'exchange sex for drugs and money', and seems to suggest that the use of quantitative scales was inappropriate in this study. We agree with the truism that quantitative research has its limitations, and that behavioural scales should be used with due caution. We would, however, emphasise that given that HIV/AIDS is currently the most important contributor to South Africa's burden of disease, quantitative research to ascertain its behavioral antecedents, associations, and consequences is of paramount importance. Such antecedents undoubtedly include transactional sex between men and women.[4] The instruments used in our study were appropriate for its focused objectives, although future work to provide additional information on their psychometrics in the local context would certainly be valuable.

This is an opportune time to correct an error in the paper — the Brief Cope was described as a 12-scale measure, but is in fact a 14-scale instrument.

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Ventricular fibrillation in a clinically normal heart

To the Editor: The recent scientific letter by Stanley[1] reports on an interesting case of idiopathic electrical cardiac disorder — ventricular fibrillation — in a patient with normal heart anatomy and haemodynamic functions. Idiopathic (or 'primary') ventricular fibrillation remains an enigma although over the last decades significant advances have been made in understanding the causes and mechanisms in some subgroups of patients.[2]

Brugada syndrome is one of the conditions recently recognised and defined at clinical and cellular levels. Polymorphic ventricular tachycardia or fibrillation in patients with Brugada syndrome who have normal heart anatomy is initiated by so-called phase 2 (of monophasic action potential) re-entry among different layers of myocardium (epi-, mid-, and endocardial), which occurs due to an abnormal function of cellular membrane sodium channel SNCA5.[3]

Unfortunately, the diagnosis of Brugada syndrome in the reported patient is based solely on surface ECG patterns that are equivocal. There is no real ST-segment elevation in right precordial leads and the partial right bundle-branch block has a narrow r' wave while the typical r' wave should be wider and part of a saddle-back pattern (www.crtia.be). The surface electrocardiogram in Brugada syndrome can be variable; therefore, pharmacological testing using class I antiarrhythmic drugs is recommended to uncover or highlight abnormal patterns. In the presented case, neither pharmacological nor genetic testing was performed. The easy induction of ventricular fibrillation during electrophysiological study was also a nonspecific finding possibly suggesting an electrical vulnerability but not confirming the diagnosis of Brugada syndrome.

In conclusion, Stanley presents an interesting case of idiopathic ventricular fibrillation that was appropriately managed by implantation of a cardioverter/defibrillator, and that underlines the significance of ICD for secondary prevention in cardiac arrest survivors and in patients with symptomatic ventricular tachycardias.[4]

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Traditional formulary?

To the Editor: I see the HPCSA wants to register traditional healers, thereby ensuring better control and that medical aids will then also pay for their services. I wonder, will they be able to dispense traditional medicines as they have done for many years, and will these medicines be specified in a formulary? If they are allowed to dispense medicines, why is this different from Western-trained doctors?

I would be interested to hear what other doctors think. By the way, I am not a dispensing doctor.

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