorating is a pragmatic stance taken by intensivists in South Africa to make sure that only the most deserving patients receive the agent. These patients are also required to meet the inclusion and exclusion criteria for the PROWESS trial.[4] Best supportive care will include appropriate source control and inotropes, lung protective ventilation, insulin and steroids as appropriate, nutrition, infection control, appropriate antibiotics and high-quality nursing care.[5] This care is best supervised by an intensivist. Despite the assertion of Taylor and Burns that there is a shortage of intensivists in South Africa, the undersigned all provide intensivist services in private hospitals throughout South Africa. We do not only care for our own patients but are available to provide advice to non-intensivist colleagues. We are all deeply aware of the impact that excessive and inappropriate use of DroAA will have on funders such as Medscheme. However, the fear of this use has not been borne out by clinical practice under intensivist supervision. None of the undersigned has treated more than three patients with APC since its release 8 months ago. Given the cost of other interventions such as cancer chemotherapy and coronary bypass surgery this hardly seems excessive or likely to impact significantly on Medscheme's ability to provide care for its beneficiaries. We would like to appeal to Medscheme and other funders that DroAA not be withheld from patients deemed appropriate by intensivists.

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Nocturnal enuresis guidelines

To the Editor. The authors and Ferring are to be congratulated on their efforts in producing a useful document to aid practitioners in the management of nocturnal enuresis and to publicise the fact that treatment is widely available.[1]

However, I feel it is inappropriate to condemn the use of tricyclic antidepressants in the treatment of this condition. Caution is understandable, but in my 15 years of treating a large number of enuretic children at Red Cross War Memorial Children's Hospital and in private practice in Cape Town, I have yet to come across a serious, irreversible side-effect related to the use of these drugs. It is true that side-effects do occur, and patients have to be counselled. It is also true that overdosage with desmopressin (DDAVP) can result in fluid overload and hyponatraemia, a potentially lethal side-effect.

One side-effect of DDAVP compared with imipramine, which the authors did not mention, is that of impoverishment. I surveyed three local pharmacies and found the average price of a month's supply of DDAVP 0.2 mg tablets to be R710.92 compared with R105.00 for Tofranil 25 mg and R29.26 for an imipramine generic. Most families would find it difficult to find R700 per month to spend on treatment of what is, in the authors' own words, a non-lethal disorder, even for a limited period.

Concerning the enuresis alarm, it is my experience that while this certainly is the best treatment, its use requires remarkable dedication on the part of the parents and the child as well as a degree of insight, understanding and acceptance of the condition that unfortunately does not exist in all families. Many parents are still of opinion that enuresis is caused by laziness or naughtiness, and a harsh and disciplinarian attitude is adopted.

Imipramine increases functional bladder capacity and improves arousal from sleep in response to a full bladder, two of the three components of the three-part model of enuresis presented by the authors. It is not a perfect drug, but it nevertheless deserves a place in the management of monosymptomatic nocturnal enuresis in South Africa.

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