better in the breast-fed arm, significantly so in the first 6 months. The cardinal point to remember is that these similarities in outcome, and the nutritional benefit of breast-feeding, occurred after 24 months (median duration of breast-feeding 17 months), when the HIV infection rate in the breast-feeding arm was a whopping 37% compared with 21% in the formula arm. Accordingly breast-feeding over this prolonged period remained effective for these outcomes despite the very high HIV infection rate; the obvious answer is to reduce HIV transmission through breast-feeding while retaining its advantages! Six months provides adequate benefits of breast-feeding, and the transmission risk of HIV is at worst about 5% (the latter is from a meta-analysis of nine African trials involving 4 085 children).[4] If our group's hypothesis is correct this figure may be even lower with exclusive breast-feeding.

What is critical to the thrust of this letter is that in the Nairobi trial all women 'had access to potable water, extensive health education regarding safe preparation of formula, a reliable supply of formula, and access to medical care for their infants'. So breast-feeding stood up to comparison with formula in a developing country setting, which is as good as it can get for minimising the disadvantages of formula.

There are other examples of breast-feeding in urban environments. In Durban and Harare (an extremely large trial) studies are detecting substantial benefits in children of HIV-infected mothers who breast-feed in preference to formula-feeding.

We have to promote solutions that are not abstracted from this continent's priorities and that respect the durability and strength of African traditions; breast-feeding is more than just about infant feeding, it affirms a wider public good.

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Auto-antibody testing in obstetric patients

To the Editor: We read with interest the article by Afman *et al*.[1] on the relationship of auto-antibodies and obstetric outcome in a tertiary high-risk obstetric unit. In our view the lack of an association between antinuclear antibodies (ANAs) and adverse pregnancy outcome may be due to a fundamental error in interpretation of the ANA results. The authors have grouped the 33 true ANA-positive patients with the 13 patients who had only an anti-cytoplasmic pattern on indirect immunofluorescence (IIF) testing. The latter staining pattern is a 'by-product' of the IIF test using HEp-2 cells, and in this study is likely to be due to anti-parietal and anti-smooth muscle antibodies that were presumably confirmed on tissue substrate (method not given in paper). By definition, antibodies directed at cytoplasmic components cannot be considered to be ANAs. Hence, the comparison should have been between the 33 true ANA- positive patients and relevant control patients. A secondary issue is that negative IIF does not rule out the presence of anti-Ro antibodies even when HEp-2 cells are used as substrate. Anti-Ro antibodies are highly associated with the rare event of neonatal lupus and need to be sought by other methods if there is any suspicion of this condition.

Secondly, it would have been helpful to know the total number of patients in the two groups who were HIV-positive, and the frequencies of the respective auto-antibodies. We also note the finding that anticardiolipin (ACL) antibodies were more frequent in women with severe pre-eclampsia. In a previous study based on our own experience in a routine antenatal clinic, ACL antibodies were poorly predictive for pre-eclampsia,[2] so the test may be more useful where there is a higher pretest risk of an associated event. Finally, we feel the title of the paper is not an accurate reflection of the study. ACL antibodies are not directed against nuclear antigens. 'Auto-antibody testing in obstetric patients' might be a more accurate title and a better reflection of the nature of the study.

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Pressure chamber explosion — Southern African Underwater and Hyperbaric Medical Association statement

To the Editor: Members of the Southern African Underwater and Hyperbaric Medical Association (SAUHMA), a special interest group of the South African Medical Association, were shocked to learn of the death of the Eloff brothers when a chamber they apparently built and used exploded, killing

them both. A third member of the family was injured, and there was extensive damage to property.

In brief, hyperbaric oxygen (HBO) therapy uses oxygen under pressure in a chamber in a well-controlled manner as a primary or adjunctive treatment for a number of recognised medical and surgical conditions.

SAUHMA's executive and its members have received a number of calls from concerned patients currently undergoing HBO therapy at recognised and certified treatment facilities. Patients and relatives are naturally concerned about their own safety after the terrible event.

Any avoidable accident that involves loss of life, injury, or damage to property is indeed a tragic occurrence.

Worldwide accidents involving pressure vessels are rare. While the facts of this case are not yet understood, or in fact even known, SAUHMA is able to provide the assurance that, provided the basic rules pertaining to hyperbaric equipment are adhered to, hyperbaric medicine is and will remain a safe and well-controlled form of treatment.

The authorities in South Africa have provided us with modern and relevant legislation and standards that govern and guide the use of any potentially lethal or dangerous gas containers.

