



HAART for hospital workers

Kerry Uebel and colleagues (p. 423) have taken a bold step in introducing an antiretroviral (ARV) programme for staff at McCord Hospital, KwaZulu-Natal. The hospital previously offered a comprehensive package of prevention, treatment and care for patients with HIV/AIDS, but not for staff. As a result few staff had come forward to be tested or for treatment even when sick. In fact 4 female staff members died of AIDS in the hospital and all were afraid of being tested or identified as being HIV-positive.

The response was to introduce an ARV programme for staff members that addressed specific issues that were the main reasons for the continuing fear, stigma and denial surrounding staff HIV infection. An important component of this was locating HIV services within the existing staff clinic, rather than having it as a separate entity.

The response to the programme, which has been in place since November 2001, is good as measured by the number of staff tested for HIV, having CD4 counts and going onto TB prophylaxis and starting ARV therapy. This also emphasises the importance of treatment in any comprehensive HIV programme. As the authors point out, offering HIV care and treatment to staff is humane, feasible and cost-effective and represents an important entry point for the use of ARV therapy.

Sedation in dying patients

Palliative care is still a sadly neglected area of medicine, and there is plenty of misunderstanding about the role of sedation at the end of life. David Cameron and colleagues (p. 445) use experience at Sungardens Hospice to look objectively at the use of sedation to relieve refractory symptoms in dying patients.

There is apparently wide variation in the prevalence of sedation at the end of life, generally due to differences in definitions and application. An important aspect of this is the relatively widely held view that sedation of dying patients is effectively 'slow euthanasia'. Cameron *et al.* feel that that internationally accepted and recognised guidelines for sedation are necessary.

Interestingly, they cite several studies that show that sedation of patients with advanced cancer does not necessarily mean shortening their lives, and this was my experience when working in radiotherapy at Groote Schuur some years ago. The main reasons for sedation in this study were refractory delirium and dyspnoea, along with nausea and vomiting.

The controversy surrounding fluids and food at the end of life is also explored in the paper. Parenteral fluids are seldom used at Sungardens Hospice, and most patients stop eating and drinking during the last few days of life with no apparent discomfort.

Pain and AIDS

Pain, it appears, is the worst symptom of advanced HIV disease. And the pain appears in syndromes along with some unique and challenging symptoms, according to Norval (p. 450). As she points out, most of the literature in South Africa focuses on the potential use of ARV drugs, prevention of mother-to-child transmission and the government's policies, or lack thereof, surrounding the virus. But AIDS, once developed, is often a disease that needs palliation for symptoms such as pain, cough, dyspnoea, diarrhoea, anorexia, nausea, pruritus or malaise. In my experience palliation is too often thought of as something for 'cancer patients' and not for other distressing and not always terminal diseases, and Norval bears this out in the article. As she says, symptom control is a vital part of the management of AIDS patients, who, even with ARVs, are likely to experience severe illnesses.

Another important point made is that palliative care includes the active treatment of reversible conditions and opportunistic infections. The paper gives a good analysis of the main pain syndromes associated with advanced HIV infection, showing that pain itself is the most prevalent symptom, and the lower limbs the most common source of pain. This was a result of HIV-related peripheral neuropathy. In this study, the mean number of symptoms experienced by AIDS patients was 9, a considerable burden to the patient and a challenge to the doctor.

Improving the quality of diabetic care

As type 2 diabetes increases in incidence and prevalence around the world and in South Africa, it is becoming increasingly important to understand the effective management of these patients. A study by van Zyl and Rheeder (p. 455) shows that educating doctors is one of the best ways to improve the quality of this care. Numerous clinical guidelines for managing diabetes have been compiled and circulated to health care workers, according to the authors, but the general standard of diabetic care is still suboptimal.

This study shows how a structured consultation schedule and doctor training programme, which included an audit of patient records, improved the main outcome measure of the study, namely the HbA_{1c} value. It is pointed out that this improved quality of care means spending a little longer with the patient, surely a small price to pay for a healthier patient population.

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