The Occupational Health and Safety Act (Act No. 85 of 1993) and the Vessels under Pressure Regulations incorporated therein contain a clear blueprint of the duties and responsibilities of all the parties, viz. the users, manufacturers and suppliers. Once can read up on the matter using the link **http://www.labourwise.co.za/laws/Safety.PressureVessels.htm #Design** which is offered free of charge. In addition, we have an SABS Code of Practice (SANS 0377-1) for Pressure Vessels for Human Occupancy, and since 1999 we have had the SAUHMA Risk Assessment Guide which provides guidance for medical practitioners, operational staff and anyone tasked with the responsibility of ensuring that a facility is safe. All these documents are clear, appropriate and cover all the aspects of concern, and all of them have been compiled by people with a wealth of practical experience.

Safety is, of course, only partly ensured by a chamber being built in compliance with rules and regulations; it is essential that those operating and maintaining the equipment are trained, experienced and competent to do so. This is all well described within our legislation.

We do not lack for clear or relevant guidance in our country. Based on over 80 years of relevant experience from around the world, nowhere has any compliant facility ever seen the effects

that this horrific accident have brought home to us. What we do need to realise though, is that we have to understand the risks involved and therefore perform our duties in such a way as to minimise, remove or at least contain these risks if we are to be truly safe. Safety is vitally important and understanding is the key.

We earnestly appeal to all people contemplating the use of HBO to ensure three things before entering any chamber: (*i*) ensure that HBO is, in fact, medically indicated and advisable for the particular illness or condition; (*ii*) ensure that the chamber is tested, licensed and approved by the Department of Labour and that such approval is up to date; and (*iii*) ensure that the chamber personnel and operators are fully trained and registered in medical HBO administration.

SAUHMA is always very willing to offer expert advice and help to anyone who might need assistance with regard to HBO and its medically approved indications Simply contact us through Divers Alert Network (DAN) at (011) 254-1991/2. SAUHMA also has in its members a wealth of expertise and we would gladly assist the authorities with their investigation of the incident.

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Psychopathology and coping in recently diagnosed HIV/AIDS patients — the role of gender

To the Editor: Olley *et al.*[1] provide valuable insight into the burden of mental illness among patients with HIV/AIDS and make useful recommendations. However, there is no evidence to support the hypothesis that 'women with HIV/AIDS may face greater stigmatisation'. Stigma is a complex concept and confounds the relationship between HIV and mental illness. Olley *et al*.[1] offer no measure or indication of 'high levels of stigmatisation and stress faced by HIV/AIDS patients in South Africa'. Berger *et al*.[2] have recently validated an HIV stigma scale, which would have provided valuable information in this sample.

The reliability of assessing sexual risk behaviour in a single interview using an adapted scale is questionable. Gender differences in HIV infection in this sample and the general population indicate that it is women who are more at risk of HIV infection. There is a larger body of evidence to support the claim that women are more likely than men to 'exchange sex for drugs and money'.[3] Social inequality and poverty are the factors responsible for women's vulnerability to HIV infection.[4] This contradicts the assertion that men 'exchange sex for drugs and money'.[1] Scales and other psychometric tests can improve qualitative research. However Barbour[5] warns that 'overzealous and uncritical use can be counterproductive'.[5] Its inappropriate use will threaten construct validity. This, in addition to the selection bias, may have contributed to the inability to detect gender differences in this sample.

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Tariff relativity

To the Editor: It is most unusual to find in one journal, two writers with whom I served on Federal Council. With Dougie Gurnell we put together the Tariff for GPs. René le Roex was Chairman of the CCCP, of which I was a member. Both wrote in the April issue of the *SAMJ*,[1,2] and it is to René's article that I refer.[2] He makes no mention of all the effort we put into maintaining the relativity between the various disciplines, which had been established by several Commissions. I wrote to the Commissioner of the Competition Commission and said that their policy would eliminate the above relativity and create chaos. This is precisely what has happened as each group now negotiates its own tariff with the various Administrators and relativity has gone down the plughole.

All those years of effort are being wasted in this new era where medicine has become a business, no longer a calling, and certainly no longer fun. It used to be a pleasure to take on a family and live with them, at least through their health troubles, visiting them in their homes, when necessary even at night. All gone — now it appears to be survival with no concern but for oneself.

Maybe the bad old days weren't so bad after all, despite the advent of third party payers.

I only hope our profession survives.

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